AFTER BABY M:
THE LEGAL, ETHICAL AND SOCIAL DIMENSIONS OF SURROGACY

State of New Jersey

A Publication of the New Jersey Commission
on Legal and Ethical Problems
in the Delivery of Health Care

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James J. Florio, Governor

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and efforts in the publication of this report.

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September 23, 1992

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The Honorable Garabed Haytaian
Speaker, New Jersey General Assembly
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The Honorable Donald T. DiFrancesco
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The Honorable Robert N. Wilentz
Chief Justice of the Supreme Court
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Dear Governor Florio, President DiFrancesco, Speaker Haytaian, and Chief Justice Wilentz:

On behalf of the New Jersey Bioethics Commission and its special Task Force on New Reproductive Practices it is our privilege to provide a copy of the Commission's publication, *After Baby M: The Legal, Ethical And Social Dimensions of Surrogacy.*

The Commission, created by the Legislature in 1985, was mandated to study the difficult ethical and legal dilemmas posed by modern advances in science and medicine and on the basis of its findings to make recommendations to the Legislature, the Governor and the citizens of New Jersey. This report contains a comprehensive and current account of the Commission's deliberations and recommendations in the nascent field of new reproductive practices in general and surrogate propagation in particular. This analysis was born of the belief that the goal of developing sound public policy and law anent surrogacy is best achieved by careful examination of the basic principles, emerging value conflicts, fundamental questions and existing consensus surrounding surrogate reproduction. This report contains an in-depth discussion of the medical, social, ethical and legal concerns which inform and animate the Commission's and Task Force's new reproductive recommendations.

All at the Commission have asked us to express the sentiments of pride and privilege in present and past service to you and your colleagues and the hope that we have successfully fulfilled your important and challenging legislative mandate.

Very Truly Yours,

Paul W. Armstrong

(P. W. Armstrong)
Chairman

Sister Jane Frances Brady
Vice-Chairman

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The Commission has the statutory authority to empanel advisory ad hoc Task Forces to provide additional experience and expertise in the study of particular bioethical issues and to develop policy recommendations for the Commission's consideration. In the aftermath of the celebrated New Jersey decision *In the Matter of Baby M*,[2] the Commission established the Task Force on New Reproductive Practices. The Task Force's charge was to respond to the New Jersey Supreme Court's invitation in *Baby M* to explore society's "values and objectives...in this troubling, yet promising, area",[3] and to present recommendations for public policy to the full Commission. As a matter of both statutory requirement and Commission policy, the Commission retains final authority and responsibility for recommendations forwarded to the Governor and the Legislature.

This report on surrogacy is issued jointly by the New Jersey Bioethics Commission and its Task Force on New Reproductive Practices. The Commission wishes to express its sincere appreciation to all members of the Task Force for their commitment, dedication and extremely thoughtful work over the course of more than two years of study.

The Task Force on New Reproductive Practices

The Task Force on New Reproductive Practices was created in 1987 and began its deliberations in March 1988, immediately following the New Jersey Supreme Court's decision in *Baby M*. The Task Force initially comprised 19 members, 5 of whom were also Commission members. In addition, the Commission's Chair and Vice-Chair sit *ex officio*.* The Task Force's membership was designed to reflect a broad spectrum of experience and perspectives with individuals selected for their professional expertise in areas related to surrogacy and other of the new reproductive practices, such as medicine, reproductive and molecular biology, public health, clinical and developmental psychology, social work, family law, adoption, women's rights, theology and philosophy. The Commission's charge to the Task Force was to focus on the overall implications of the new reproductive technology, commencing with a report on surrogacy.

* A list of Task Force members and capsule biographies appears in Table 3 of the Appendix.

The Task Force met on a total of more than 20 occasions bet March of 1988 and September of 1990, including 5 joint meetings the full Commission.* Consistent with the Commission's commitme conducting all of its deliberations in public, and sensitive to the ran views and perspectives on surrogacy reflected in our pluralistic soc all Task Force meetings were open to the public and were regu reported in New Jersey's print media.

The Task Force's approach to its work was from the begin guided by the legislative mandate to provide a "comprehensive scholarly examination" of the issues surrounding surrogacy. Follo an initial presentation by one of the nation's leading scholars[4] and formation of a distinguished and diverse Task Force, the Task Forc upon an extended process of self and public education, deliber refraining from discussing ultimate policy issues until all members c participate in a common learning process and speak from a shared of knowledge and experience. During this early stage, the Task F studied the historical, legal and social context of surrogacy. examination included exploring the social and psychological implicat arising from the new reproductive practices; analyzing the New Je Supreme Court's opinion in the *Baby M* case; reviewing report several influential study commissions, both in the United States internationally; examining the medical and psycho-social aspect infertility; reviewing existing law, policy and practice relating to adop in New Jersey; and examining theological views and feminist perspect on surrogacy. In addition to attending regular meetings, Task F members were provided with comprehensive and wide-ranging rea materials drawn from scholarly literature, other study commissi legislative proposals, commissioned papers, staff presentations, presentations by Task Force members and invited speakers.**

This process of self and public education was further exten during a public hearing, held jointly by the Task Force and Commission in May 1988. At this public hearing, testimony received from a range of individuals, including the attorneys involve

* A list of Task Force meetings appears in Table 4 of the Appendix.

** A list of consultants and invited speakers who contributed to the Commission and Force study of surrogacy appears in Table 5 of the Appendix.

the *Baby M* case, the director of a surrogacy center, feminists with contrasting perspectives on surrogacy, legal scholars, persons working in the adoption field, individuals with personal or professional experience relating to the social and psychological problems surrounding infertility, and individuals representing various theological and community perspectives."

Following this initial learning process, the Task Force's work moved into a second stage, in which questions of social policy, ethics, and increasingly, the role of law, came to the fore. During this period, the Task Force sought to achieve consensus both on an overall approach to surrogacy and on the resolution of particular policy questions. The Task Force also heard reports from staff members who had visited a number of surrogacy centers located outside New Jersey.

In the third stage of the project, the Task Force's meetings focused on the formulation of specific policy recommendations and on the legal and policy issues underlying these conclusions. Following closure of Task Force deliberations, the Task Force's conclusions and recommendations were presented to and discussed with the full Commission over the course of several joint meetings. Some minor amendments to the original recommendations were incorporated and jointly adopted by the Commission and Task Force.

In sum, the policy recommendations reflect a conclusion that there should be a strong public policy discouraging surrogacy and that legislation should be enacted which, *inter alia*, prohibits commercial surrogacy; renders illegal and unenforceable the contractual provisions of a commercial surrogacy agreement; renders unenforceable the contractual provisions of a non-commercial surrogacy agreement; and provides an initial presumption in favor of the birth mother in the case of a custody dispute. The policy recommendations and their underlying rationale are summarized below.

" A list of the witnesses who testified at the public hearing is provided in Table 6 of the Appendix.

Defining Surrogacy

The prototypical surrogacy arrangement, such as occurred in the *Baby M* case, can be described as follows: a man and a woman (not his wife or sexual partner) contract with each other to produce a child who, although genetically related to both, will be reared by the man and his wife. In essence, the birth mother (the so-called "surrogate")" agrees to be artificially inseminated with the man's sperm, gestate the fetus and carry it to term, give birth, transfer the child to his or her natural father and his wife, and relinquish her own parental rights. The purpose of the arrangement is to allow a couple, which (most often) includes an infertile female partner, to have a child who will be genetically related to at least one of them -- the male partner.

While this description conforms to the familiar model of surrogacy, it should be noted that many variants exist. A working definition of the scope of the practice should encompass the range of reproductive possibilities currently available and those imaginable in the near future, in particular the less conventional "gestational" surrogacy. Gestational surrogacy may be considered when the wife of the couple intending to rear the child is able to produce viable eggs but is unable to carry a pregnancy to term without risk to her health or the health of the fetus. In this arrangement, an ovum is extracted from the wife (or in other variants, from another egg donor). The ovum is fertilized outside the woman's body *in vitro* (literally, "in glass") with the husband's sperm, and the resulting embryo is then transferred and implanted into the uterus of the birth mother who carries it to term and gives birth. The child is thus genetically related to both members of the couple and is not genetically related to the birth mother whose reproductive role is purely gestational. Though at present used relatively rarely due to the high medical cost and comparatively low success rate of the *in vitro* fertilization technique, where permitted by law gestational surrogacy may be expected to increase in the future.

" The Commission and Task Force find that the term "surrogate" is troublesome and somewhat of a misnomer. Throughout this report, the term "surrogate" is avoided, and instead the phrase "so-called 'surrogate'" or "birth mother" is used to describe the woman who is pregnant and gives birth.

The Commission and Task Force have adopted and recommend for purposes of public policy the following definition of "surrogacy":

> **"Surrogacy" means an arrangement, whether or not embodied in a formal contract, entered into by two or more persons, including but not limited to the birth mother (the so-called "surrogate") and an intended rearing parent or parents, who agree, prior to insemination (or, in the case of an implanted embryo, prior to implantation) to participate in the creation of a child, with the intention that the child will be reared as the child of one of the parents, who is not the birth mother. Under this definition, "birth mother" refers to a person who bears a child, whether or not that person is a genetic parent of the child.**

Several features of this definition should be noted. First, it allows for the possibility that the genetic relationship to the child may be achieved through the mother (via donation of her egg and gestation by another woman), as well as, in the more familiar case, through the father. Thus, an arrangement between two women, in which one woman contributes her egg and the other woman bears and gives birth to the child with an intention that the woman with the genetic relationship will rear the child, constitutes "surrogacy."

Second, it is not required that the agreement be embodied in a formal contract, nor even that it be in writing. However, there must be an agreement, and the intention to enter into that agreement must be formed prior to insemination (or, in the case of gestational surrogacy, prior to implantation). The essence of a surrogacy arrangement is the deliberate, planned creation of a child who will be reared by a person or persons other than his or her birth mother. Where the intention is formed "after the fact", the situation does not constitute surrogacy, but rather is an attempt to deal with the consequences of an unwanted, unplanned conception. To be surrogacy, the child must have been conceived for the purpose of being raised by an adult other than the birth mother.

Third, the definition does not distinguish between the means of conception employed, *i.e.*, it encompasses insemination by sexual as well

as artificially assisted means. This conclusion is based on a number c considerations. If the parties have the requisite intention to enter into surrogacy arrangement, it should not matter what means they employ t achieve their end. Objections to the practice of surrogacy generally d not depend upon whether conception takes place naturally or throug artificially assisted means. In addition, defining surrogacy too narrowl to encompass only artificially assisted conception would create a obvious loophole, allowing parties to easily evade the consequences of prohibitive surrogacy law by claiming that conception was by natur means and outside the legal definition. Since normally no witnesses t the conception will be present,* this claim would be easily made Finally, were "surrogacy" limited to conception by artificial means, som intent upon entering the arrangement with all of the requisite features o surrogacy might be encouraged to in fact conceive through natural mean solely for this purpose.

The Commission and Task Force also discussed at length th appropriate policy definition of what constitutes "commercial surrogacy and of who is a "broker/intermediary":

> **"Commercial surrogacy" means a surrogacy arrangement involving (a) the payment, or agreement to pay, money or any valuable consideration to a broker/intermediary; or (b) the payment, or agreement to pay, money or any valuable consideration (other than payment or reimbursement of medical and hospital expenses currently allowable under adoption law) to a birth mother.**

Clearly, the essence of commercial surrogacy is payment to at least on of two parties -- to a birth mother (excluding certain allowable expenses or to a broker/intermediary. Ordinarily, commerical arrangement involve payment to both parties. Focusing again on the intention of the parties, it is not actual payment of money or other consideration, but the agreement to pay which makes a commercial surrogacy arrangement. Ir

* Where the conception occurs by artificial insemination, no third party need be presen as the woman can easily inseminate herself using an instrument no more sophisticated than a turke baster. Obviously, in the case of gestational surrogacy, which involves *in vitro* fertilization, a third party will be present.

fact, conception and pregnancy need not have occurred for a surrogacy arrangement to have been formed.

It should be noted that where a professional involved in a surrogacy arrangement, such as a physician, an attorney, or a psychologist, receives a fee, the arrangement would not constitute commercial surrogacy unless a fee is also received either by the birth mother or by a broker/intermediary. Further, an important distinction should be drawn between professionals who assist in counseling before the contract has been entered into, and professionals who assist in counseling after the parties have undertaken to carry out their agreement. Those professionals who screen women and couples in the commercial context and who are involved in facilitating the agreement likely have a role in the formation and carrying out of a commercial transaction. Such medical or psychological screening differs, however, from participating in counseling of participants after they are already involved in a surrogacy arrangement. Counseling after the fact should not be criminalized nor subject to legal sanction. Nor should a physician's provision of care during the so-called "surrogate's" pregnancy, labor and delivery be characterized as illegal. Any such restrictions would violate understandings of the nature of the professional-patient relationship, including the duty of confidentiality, and would deprive people of professional assistance where it might be needed.

> **"Broker/intermediary" means an individual who, or an agency, association, corporation, partnership, institution, society or organization which, knowingly seeks to introduce or to match a prospective birth mother with a prospective biological father, for the purpose of initiating, assisting or facilitating a commercial surrogacy arrangement.**

The term "broker/intermediary" is defined broadly so as to include both natural and legal persons, *e.g.*, corporations, partnerships, or associations which facilitate surrogacy arrangements.

The Need for a Surrogacy Statute

In the aftermath of *Baby M*, which held that commercial surrogacy violates New Jersey's adoption laws and is illegal, and

"perhaps criminal",[5] it is most unlikely that commercial surrogac arrangements are being formed in New Jersey. The Commission an Task Force are not aware of any persons known to be doing business a broker/intermediaries in the state. Nevertheless, legislation specificall addressing surrogacy would address a number of questions peculiar t surrogacy regarding which current law is either silent or unclear an would promote a number of important policy objectives.

While current adoption law, applied in the *Baby M* case addresses some aspects of surrogacy arrangements, in several importar respects surrogacy differs from adoption, and existing adoption law doe not adequately express the public policy which should govern surrogacy First, whether the payment of money in violation of the adoption statute amounts to a criminal offense is unclear. In *Baby M*, the New Jerse Supreme Court left this question open, stating that such payments wer "perhaps criminal."[7] In order to firmly deter the practice of surrogac this matter should be put beyond any doubt with legislation specificall criminalizing commercial surrogacy.

Second, the New Jersey adoption laws do little to discourage th practice of non-commercial surrogacy. In fact, the New Jersey Supreme Court in *Baby M* expressly stated that it found "no offense to our presen laws where a woman voluntarily and without payment agrees to act as a "surrogate" mother, provided that she is not subject to a binding agreement to surrender her child."[8] Stuatory law would be the bes vehicle to discourage non-commercial surrogacy.

Third, adoption statutes contemplate an approach to custody and parental rights which requires some modification in the case o surrogacy. Whereas in adoption the intended rearing parents are uninvolved in the creation of the child, in surrogacy one of the intended rearing parents is the biological father of the child. Thus, in surrogacy a central issue concerns the resolution of custody disputes between the two *biological* parents, an issue which does not arise in the adoption context.

Fourth, a surrogacy statute would specifically address provision of a post-birth waiting period in which the birth mother could decide whether she will relinquish custody. Whereas adoption statutes set forth a procedure to terminate parental rights subsequent to the relinquishment

of custody by the natural parents,[9] surrogacy contracts attempt to bind the so-called "surrogate" prior to conception. A waiting period allows the birth mother an opportunity to reconsider her decision after the birth, maximizing the likelihood that her decision will be informed and voluntary.

Finally, adoption statutes do not address all of the technological complexities and possibilities present in the new reproductive practices, such as the distinguishable roles of "genetic mother" and "gestational mother." As the promise and permutations of the new reproductive practices continue to grow, it may well be increasingly difficult to fit the new practices and technologies into the familiar models supplied by traditional family law concepts. The New Jersey Supreme Court recognized this in urging legislative consideration "to focus on the overall implications of the new reproductive biotechnology."[10]

Therefore, the Commission and Task Force recommend that legislation be enacted to specifically address the practice of surrogacy.

> **The State of New Jersey should enact legislation to discourage the practice of surrogacy and to prohibit its most offensive features. The legislation should, *inter alia*, criminalize commercial surrogacy, render both commercial and non-commercial surrogacy arrangements unenforceable, and govern the determination of parental rights and responsibilities in the event of a disputed surrogacy arrangement, in accordance with the specific recommendations below.**

Commercial And Non-Commercial Surrogacy

Without question, an infertile couple's desire to choose the option of surrogacy in order to found a family is one deserving of substantial respect and appreciation. Those wishing to be parents have a strong desire to raise children, suffer individual pain and marital stress caused by involuntary childlessness, and are confronted with the inadequacy of existing medical solutions for their infertility, as well as the demands and difficulties of the adoption process.[11] For some couples surrogacy is the only available opportunity for parenthood. It is particularly noteworthy that couples now raising children born of surrogacy report deep gratification, and many birth mothers report sincere contentment.[12]

However, the Commission and Task Force believe that surrogacy should not be a legally or socially approved response to infertility. Surrogacy, in particular commercial surrogacy, contravenes important societal values and is potentially harmful to the children of surrogacy, birth mothers, and possibly others as well. In reaching the conclusions and recommendations discussed below, the Commission and Task Force considered at length a wide range of perspectives and arguments on all sides of the issues. It should be noted that Commission and Task Force members are not unanimous in their support of all policy recommendations. Several Commissioners favor a more permissive regulatory approach. All recognize, however, that any social and policy response has its likely costs and benefits, particularly given our limited historical experience with surrogacy.

It is inherent in the nature of surrogacy, whether commercial or non-commercial, that the practice promotes viewing women's reproductive capacities as distinct from, rather than as an integrated part of, their lives. Surrogacy involves the deliberate separation of pregnancy from social parenthood, suggesting that pregnancy ought not be understood as an intimate, personal, and self-defining experience, but as one divorced from full self-involvement, fostering a divided self. Thus, surrogacy challenges our understandings of pregnancy as an integrated, self-expressive experience, and encourages narrow identification of women with pregnancy and reproduction.

The Commission and Task Force also believe that our obligations to future generations counsel that surrogacy, in particular commercial surrogacy, poses risks of psychological and emotional harm to birth mothers and, most importantly, to the children of surrogacy. Here, lessons from our experience with adoption and donor insemination are instructive. Given the infancy of the practice of surrogacy and the paucity of empirical research, however, this conclusion is necessarily speculative. Preventing future harm bolsters, rather than justifies, shared concerns about the nature of surrogacy.

Additional and more profound problems are presented by commercial surrogacy.

Commercial Surrogacy

Although the vast majority of our societal "transactions" occur to varying degrees within the ambit of the marketplace, in some cases judgments about the significance of certain societal goods and values (such as personal relationships) warrant blocking the sale and purchase of those goods through the marketplace. The Commission and Task Force share the view of the New Jersey Supreme Court in *Baby M* that "[t]here are, in a civilized society, some things that money cannot buy."[13] This conclusion rests predominantly on the grounds that commercial surrogacy likely will foster exploitation of women and commodification of women, children, and the reproductive process.

Surrogacy for sale is potentially exploitative of so-called "surrogates" in particular, and of women in general. Here the key issue is whether so-called "surrogates" are coerced or unduly influenced by the offer of money to enter the surrogacy arrangement. The range of personal and subjective judgments about risk taking for a given sum of money, as well as the mixed motives for engaging in commercial surrogacy reported by birth mothers, makes it difficult to objectively define what constitutes an "undue" inducement. What is "exploitative", "coercive", or "undue" is a matter of degree. However, the offer of money is not only likely to be an undue inducement; it is a morally offensive influence upon women who are poor and uneducated, and those who may be unemployed, receiving welfare, and with few or no alternative sources of financial support. Furthermore, though it may be difficult to regard the so-called "surrogate" as being "coerced" by economic circumstances, the "degradation" involved in her role, whether or not she feels personally degraded, constitutes an equally offensive form of exploitation which should not be legally sanctioned.

A free market in surrogacy also threatens to foster a shared perception of women, children, and the parent-child relationship as "commodities" to be traded in the marketplace. Societal or legal acceptance of commercial surrogacy poses a real risk of subtle and progressive transformation of certain social attitudes by which we may come to think about women, children, and procreation in terms of marketability, advertising, pricing, and packaging. Such attitudes devalue the inherent human worth not only of those who participate in surrogacy for pay, but of all of us. Of particular concern is that

children too may come to be viewed, and may be taught to view themselves, as "luxury items" available to those who can afford the price. Treating parental rights as marketable property rights fosters a perception of children as "objects" created or "manufactured" in order to satisfy the needs and desires of the contracting parties. The effects of commodification may implicitly extend as well beyond the surrogacy context to other societal values and practices. Society should not embrace such an ethos.

Therefore, the Commission and Task Force recommend that:

The practice of commercial surrogacy should be illegal.

Given these concerns regarding the commercial element in surrogacy, any contractual provision of a commercial surrogacy arrangement should be not only illegal but also unenforceable. In other words, in addition to the agreement being prohibited by law, neither party should be permitted to rely on the agreement (whether the agreement is formal or informal) to enforce alleged obligations against the other party.

Any commercial surrogacy arrangement or any contractual provisions in connection with a commercial surrogacy arrangement should be both illegal and unenforceable.

A policy designed to prevent an illegal activity requires that the law have the force of sanction behind it. In order to deter the practice of surrogacy in general, and of commercial surrogacy in particular, criminal sanctions should be imposed upon broker/intermediaries and professionals who knowingly participate in commercial surrogacy arrangements. *Broker/intermediaries* should be subject to criminal penalties, with the possibility of incarceration, in the court's discretion. The predominant goal of deterrence warrants imposition of substantial fines. *Professionals*, such as physicians, psychologists, and attorneys who provide services with knowledge that they are participating in an illegal surrogacy arrangement and who are paid for those services should also be subject to the possibility of incarceration (although there should be a presumption in favor of non-incarceration), as well as imposition of fines. The conduct should be deemed to constitute unprofessional

conduct if the matter is referred to a licensing board. As noted above, the law should be careful not to discourage professional counseling and rendering of essential medical services after the surrogacy arrangement has been formed.

Criminal penalties are deemed inappropriate for the *contracting couple* (the biological father and his wife), or the *birth mother*. The object of deterrence is better achieved in other ways, notably by a custody presumption in favor of the birth mother and an obligation of support by the non-custodial parent in case of a dispute (discussed below). A further consideration counseling against criminalization is that the child might be socially and psychologically damaged by the knowledge that the circumstances of his or her birth caused his or her parents to be labelled "criminals." The contracting couple as well as the birth mother who knowingly participate in a commercial surrogacy arrangement should, however, be subject to a civil fine.

Those who knowingly participate in a commercial surrogacy arrangement should be subject to penalties, as follows:

(a) A broker/intermediary should be subject to criminal penalty, including the possibility of incarceration, and a fine.

(b) A professional should be subject to criminal penalty, with a fine imposed. There should be a presumption in favor of non-incarceration. Where the matter is referred to a licensing board, there should be a presumption that the conduct constitutes unprofessional conduct.

(c) The biological father and his spouse should be subject to civil penalties, with a fine.

(d) The birth mother should be subject to civil penalties, with a fine.

These recommendations concerning sanctions are intended to advise the Legislature of the severity of sanctions believed necessary to provide an

appropriately strong deterrent to the practice and to punish those engage in commercial surrogacy arrangements.

Non-Commercial Surrogacy

In the absence of a financial transaction, the serious objectic commercial surrogacy on grounds of exploitation and commodifica should not drive public policy. Nonetheless, non-commercial surro (sometimes called "altruistic" surrogacy) poses sufficient concer warrant discouraging the practice.

Non-commercial surrogacy ordinarily occurs between famil close friends who agree to collaborate in creating a child for a coupl which the wife is unable to conceive or to carry the pregnancy to te As with commercial arrangements, non-commercial surrogacy invol the deliberate separation of pregnancy and parenting (a divided selfho which may diminish, rather than enhance, societal values and percepti regarding the reproductive process and the role of women. Often be an intra-family arrangement, non-commercial surrogacy may pose gre risk of psychological and emotional harm than in the relationship strangers typical of commercial transactions. Constant contact with "t mothers" may create greater stress for the child, the birth mother, other family members. Furthermore, as family arrangements with involvement of broker/intermediaries, non-commercial surrogacy lik occurs without prior counseling, medical screening, or legal advice, perhaps without full articulation of the parties' mutual understandin These factors could work to the detriment of all involved.

The majority of the Commission and Task Force conclude t non-commercial surrogacy agreements should be discouraged, but prohibited, in law and policy. In light of the genuine love a commitment often involved in altruistic reproductive collaboratic society's larger objections to surrogacy do not warrant prohibitic Moreover, the State should not intervene in the private emotional, sexu and reproductive lives of families who wish to collaborate in creating child with the assistance of new reproductive techniques. Intrusion the State in this area carries a high social cost and could set a dangero precedent. Instead, the chief vehicle for discouraging the practice shou be the unenforceability of the agreements if disputes arise, and a

presumption in favor of the birth mother which puts everyone on notice that the birth mother likely will prevail in a custody battle.

Any non-commercial surrogacy arrangement or any contractual provisions in association with a non-commercial surrogacy arrangement should be unenforceable.

When Deterrence Fails: Parental Rights and Responsibilities

The recommended legal regime should do much to discourage the practice of surrogacy, particularly in its commercial form. Yet, the possibility remains that some people will enter into surrogacy arrangements, either formally or informally, and that some children will be born through surrogacy. If the birth mother refuses to relinquish the child, and if the biological father and his wife (and in gestational surrogacy, possibly the genetic mother as well) also seek custody of the child, the competing claims, rights and responsibilities of the various parties must be addressed. Among the most important of these rights and responsibilities are custody, support obligations, and visitation rights.

A Waiting Period

An initial issue is whether the law should give the birth mother a specified period of time (a "waiting period") in which she may decide whether she wishes to retain or to relinquish custody and parental rights. The crafting of a waiting period must balance the interests of the birth mother by giving her an opportunity to make a more informed decision postpartum and after she has physiologically returned to a pre-pregnancy state; of the infant seeking security and stability with minimal detrimental effects of separation from his or her birth mother; and of the contracting couple in need of expeditious resolution that fosters planning for the responsibilities of parenting. A waiting period of 90 days, commencing from birth, properly balances and protects these interests.

The birth mother should be entitled to a waiting period of 90 days from the date of childbirth, to decide whether she wishes to retain or relinquish custody of the child. She should be entitled to physical custody of the child during the 90 day period.

If the birth mother makes known during this 90 day period her intention to keep the child, the court must then resolve the issues of custody, support, and visitation.

Custody

The "best interests of the child" is traditionally the determinative standard for awarding custody following dissolution of marriage. In the context of surrogacy, however, the best interests test is inappropriate. The alternative recommended by the Commission and Task Force is a presumption in favor of awarding custody to the birth mother.

In contrast to the best interests test, which invites lengthy, negative and destructive litigation over comparative parenting capabilities, a legal presumption would minimize delays, uncertainties, and creation of a record of rancor. Of particular note, a presumption in favor of the birth mother would discourage use of class and socioeconomic comparisons and biases, such as were evident in *Baby M* at the trial level. Further, comparative judgments are less relevant here, since the child will be a newborn at the time of litigation and there will be no real record of parenting capabilities (at least not with this child). In surrogacy cases, where the parties are likely to be of different socioeconomic backgrounds, a presumption favoring the birth mother also serves to redress the imbalance of bargaining power that ordinarily advantages the contracting couple in a custody dispute.

Two additional arguments for this approach are most persuasive to the Commission and Task Force. First, a presumption favoring the birth mother would strongly advance the goal of discouraging the practice of surrogacy, while at the same time assuring that if surrogacy arrangements are formed and subsequently contested the basic needs of the child will be met. Second, this approach recognizes that the experience of pregnancy constitutes a substantial physiological (and potentially psycho-social) involvement of the birth mother with the child. The position that a gestational mother's claim should have priority, at least initially, over that of a biological father and a genetic mother reflects the view that the contribution of the gestational mother over a nine month period is substantially greater in degree, and more significant in kind, than the contribution of an individual who only provides gametes.

The custody presumption should not, however, be absolute, and may be overcome under certain circumstances. In the event the birth mother "fails to meet minimal parenting standards necessary to satisfy the basic needs and welfare of the child", as shown by clear and convincing evidence, she should not be awarded custody. This standard for overcoming the presumption measures the capacity of the birth mother to meet the child's basic needs; ensures that the child's interests are adequately protected; and avoids use of "expert" testimony that might indulge biases and prejudices concerning the respective socioeconomic positions of the parties. Recognizing that in contested surrogacy cases a prior and established relationship between the child and both biological parents will not exist, this standard gives greater weight to the child's interests and lesser weight to the non-custodial parent's interests than does the traditional "unfitness" test applied to the involuntary termination of all parental rights.

In the event the birth mother makes known, within 90 days from the date of birth, her intention to retain custody of the child, any dispute over custody and parental rights should be governed by the following:

A legal presumption should be established, favoring custody by the birth mother, consistent with assuring satisfaction of the needs and welfare of the child. This presumption may be overcome by a demonstration, based on clear and convincing evidence, that the individual giving birth fails to meet minimal parenting standards necessary to satisfy the basic needs and welfare of the child. Such determinations should not be based on considerations of economics or social class.

Support Obligations

The Commission and Task Force also conclude that the non-custodial parent in a surrogacy arrangement should be obligated to pay child support. It is well-established under traditional family law principles that generally those who are responsible for bringing a child into the world should also bear responsibility for its welfare, even if they do not have custody. There seems little reason to apply a different rule

to surrogacy cases. Further, the possibility of a legal obligation o support would serve as an additional deterrent to the practice o surrogacy.

Support obligations should not, however, be expressly imposec by law upon the spouse of the non-custodial biological parent, an issue that might arise, for example, in case of death of the non-custodial parent. While support obligations should be determined in accordance with existing law governing support by a non-custodial parent, it would be unfair to specifically burden a spouse, who may have participated reluctantly in the original surrogacy agreement, with continuing financial responsibility for the child to whom he or she has little or no connection. It should be noted that in gestational surrogacy cases in which the birth mother is awarded custody, two biological parents -- the biological father and genetic mother -- may have support obligations. However, a person who merely donates gametes with no expectation or intention of becoming a social parent should not have any financial responsibility toward the child.

The non-custodial parent in a surrogacy arrangement should have an obligation of child support. Contractual disclaimers of support obligations should not be effective in such cases.

Visitation Rights

As stated by the New Jersey Supreme Court in the *Baby M* case, the touchstones of visitation are that it is desirable for the child to have contact with both parents, and that while the parents' interests must also be considered, assuring the best interests of the child is paramount.[14]

Competing psychological theories exist as to the value of shared parenting in cases of marital dissolution or out-of-wedlock birth. While some experts in child psychology argue that the child's interests are best served by allowing him or her the opportunity to maintain contact with all biological parents, others maintain that it may be disruptive and confusing to the child to have that contact, especially if it is contrary to the wishes of the custodial parent. As with current law, in surrogacy cases the law should recognize that a child may have competing interests in psychological stability and in maintaining contact with his or her

biological parent(s), and these interests should be considered and balanced on the facts of the particular case.

In the case of gestational surrogacy, there may be two biological non-custodial parents seeking visitation rights. Whether it is in the child's interests to maintain contact with both biological parents in such a situation would also have to be determined on a case-by-case basis. However, if the genetic parent is a mere gamete donor who never had any expectation or intention of becoming a social parent, he or she should have no visitation rights.

A presumption should be established in favor of visitation rights for the non-custodial parent, unless it is demonstrated that such visitation would be contrary to the best interests of the child. The extent and conditions of visitation should be considered on a case-by-case basis, with due regard for the child's interests both in psychological stability and in the maintenance of contact with the child's biological parents.

Abandonment

In some rare cases, none of the adults involved in the surrogacy arrangement will wish to take custody of or assume responsibility for the resulting child. This may occur, for example, in cases in which the child is born with a severe disability, more than one child is born, a child of an undesired sex is born, or where circumstances in the adults' lives (such as divorce or the death of a partner) make surrogacy and the resulting child no longer desirable.

The Commission and Task Force conclude that existing New Jersey law should govern cases in which the child of surrogacy is abandoned. New Jersey statutory and agency schemes for adoption provide a detailed process by which natural parents can arrange for adoption and terminate custody and parental rights, including placement with a private child care agency licensed to practice in New Jersey, with the Division of Youth and Family Services (DYFS), or directly with a family as a private placement adoption. There is no distinguishing feature of surrogacy that warrants a different approach.

In cases of abandonment, since both biological parents in surrogacy arrangement have participated in bringing the child into th world, both should bear financial responsibility for the child, i accordance with their respective financial abilities, until the adoptio becomes final. These financial responsibilities would protect the interest of children and further deter the practice of surrogacy. If the combine financial abilities of the biological parents are insufficient to support th child, the State should supplement the financial need. A child born of surrogacy arrangement is as entitled to an opportunity for a stable an caring home as is any other child and should not be penalized because hi or her parents engaged in an illegal or disfavored arrangement. This approach to financial support is consistent with existing law and practice in contexts other than surrogacy.

In the event neither the intended rearing parents nor the birth mother are willing or able to assume custody of the child, the child should be placed for adoption in accordance with existing law. Until such time as adoption is final, both the intended rearing parents and the birth mother should be obligated to provide appropriate financial support for the child, in accordance with their respective financial abilities.

Finally, a comprehensive approach should anticipate the repudiation of the agreement by one or both parties, either prior to or after birth. The central issue here is who will bear responsibility for the costs of medical and hospital expenses. The Commission and Task Force believe that these costs should be paid by the intended rearing parents regardless of the fact that the contract is unenforceable.

When a surrogacy arrangement is repudiated by either party, the birth mother should be entitled to medical and hospital expenses to be paid by the intended rearing parents, as currently allowable under adoption law, even though the surrogacy arrangement is unenforceable. Any expenses other than medical and hospital expenses currently allowable under adoption law should not be the responsibility of the intended rearing parents.

Multi-State Arrangements

Currently fifteen states have addressed the practice of surrogacy in their statutory law. Only a few states are hospitable to the practice, although those states whose laws are silent might be viewed as permissive by those interested in a surrogacy arrangement. Disparities among state laws may invite "forum shopping", *i.e.*, attempts to evade the strictures of New Jersey law and to take advantage of the law elsewhere. For example, a New Jersey couple might seek a so-called "surrogate" from another more hospitable state, and might seek to build additional connections to the more permissive forum by entering into the agreement, performing the insemination procedure, or effecting the transfer of custody there. Or, New Jersey residents might travel out of state to form and carry out a surrogacy arrangement.

New Jersey has a strong interest in having its law and public policy applied to the resolution of disputed surrogacy arrangements involving its own citizens, in particular prohibiting commercial transactions, assuring that any agreement is unenforceable, and resolving custody disputes, support and visitation. When a choice of law question arises in cases before the New Jersey courts, New Jersey law should be applied (consistent with constitutional notions of fairness, due process, and comity).

In disputed multi-state surrogacy arrangements within the jurisdiction of the New Jersey courts, New Jersey law should apply.

The recommendations of the Commission and Task Force are set forth in full below.

POLICY RECOMMENDATIONS ON SURROGACY

NEW JERSEY COMMISSION ON LEGAL AND ETH PROBLEMS IN THE DELIVERY OF HEALTH CARE AN TASK FORCE ON NEW REPRODUCTIVE PRACTICES

DEFINITIONS

"Surrogacy" means an arrangement, whether or not embodied in a j contract, entered into by two or more persons, including but not l to the birth mother (the so-called "surrogate") and an intended r parent or parents, who agree, prior to insemination (or, in the case implanted embryo, prior to implantation) to participate in the crea a child, with the intention that the child will be reared as the child of the parents, who is not the birth mother. Under this definition, mother" refers to a person who bears a child, whether or not that p is a genetic parent of the child.

"Commercial surrogacy" means a surrogacy arrangement involvi the payment, or agreement to pay, money or any valuable conside to a broker/intermediary; or (b) the payment, or agreement to pay, r or any valuable consideration (other than payment or reimbursem medical and hospital expenses currently allowable under adoption la a birth mother.

"Broker/intermediary" means an individual who, or an ag association, corporation, partnership, institution, society or organiz which, knowingly seeks to introduce or to match a prospective mother with a prospective biological father, for the purpose of initia assisting or facilitating a commercial surrogacy arrangement.

RECOMMENDATIONS

1. The State of New Jersey should enact legislation to discou the practice of surrogacy and to prohibit its most offensive features. legislation should, inter alia, criminalize commercial surrogacy, re both commercial and non-commercial surrogacy arrange unenforceable, and govern the determination of parental rights responsibilities in the event of a disputed surrogacy arrangemen

accordance with the specific recommendations below.

Commercial Surrogacy

2. The practice of commercial surrogacy should be illegal.

3. Any commercial surrogacy arrangement or any contractual provisions in connection with a commercial surrogacy arrangement should be both illegal and unenforceable.

4. Those who knowingly participate in a commercial surrogacy arrangement should be subject to penalties, as follows:

(a) A broker/intermediary should be subject to criminal penalty, including the possibility of incarceration, and a fine.

(b) A professional should be subject to criminal penalty, with a fine imposed. There should be a presumption in favor of non-incarceration. Where the matter is referred to a licensing board, there should be a presumption that the conduct constitutes unprofessional conduct.

(c) The biological father and his spouse should be subject to civil penalties, with a fine.

(d) The birth mother should be subject to civil penalties, with a fine.

Non-Commercial Surrogacy

5. Any non-commercial surrogacy arrangement or any contractual provisions in connection with a non-commercial surrogacy arrangement should be unenforceable.

When Deterrence Fails: Parental Rights and Responsibilities

6. The birth mother should be entitled to a waiting period of 90 days from the date of childbirth, to decide whether she wishes to retain or relinquish custody of the child. She should be entitled to physical custody of the child during the 90 day period.

7. In the event the birth mother makes known, within 90 days from the date of birth, her intention to retain custody of the child, any dispute over custody and parental rights should be governed by the following:

(a) A legal presumption should be established, favoring custody by the birth mother, consistent with assuring satisfaction of the needs and welfare of the child. This presumption may be overcome by a demonstration, based on clear and convincing evidence, that the individual giving birth fails to meet minimal parenting standards necessary to satisfy the basic needs and welfare of the child. Such determinations should not be based on considerations of economics or social class.

(b) The non-custodial parent in a surrogacy arrangement should have an obligation of child support. Contractual disclaimers of support obligations should not be effective in such cases.

(c) A presumption should be established in favor of visitation rights for the non-custodial parent, unless it is demonstrated that such visitation would be contrary to the best interests of the child. The extent and conditions of visitation should be considered on a case-by-case basis, with due regard for the child's interests both in psychological stability and in the maintenance of contact with the child's biological parents.

(d) In the event neither the intended rearing parents nor the birth mother are willing or able to assume custody of the child, the child should be placed for adoption in accordance with existing law. Until such time as adoption is final, both the intended rearing parents and the birth mother should be obligated to provide appropriate financial support for the child, in accordance with their respective financial abilities.

8. When a surrogacy arrangement is repudiated by either party, the birth mother should be entitled to medical and hospital expenses to be paid by the intended rearing parents, as currently allowable under adoption law, even though the surrogacy arrangement is unenforceable. Any expenses other than medical and hospital expenses currently allowable under adoption law should not be the responsibility of the intended rearing parents.

Multi-State Arrangements

9. When a disputed surrogacy arrangement is within the jurisdiction of the New Jersey courts and involves citizens of or contacts with the state of New Jersey and one or more other states, New Jersey law should apply.

NOTES

1. P. L. 1985, Chapter 363.

2. *In the Matter of Baby M*, 109 N.J. 396, 537 A.2d 1227 (1988), *affirming in part, reversing in part*, 217 N.J. Super. 313, 525 A.2d 1128 (1987).

3. 109 N.J. at 469, 537 A. 2d at 1264.

4. Dr. Jay Katz, professor of law and psychoanalysis at Yale Law School and a leading scholar in bioethics, addressed the full Commission on the subject of reproductive technologies in September of 1987.

5. 109 N.J. at 411, 537 A.2d at 1234.

6. *N.J.S.A.* 9:3-54 (West 1977).

7. 109 N.J. at 411, 537 A.2d at 1234.

8. *Id.* at 411, 537 A.2d at 1235.

9. *See N.J.S.A.* 9:3-41; 9:3-48 (West 1977).

10. 109 N.J. at 469, 537 A.2d at 1264.

11. *See* chapter one for a discussion of psychological, social, and cultural views of parenthood and family; *see* chapter two for discussion of infertility and adoption.

12. *See* chapter three for discussion of the experience of couples and so-called "surrogates."

13. 109 N.J. at 440, 537 A.2d at 1249.

14. *Id.* at 446, 537 A.2d at 1263.

CHAPTER ONE

THE SOCIAL CONTEXT

Formulating public policy on the plethora of new reproductive practices in general, and surrogacy in particular, raises fundamental questions about numerous concepts and values, the meaning and importance of which are often assumed without being carefully examined. For the first time in history, advances in science and medicine now afford individuals a high degree of choice and control about whether, when, and by what means to conceive children. They can also provide considerable information about the characteristics of a fetus or future offspring. By enabling the separation of the genetic, gestational and rearing components of parenthood and by introducing third parties into the procreative process, the new reproductive practices stimulate and perhaps necessitate the exploration of shared understandings about certain important issues, such as the significance of parenthood as a part of adult life, the desirable arrangements in which to raise children, and the role of state law and policy in promoting or constraining individual decisions and actions concerning reproduction. This chapter introduces some diverse views regarding such questions as the parent-child relationship, the family unit, and government's proper role in family life and in individual decisionmaking about procreative choices. These underlying issues are further examined in subsequent chapters of the report.

The goal of providing direction for law and policy in New Jersey is best served by careful examination of basic questions, emerging value conflicts and existing consensus regarding surrogacy. Whatever one's ultimate conclusions, grappling with the questions posed by surrogacy promotes valuable individual and collective examination of matters fundamental to personal and social life.

Psychological and Social Meanings of Parenthood

Surrogacy and other forms of assisted reproduction attest to the importance many of us attach to parenthood. To understand better the impact a practice such as surrogacy might have on individuals and on society, it is important to examine some of the psychological, sociological, and philosophical aspects of parenthood.

Motivations for Parenthood

Historically, social groups and organized religions have been concerned with assuring reproduction and establishing norms for appropriate reproductive behavior. Religions and cultures cared not merely about ensuring that people would reproduce in numbers sufficient for the survival of the species, but also about the circumstances under which children would be conceived and reared. Although particular norms and customs have varied over time and among groups, the existence of such norms is nearly universal.[1] A pervasive norm in Western society is that children are to be conceived and raised within a socially and legally recognized marriage, and that primary parental responsibility rests with the couple who created the child.

Since the practice of surrogacy involves a separation of biological and rearing roles, it is useful to explore the many motivations individuals may have for becoming parents. While historically economic factors may have strongly motivated many to have children,[2] recent literature exploring the significance of parenting has focused far more on the psychological and social needs that parenting may fulfill for both women and men.[3] Pleasure in giving and receiving love, a sense of belonging to a group, the desire to nurture, and a need to be needed are seen by many as among the most important reasons for becoming a parent.[4] Further, for many people parenthood affirms their status as adults in their own families and in society, fosters potential for psychological growth, affirms masculinity or femininity, and in some cases meets obligations stemming from religious or ethnic identification. While parenthood is by no means the only way a person can fulfill his or her desires to give something to the next generation,[5] many adults believe that their relationships with their children are the most fulfilling parts of their marriages and their lives.[6]

The desire of adults to be parents, by whatever means, is the desire to be involved with children in an enduring and special way that recognizes parenthood as a lifelong commitment, not to be entered into intermittently or walked away from lightly. The longing for such manifold enrichment does not cease with the discovery of infertility or with the recognition that one's social situation precludes ordinary reproduction. On the contrary, the psychological pain and social stigma of childlessness resulting from a couple's infertility can be very profound. Whereas the physiological inability to conceive or to carry a child results from a

medical condition, the consequence, *i.e.*, the deprivation of a child, is a psychological and social one. Only some of the grief and distress reported by infertile people stems from facing the fact that their bodies have malfunctioned; the greater part of the distress stems from being deprived of the gratifications of parenthood.[7]

Components of the Parent-Child Relationship

The overwhelming majority of people who raise children are both their biological and rearing parents. Consequently, little data exist about the comparative weight individuals may attach to the various components of parenting -- namely, the genetic, gestational, and social aspects. Yet, by separating biological and social parenthood, surrogacy raises some important and distinctive questions. For example, what do people view as essential about parenthood -- biologically, psychologically, socially, morally, and legally? How should we understand the desire to have a genetically related child? And how should we understand the commitment to a genetically unrelated child on the part of a potential adoptive parent?

Surrogacy arrangements make it possible for children to have up to five adults involved with their creation and/or rearing, all of whom potentially have a claim to the title of "parent": the male and female who contribute gametes; the female who carries the child; and the person or persons (typically a heterosexual married couple, but possibly a single person or a homosexual couple) who arrange for the child's conception and who intend to rear the child once it is born. Response to the practice of surrogacy may depend, at least in part, upon how these elements of the parent-child relationship are assessed, and upon the wisdom of deliberately separating these components of parenthood.

With respect to the genetic component, how much of the satisfaction and fulfillment of parenthood stems from the recognition that the child one is nurturing, teaching, playing with, and planning for carries one's genes? Some advocates of surrogacy and other forms of assisted reproduction argue that genetic connections matter a great deal to adults and children, and that surrogacy should be permitted because it allows men (and, in the case of gestational surrogacy, also women) to experience the satisfactions of genetic as well as social parenthood. From this standpoint, the practice of surrogacy can be seen as responding to

and reinforcing, especially for males, the significance of genetic lineage in our culture.[8]

In contrast, those who attach considerable weight to the gestational component of reproduction may respond to the practice of surrogacy with some skepticism or alarm. To some pregnancy is, by definition, a highly significant experience, with physical, psychological and social implications that may endure long after the baby's birth. According to this view, to de-emphasize the gestational element of the parent-child relationship is to devalue the woman's unique contribution to reproduction and to deny the special connection between a woman and the child she bears.[9]

For others, many of the reasons for becoming a parent have less to do with the child's biological origins and more to do with the social and emotional relationship between parent and child that develops after birth in the process of raising children. Strong emphasis on the social component of parenting suggests that the commitment of the non-biological parent (such as the infertile wife of a couple using surrogacy), should carry substantial psychological and social, and perhaps moral and legal weight. This lens on the practice supports a policy permitting surrogacy arrangements. Yet, emphasis upon the social component of parenthood in this context also gives reason for pause as it could also have the effect of unduly heightening the value placed upon biological connection to a child, rather than reinforcing society's appreciation of the social aspects of the parent-child relationship.[10]

Finally, some view surrogacy as an arrangement which involves what might be termed "mental conception."[11] The intended parent or parents know that the bonds of the parent-child relationship will evolve, if not from the union of the parents' gametes, then from the arrangement entered by them with the intention of bringing a child into the world. The parenting experience thus finds its foundation in the social arrangements which bring about conception and birth rather than in the genetic or gestational connection between parent and child. On this view, a surrogacy arrangement more closely approximates the planning to have a family characteristic of ordinary reproduction, because it gives the intended parents the opportunity to initiate the creation of the child they will raise.

Perspectives on the Family

The family has historically been regarded as a primary locus for providing nurturance, security, affection, and stability; for imparting goals, beliefs, and values; and for teaching the skills necessary for a productive and fulfilling life in society.[12] Despite higher divorce rates, turbulent parent-child relationships, and apparent increases in domestic violence in recent decades, most adults still consider the family to be the most important source of meaning and value in their lives.[13] Family is generally thought of as the adult's central source of affection,[14] and as the unit in which children will be created and cared for.[15]

While the twentieth century family unit might typically be described as a married couple raising their biological children, there is in fact a wide diversity of family forms evident today in New Jersey and throughout the nation.[16] High rates of divorce and remarriage mean that perhaps as many as one third of the children born in the last decade will live in a family with a step-parent by the time they are eighteen.[17] Moreover, nearly one in five births in the United States occurs to a woman outside of marriage.[18] Consequently, many households are headed by single people, and many children live with unrelated, as well as related, adults who function as their primary caretakers.

This multiplicity of family constellations is not always looked upon with equanimity throughout society, and some of the concerns raised about the new reproductive practices may stem from distress about hastening still more changes in forms and styles of family life. While the most common candidates for surrogacy are heterosexual couples where the female has a medical condition that interferes with reproduction, surrogacy may also be the means to realize the desire for parenthood for those in other social circumstances, such as single or homosexual persons. Surrogacy and other new reproductive arrangements thus compel us to examine what we consider the essence of family life, what values we seek to uphold, and the extent to which deviation from cultural ideals is individually or collectively accepted.

Divergent views exist among philosophers and sociologists regarding the appropriateness and desirability of various forms of the family unit. Some claim that what counts in marriage and in parenthood is the intent to establish and maintain an intense, involved, multi-faceted,

long-term, committed relationship, and that biological connectedness is of secondary importance.[19] On this view, the essence of "parenthood" resides in parental responsibilities and not in the biological source of the relationship. This perspective proposes increased societal tolerance for diversity in family forms and a reduction of what some have called the "biological bias." In contrast, the more traditional conception of the family stresses the overriding significance of the bond of genetic kinship.[20] Some who emphasize the importance of the genetic connection argue that children should only be created by two people who are committed to contributing to the child's life not only as biological parents, but also as psychological and social parents. This stance would restrict the range of ethically acceptable reproductive practices to those that perpetuate the connection between sexuality and the creation of new life within a stable, committed heterosexual relationship.

The Impact of Surrogacy Upon Societal Values

In addition to evaluating the possible consequences of surrogacy upon the parties directly involved, it is important to evaluate the impact that surrogacy may have upon fundamental societal values relating to the family, children, individual privacy, sexuality, and gender equality. Establishing a policy towards surrogacy also raises the question of the appropriate role of the state in matters of procreation and parenthood.[21] Thus, beyond the impact that surrogacy may have on our understanding of concepts of "family", surrogacy may affect a number of other important values.

First, the practice of surrogacy may affect societal perceptions of the role of women. Some feminists who oppose surrogacy argue that infertile women are pressured into surrogacy arrangements to enable men to continue their genetic lineage; that surrogacy exploits poor women who lack other means to support themselves and their children; and that surrogacy, and in particular gestational surrogacy, will increase the tendency to over-identify women with their reproductive capacities. In contrast, other feminist-oriented arguments support surrogacy on the ground that surrogacy and other new reproductive arrangements may have a liberating effect, empowering both women and men to make informed decisions as to how, whether, and under what conditions they wish to become biological or social parents.

Second, some claim that surrogacy as a practice undermines respect for persons because it views the so-called "surrogate" primarily as a means to an end. Consistent with this view, by treating reproduction as a "transaction" surrogacy undermines the dignity and worth to be accorded to persons as individuals and diminishes the value of the highly personal and profoundly significant act of reproduction. This objection is arguably applicable to surrogacy in both its commercial and non-commercial forms. However, for many the concern is more deeply rooted in the nature of commercial arrangements, where the traditionally separate spheres of family and market are merged. Those who object to commercialism in reproduction argue that friendship, love, marriage, and procreation exemplify some of the intangible "goods" of life that, because of their special character, should not be subject to rules of purchase and sale.[22] The acts of marrying and having children arguably take on their "specialness" in part because they symbolize and embody people's deepest longings for closeness and commitment to others, feelings that are understood as self-defining. A central question in formulating policy on commercial surrogacy, therefore, is whether the meaning of an act which is customarily performed out of love, such as sexual intercourse or conceiving and carrying a child, is intrinsically devalued when the creation of a child centers around the exchange of money.

Third, defining public policy about surrogacy requires consideration of the impact that surrogacy may have upon the procreative process itself, and upon the relationship between sexuality and procreation. The human body, sexuality, and the creation of life are viewed by many as having very deep personal meaning. Some of the significance attached to children and to creating life may stem from the fact that children are the result of intimate physical and sexual acts, and as such are outward signs of the love that their biological progenitors have for each other.[23] Similarly, some of the significance we attach to our bodies and to sexuality may reside in the link to reproduction, to the fact that sexuality is a life-producing force. Persons who see children as ideally resulting only from a loving, sexual union may view the introduction of third party "reproductive collaborators" as threatening the "mystery" of sexuality and as demeaning to the procreative process. Thus, even though surrogacy involves reproduction without sex, creating public policy toward surrogacy requires a shared understanding of the meaning we wish to attach to procreation and sexuality.

Finally, and perhaps most important, the effect that surrogacy arrangements may have upon children and on cultural understandings of children must be examined. Some argue that the practice may jeopardize children's status as unique individuals by fostering a view of children as "luxury items" or "commodities", available either by gift or sale. Moreover, while it is true that many children are conceived under circumstances in which their creation may not have been desired by their biological parents, it is not clear whether the state should condone a practice which permits children to be created with the deliberate intention on the part of one biological parent to relinquish the child. The potential effects upon the children of surrogacy raise several significant, though somewhat speculative questions. Can a child's recognition of the circumstances of its birth in itself constitute a "harm" or a "wrong" to the child? How will a child perceive the fact that he or she was conceived in order to be given away to another? Might a child of a commercial surrogacy arrangement develop his or her own sense of worth in terms of the "market value" of the arrangement? Will a child conceived in such atypical circumstances and whose creation required ingenuity and arrangement (and, in commercial cases, the payment of money) be loved for himself or herself, or will more be expected and demanded of such a child? Might a child whose mother acted as a so-called "surrogate" become fearful that he or she might be given away to another family, as was the fate of his or her half-sibling? As contemporary experience with surrogacy is limited, there is no empirical evidence to support any definitive answers to these questions. Nonetheless, the welfare of the child should be of paramount importance, and should be a primary objective of social policy.

In sum, by separating the traditionally inseparable bonds of the genetic and gestational components of parenthood, making it possible that a child can have different genetic, gestational and social parents, the new reproductive practice of surrogacy raises numerous and fundamental questions about our views of parenthood, family and children. Consideration of these questions, more fully explored in subsequent chapters of this report, has been a central focus of the Commission and Task Force deliberations and of the policy recommendations on surrogacy.

NOTES

1. J. Ross Eshleman, *The Family: An Introduction* (Allyn and Bacon 5th ed. 1986), chapter 18 (hereinafter "Eshleman"); Linda M. Whiteford, "Commercial Surrogacy: Social Issues Behind the Controversy," in *New Approaches to Human Reproduction? Social and Ethical Dimensions*, Linda Whiteford and Marilyn Poland, eds. (Westview Press 1989), pp. 145-69 (hereinafter "Whiteford and Poland").

2. Historically, children have been of enormous instrumental value to their parents as workers such as on family farms or in family run businesses while they were growing up, and later as caretakers for their aging parents no longer able to manage their own affairs and needs. *See* Viviana A. Zelizer, *Pricing the Priceless Child* (Basic Books 1985), pp. 56-64.

3. Lois W. Hoffman and Martin L. Hoffman, "The Value of Children to Parents," in *Psychological Perspectives on Population*, J.T. Fawcet, ed. (Basic Books 1973) (hereinafter "Hoffman and "Hoffman"); Mary Joan Gerson, "A Scale of Motivation for Parenthood: The Index of Parenthood Motivation," *Journal of Psychology* 113 (1983): 211-20 (hereinafter "Gerson Index"); Mary Joan Gerson, "The Prospect of Parenthood for Women and Men," *Psychology of Women Quarterly* 10 (1) (1986): 49-62 (hereinafter "Gerson Prospect"); Eric H. Erikson, *Identity and the Life Cycle* (W. W. Norton, 2nd printing 1980) (hereinafter "Erikson Identity"), pp. 103-04; Eric H. Erikson, *The Life Cycle Completed: A Review* (W. W. Norton 1982) (hereinafter "Erikson Life Cycle"), pp. 67-68.

4. *See* sources cited *supra* note 3.

5. Erikson Identity, *supra* note 3, pp. 103-04; Erikson Life Cycle, *supra* note 3, pp. 67-8.

6. Hoffman and Hoffman, *supra* note 3; S. Dowrick and S. Grundberg, eds., *Why Children* (Harcourt, Brace, Jovanovich 1980).

7. *See* Paul W. Armstrong and T. Patrick Hill, *"Baby M: New Beginnings and Ancient Mileposts; Seton Hall Law Review* 18 (4) (1988): 848-54; Testimony of Elizabeth Aigen and Kathryn Quick, Joint Public Hearing of the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care and the Task Force on New Reproductive Practices, May 11, 1988 (hereinafter "Joint Public Hearing"); Stephen Perkel, "An Exploratory Study of Infertility, Psychopathology, Sex-Role

Identity, Self-Esteem, and the Social Meaning of Parenthood" (unpublished doctoral dissertation submitted to the University of Pennsylvania School of Social Work 1987).

8. As stated by one commentator "Much of this demand for access to the 'babymaking market' follows from the social and psychological importance people attach to the ideal of having children who are genetically theirs...In our culture, the desire to reproduce through bloodlines, to connect a future generation through one's genes, continues to exert a powerful and pervasive influence. Evidence from other societies and from subcultures within America suggests that this desire is not innate or biologically determined but is socially constructed." Joan Heifetz-Hollinger, "From Coitus for Commerce: Social and Legal Consequences of Non-Coital Reproduction," *University of Michigan Journal of Law Reform* 18 (4) (1985): 874-75.

9. Wendy Chavkin, Barbara Katz Rothman, Rayna Rapp, "Alternative Modes of Reproduction: Other Views and Questions," in *Reproductive Laws for the 1990s*, Sherill Cohen and Nadine Taub, eds. (Humana Press 1989), pp. 405-09; George J. Annas, "Commentary: Regulating the New Reproductive Technologies," in *Reproductive Laws for the 1990s*, Sherrill Cohen and Nadine Taub, eds. (Humana Press 1989), pp. 411-20; Alice Rossi, "A Biosocial Perspective on Parenting," *Daedalus* 106 (2) (1977): 1-31; Michelle Stanworth, "Reproductive Technologies and the Deconstruction of Motherhood," in *Reproductive Technologies: Gender, Motherhood and Medicine*, Michelle Stanworth, ed. (Univ. of Minnesota Press 1987), pp. 10-35; *see generally Test-Tube Women: What Future for Motherhood?*, Rita Arditti, Renate Klein, and Shelley Minden, eds. (Pandora Press 1984); *Made to Order: The Myth of Reproductive and Genetic Progress*, Patricia Spallone and Deborah Lynn Steinberg, eds. (Pergamon Press 1987).

10. Kathleen Nolan, Presentation to The Hastings Center (unpublished paper, June 27, 1989).

11. Andrea E. Stumpf, "Redefining Mother: A Legal Matrix for the New Reproductive Technologies," *Yale Law Journal* 96 (1986): 196 (hereinafter "Stumpf").

12. Eshleman, *supra* note 1, chapter 18; Brigette Berger and Peter L. Berger, *The War Over the Family: Capturing the Middle Ground* (Anchor/Doubleday 1983) (hereinafter "Berger and Berger"), pp. 85-97; *see generally* Christopher Lasch, *Haven in a Heartless World: The Family Beseiged* (Basic Books 1977).

13. Eshleman, *supra* note 1, chapter 18; Berger and Berger, *supra* note 12, pp. 85-97; *see generally* Arlene S. Skolnik, *The Intimate Environment: Exploring Marriage and the Family* (Little Brown, 3rd ed. 1983).

14. William Ruddick, *Having Children* (Oxford Univ. Press 1979) (The most appealing aspects of family life involve the continual rendering of services, kindnesses, attentions, and concerns beyond what is obligatory); Berger and Berger, *supra* note 12 (reporting that 92 percent of adults rank family life ahead of friendship, work, patriotism, and religion), p. 164.

15. Eshleman, *supra* note 1, chapter 18; *see generally* Barrie Thorne and Marilyn Yalom, "Some Feminist Questions," in *Rethinking the Family: Some Feminist Questions*, Barry Thorne and Marilyn Yalom, eds. (Longman's 1982).

16. Eshleman, *supra* note 1, chapter 18; Jerrold K. Footlick, "What Happened to the American Family?," *Newsweek* (Special Issue, Winter-Spring, 1990): 14-18 (hereinafter "Footlick"); Jean Selignann, "Variations on a Theme: Gays, Single Mothers, and Grandparents Challenge the Definition of What Is a Family," *Newsweek* (Special Issue, Winter-Spring 1990), p. 39.

17. One writer has described the contemporary situation regarding families as follows:

> The American family does not exist. Rather, we are creating many American families of diverse styles and shapes. In unprecedented numbers, our families are unalike. We have fathers working while mothers keep house; fathers and mothers both working away from home; single parents; second marriages bringing children together from unrelated backgrounds; childless couples; unmarried couples with and without children; gay and lesbian parents. We are living through a period of historic change in American family life. Footlick, *supra* note 16, p. 20.

18. Eshleman, *supra* note 1, chapter 18.

19. William Ruddick, Presentation to the Task Force on New Reproductive Practices, New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care (June 22, 1988); Stumpf, *supra* note 11.

20. J. Robison, "Non-Coital Reproduction," *Psychology of Women* 16 (4) (Fall 1989): 1, 3-5; Sidney Callahan, "The Ethical Challenge of the New Reproductive Technology," in *Medical Ethics, A Guide for Health Professionals*, J.F. Monagle and David C. Thomasma, eds. (Aspin Publishers 1987), pp. 26-37 (hereinafter "Callahan") (Only those practices permitting the "normal, socially adequate, heterosexual married couple to have a child which they would or could have if their fertility were not an obstacle" should be viewed as ethically acceptable); Whiteford and Poland, *supra* note 1, pp. 145-69.

21. According to some, society has a stake in matters of procreation and parenthood because children are part of a collective ultimately larger than the family that created and nurtured them. Jeffrey Blustein, for example, states that "[t]he public has a legitimate concern with the selection of childrearers and with the way in which children are reared, because a society's children are its future citizens and the future contributors to its material, cultural, and moral advancement. Collectively, children are a social asset." Jeffrey Blustein, "Child Rearing and Family Interests," in *Having Children*, Mihoro O. O'Neill and William Ruddick eds. (Oxford Univ. Press 1979), p. 119 (hereinafter "Blustein").

Chapter four of the report discusses some of the legal issues associated with the question of whether and to what extent the state should be permitted to interfere with individual procreative decisionmaking and whether there exists a "right" of individuals to obtain medical or other third party assistance to become parents.

22. Michael Walzer, *Spheres of Justice* (Basic Books 1983); Margaret Jane Radin, "Market-Inalienability," *Harvard Law Review* 100 (June 1987): 1839-937; *see also* Michael Walzer, Presentation to the Task Force on New Reproductive Practices, New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care (October 5, 1988).

23. Callahan, *supra* note 20, pp. 26-37; *see generally* Blustein, *supra* note 21.

CHAPTER TWO

INFERTILITY: PREVALENCE, CAUSES, AND RESPONSES*

> My experience with infertility has found it to be very often a disease that has virtually no symptoms until you cannot produce a child and very often no cure. It is silent, devastating and appears to choose its victims at random. No, you do not die from infertility, but there are times you wish that you could.
>
> In my personal fight with infertility my husband and I have been studied, poked, probed, tested, bled and monitored over a period of six years. I have had numerous operations; one of which was a delicate, 8-hour microsurgical procedure. Each time the result was the same. Different doctor, but same speech: "Sorry, we can't help you."
>
> ...I have suffered from family births, baby showers, and friends who were actually afraid to tell me they were pregnant, because they didn't want to hurt my feelings. Over the last five years - over five years, trying to become pregnant became my top priority and my career. It consumed our days and our nights.
>
> Kathryn Quick

With these words, Kathryn Quick poignantly described her and her husband's five year struggle to conceive a child. Her remarks, presented at the May 1988 public hearing on surrogacy,[1] highlight both the medical and social dimensions of infertility. In her testimony, Ms. Quick describes infertility as a disease. Infertility has also been classified as a disorder, a handicap, an illness, a syndrome, a condition, a condition caused by a disease, a clinical problem and a disability.[2] All of these characterizations stress the medical aspects of infertility. They draw attention to the physiological problems that prevent a couple from conceiving a child.

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* The Commission and Task Force would like to acknowledge the important contributions of Elizabeth Duffy, Princeton University (class of 1988) to the research and writing of this chapter.

Significantly, it is seldom these physiological conditions that cause the pain associated with infertility. Although Ms. Quick complains about arduous diagnostic procedures and fertility treatments, she describes infertility itself as silent and symptomless. What Ms. Quick and others find devastating is their childlessness. The social expectations that define parenthood as a desirable, even essential, social norm make infertility an extremely painful condition. Indeed, such expectations lead to feelings of resentment, pity, inadequacy, impatience, loss, vulnerability and isolation.[3] Gatherings with family and friends become occasions to be endured rather than enjoyed.

Societal responses to infertility depend, in part, on whether infertility is perceived as a medical condition or as a social phenomenon. Before exploring the various responses to infertility, this chapter briefly examines the prevalence, causes and prevention of infertility. The chapter is not intended to be an exhaustive study of the subject. Rather, it focuses on what needs to be known about infertility to evaluate critically the new reproductive practices, in particular surrogacy.

Prevalence

In order to estimate the number of people who might seek fertility services, one needs to know the magnitude of the infertile population. Unfortunately, little data on the prevalence of infertility in the United States exist. Further, the usefulness of existing data is compromised by two factors. First, experts disagree about how to define "infertility". Seldom does the definition chosen by the statistician or the clinician match the one sought by the policymaker. Second, the infertility statistics do not distinguish between male and female infertility, making it especially difficult to predict the candidate pools for gender-specific services such as surrogacy.

Existing data

As of 1992 only three comprehensive studies on the prevalence of infertility have been published in the United States. In 1965, Princeton University released the National Fertility Study, and in 1976 and 1982, the National Center for Health Statistics conducted the National Survey of Family Growth (NSFG), Cycle II and NSFG, Cycle III, respectively.

In the NSFG studies, "infertility"[4] is defined as an inability to conceive after twelve months of unprotected intercourse. In the 1982 NSFG, researchers surveyed 7,969 women between the ages of 15 and 44. The 3,551 married women who were questioned were asked whether they or their husbands were unable to conceive. 8.5% of the surveyed couples were infertile, another 38.9% were surgically sterile, and 52.6% were fertile. Extrapolating from these percentages, the National Center for Health Statistics estimated that 2.4 million married couples were infertile.[5] Of these couples, approximately 1 million were childless, and the other 1.4 million had one or more children prior to becoming infertile.

Interestingly, it appears that overall infertility rates have increased only slightly in recent years.[6] The one age group in which there has been a significant increase in infertility is among women between 20 and 24 years of age. This increase is primarily attributable to infection caused by sexually transmitted diseases (STD's).[7]

Problems of Definition

Estimates regarding the size of the infertile population are of limited use in attempting to predict the future candidate pools for fertility services, such as surrogacy, because they suffer from both overinclusiveness and underinclusiveness.

On the one hand, the arbitrary choice of 12 months in defining "infertility" inflates the estimate. Theoretically, if an average woman with no infertility problems has an approximate monthly probability of conception of 20%, 93% of all women will conceive after one year of unprotected intercourse.[8] Studies have found, however, that the inability of a couple to conceive after 12 months of intercourse without contraception is a poor predictor of future conception.[9] Until recently, most couples did not seek professional help to alleviate infertility until after several years of failed attempts.[10] Thus, some women who do not become pregnant within the first year and whom the NSFG classifies as "infertile" may eventually conceive without intervention. Further, some people who are unable to conceive and are thus included in the "infertile" category simply have no desire to have children.

On the other hand, a number of couples who might seek fertility services now or in the future are masked by the NSFG definition.

Infertility as defined by the NSFG refers only to couples who try to conceive and fail. Women who have always used contraception and women who have never had intercourse are assumed to be fertile. Those couples in which the woman can conceive but it is difficult or dangerous for her to maintain the pregnancy are also classified as fertile by the NSFG. Finally, couples who already have one or more children but are unable to have another child because one of the partners has been sterilized are *not* classified as infertile. With the increased popularity of voluntary sterilization and the prevalence of second marriages, the number of couples in this last category has risen rapidly.

For all of the above reasons, statistics regarding the absolute number of "fertile" and "infertile" people in the country are of limited usefulness. Indeed, the data do not address what is arguably the most important question for policymakers: how many people who would like to have children cannot have them, and thus might seek fertility services?[11]

Use of Infertility Services

The use of infertility services in the United States has increased dramatically in the last two decades. Indeed, the estimated number of visits to private physicians' offices for consultation related to infertility rose from about 600,000 in 1968 to over 900,000 in 1972 to 1.6 million in 1984.[12] The reasons for this dramatic increase are numerous. Delayed childbearing practices, particularly of middle and upperclass women, have doubtless contributed to the increased use of infertility services. Female fertility decreases somewhat before age 35 and more dramatically after age 35.[13] Couples who postpone childbearing have fewer years in which to attempt to create a family. Moreover, those women who have used oral contraceptives for a significant period of time often find that conception takes longer to achieve.[14] Significantly, older couples often have the most difficulty adopting a child and, thus, may be more likely to explore some of the new reproductive practices, including surrogacy.

Other social factors also account for the increased use of infertility services in recent years. Today couples are more likely to acknowledge and seek treatment for what even in the recent past has been a "taboo" topic: infertility. Physicians have also become more adept at diagnosing and more interested in treating infertility.[15] Finally, the availability of abortion and the increased social acceptance of single

mothers have reduced the number of children available for adoption, making some of the new reproductive practices attractive alternatives to the increasingly difficult process of adoption.

Causes of Infertility

The underlying causes of infertility are numerous and for the most part not well understood. This limited knowledge reflects both the difficulty of diagnosing infertility and the relatively low priority given to fertility research in the past. The significant contributions of social factors to the prevalence of infertility also complicate the understanding of the causes of infertility.

Diagnosing Infertility

The evaluation of infertility is inherently imperfect. Tests performed on a single day or even during a single month do not always accurately reflect a woman's menstrual cycle, and semen samples also vary considerably from time to time. Because infertility is a problem of the couple, it is important to evaluate both the women and the man when assessing a couple's infertility status.

Semen analysis is the most common method used to detect male infertility. In semen analysis, doctors measure the volume, pH and viscosity of the seminal fluid and the quantity, morphology and motility of the sperm.

Many more methods have been developed to diagnose female infertility. By charting changes in a woman's basal body temperature, monitoring her hormonal output or evaluating her cervical mucus, a doctor can determine whether or not ovulation is occurring. These findings are often verified with an endometrial biopsy, which measures the effect of progesterone on the uterine lining. Ultrasonography enables a doctor to visualize the ovaries and ovarian follicles, and hysterosalpingography, hysteroscopy and laparoscopy are used to detect anatomical problems of the uterus, fallopian tubes and other areas of the reproductive tract. The post-coital test is the most widely practiced evaluation of the interaction of the cervical mucus and semen.

Studies suggest that between 30% and 70% of infertility is due to female factors and between 30% and 50% is due to male factors.[16]

The contribution of the female factors may be overestimated, because the male factors are studied less frequently than the female ones. Female and male factors also often appear in combination. In up to 20% of infertile couples, no clinically apparent cause of infertility is demonstrable using the standard techniques outlined above.[17]

Female Factors

The maturation, release, fertilization and implantation of an egg are complex processes. Problems in any one of these events can impair a woman's fertility.

Women are born with all the eggs they will use during their lifetime. In menstruating women, each month one of these eggs matures and is released from the ovary in which it is stored. The process of menstruation is carefully regulated by hormones. Follicle-stimulating hormone (FSH) carries a message to the ovaries to begin maturing an egg in one of the ovarian follicles, and luteinizing hormone (LH) triggers the mature egg's release. About a quarter of infertile women have ovarian or ovulation disorders.[18] Women who produce too little or no FSH do not ovulate. If a woman secretes LH too late, she will ovulate, but the over-ripe egg cannot be fertilized. About one in one thousand women suffer from Turner's Syndrome. These women have only one "x" chromosome, no ovaries and hence no eggs.

Before the egg is released, the end of the fallopian tube closest to the ovary surrounds the follicle. When the egg leaves the ovary it enters the fallopian tube and is transported by cilia and muscle contraction down the tube. In 30-40% of infertile women adhesions interfere with the release of the egg and movement of the egg down the tube.[19] A particularly common cause of such interference is endometriosis, a condition characterized by the presence of uterine lining cells outside of the uterus. Endometriosis affects 7-17% of menstruating women. Approximately 35% of these women are sub-fecund.[20]

During ovulation various changes occur within the cervix, the entrance to the uterus, to facilitate the meeting between the egg and sperm. Estrogen, a hormone secreted during ovulation, increases the amount of cervical mucus and makes the mucus more penetrable by the sperm. About 10% of infertile women have hostile cervical mucus which

prevents sperm from entering the uterus.[21] Such mucus usually contains antibodies that immobilize and disintegrate sperm.

Estrogen and progesterone, another hormone produced during ovulation, also prepare the uterus for implantation. The production of these hormones causes blood and nutrients to accumulate in the uterus. If an egg is fertilized in the fallopian tube, it implants itself in the rich uterine lining, where it will develop into a fetus. If the egg is not fertilized, the woman menstruates or sheds her uterine lining about 14 days after ovulation. Some women have inhospitable linings; such women secrete too little progesterone to adequately prepare their uterine linings for implantation.

Once the fertilized egg has been implanted, the embryo must develop for nine months before a child is born. Uterine abnormalities, including hostile linings, odd shapes and the presence of benign tumors account for between 10 and 15 percent of early miscarriages.[22] Another half of first trimester miscarriages are due to chromosomal abnormalities. Most of these miscarriages are caused by chromosomal or genetic aberrations in the fetus itself. Women over thirty-five years and women with certain genetic diseases, such as muscular dystrophy, are also at increased risk for miscarriage. Although the NSFG does not classify women who cannot carry a child to term as "infertile", these women have problems for which surrogacy might be viewed as a potential solution.

Male Factors

Until recently, infertility research focused almost exclusively on female factors. Thus, much less is known about male infertility than female infertility. Investigation of male infertility has centered on three factors: sperm abnormalities, obstructions, and chromosomal and immunological disorders.

The male sex organs, the testes, consist of a complicated system of tubes in which millions of sperm are produced and stored. Men with abnormal or too few sperm have difficulty impregnating women. Indeed, 80% of men with sperm counts below 20 million/ml cannot achieve conception.[23] Azoospermia (the complete lack of sperm in the ejaculate) is characterized by the absence or abnormal positioning of the testes or a genetic disorder preventing sperm production. Oligospermia (low sperm density) usually indicates a hormonal disturbance in

spermatogenesis. A probable but still unconfirmed contributor to semen disorders is the varicocele or varicose vein of the testis. The varicocele seems to impair semen quality by affecting the cells not directly producing sperm.

Once the sperm are produced, a tube called the *vas deferens* carries them from the epididymis to the urethra where they are released. About 25% of infertile males have some degree of obstruction which interferes with this transmission.[24] Various types of congenital and acquired defects, as well as infection, may disrupt the passage of the sperm through the epididymis or *vas deferens*. Hypospadias, an abnormality of the penis in which the urethra opens on the undersurface, hinders the sperm's release. Men with sexual dysfunctions such as premature and retrograde ejaculation are also often sub-fecund.

A smaller but nevertheless significant number of infertile males suffer from genetic or immunological disorders. Four genetic defects -- Klinefelter's syndrome, Reifenstein's syndrome, Kallman's syndrome and cystic fibrosis -- are known to impair male fertility. Other disorders which result in infertility -- undescended testes, spermatogenic arrest and Sertoli-cell-only syndrome -- may also have a genetic basis. Finally, some men suffer from auto-immune disorders.

Contributing Factors

The factors outlined above are the underlying medical causes of infertility. A number of other factors, including infection, environmental agents, contraception, iatrogenic factors and maternal age, contribute to the prevalence of infertility by exacerbating or even causing these clinical conditions.

Infection has a very pronounced effect on infertility. Indeed, the greatest single cause of female fertility problems is damage to the fallopian tubes, ovaries or uterine lining as a result of pelvic inflammatory disease (PID), an infection caused by STD's.[25] Women with PID are infertile throughout the duration of the disease and can sustain permanent damage to their reproductive tracts. The annual incidence of PID has increased dramatically in the past few decades. Whereas only 1.75% of the women surveyed in 1965 had contracted PID, 14% of the women surveyed in 1982 reported suffering from PID

at least once. Post-partum and post-abortion infections and the use of an intrauterine device (IUD) increase a woman's risk of developing PID.

Infection also contributes to male infertility. STD's most often affect the quality and longevity of sperm mobility. STD's can also inhibit the glandular function of the accessory glands involved in the production of sperm and induce an auto-immune response to an individual's sperm.

Environmental factors too may impair fertility. Exposure to ionizing radiation, lead, or ethylene oxide, for example, may adversely affect the reproductive system. Other environmental factors which have been linked to higher rates of infertility include chemical agents such as pesticides and anaesthetic gas, physical factors such as altitude and temperature, and personal habits such as smoking and the use of drugs, including certain prescription drugs like diethylstilbestrol (DES).[26] In fact, almost any factors that adversely affect the body's normal functioning may impair fertility. Stress, illness, strenuous exercise and poor nutrition, for example, can disrupt a woman's menstrual cycle or lower a man's sperm count.

Another personal behavior that may have an effect upon fertility is the choice of contraceptive methods.. The incidence of voluntary sterilization has increased dramatically in recent years. As noted above, 38.9% of the couples surveyed in the 1982 NSFG had been surgically sterilized. More than a quarter of these couples expressed the desire for more children as their life circumstances and goals changed. In one study, nearly 10% of surgically sterilized couples later attempted to have the process reversed.[27]

Other methods of contraception have less dramatic but still significant effects on fertility. Occasionally women will experience a few months of continued infertility after discontinuing the use of oral contraceptives. Moreover, the use of an IUD increases a woman's risk for tubal infertility, and abnormalities in the cervical mucus of diaphragm users have sometimes been discovered.

Some medical procedures can also inadvertently contribute to infertility. In women, surgical procedures can impair fertility by producing fallopian tube or ovarian adhesions or causing infection. Such iatrogenic damage has been reported after birth, caesarean sections,

abortions, appendectomies, appendicitis and other obstetric, gynecological and pelvic procedures. In men, hernia operations and vasectomies often obstruct the *vas deferens*. Cancer therapies, including surgery, radiation and chemotherapy, reduce both male and female fertility.

A final contributing factor, specific to female infertility, is the woman's age. Female fertility peaks between the ages of 18 and 30 and begins to decline significantly after the age of 35. The 1982 NSFG study found that, excluding the surgically sterile, 14 percent of married couples with wives aged 30-34 were infertile, while 25 percent of couples with wives aged 35-39 were infertile.[28] The exact impact of age on fertility is unclear, but some doctors suspect that aging affects ovulatory function, exacerbates the role of infection and increases the incidence of miscarriages. Societal trends in recent years, such as marrying and having children later in life and greater numbers of second marriages have made maternal age an increasingly important contributing factor to infertility problems.

Preventing Infertility

Much of the attention focusing on the problem of infertility in recent years has been aimed at the treatment of infertility, particularly the costly and sometimes controversial new reproductive practices. In the meantime, arguably too little attention has been paid to its prevention. Although preventive measures will never entirely eradicate infertility, such measures could mitigate many of the factors which both contribute to the incidence of infertility and make childlessness such a devastating condition. As noted above, scientists have only recently begun to study systematically the causes of infertility, particularly in males. Greater knowledge of the factors which impair reproduction will facilitate not only the diagnosis and treatment of infertility but also its prevention.

The most preventable types of infertility are those caused by infection, personal habits (for example, smoking, alcohol consumption, and drug use) and environmental factors. Much can be done to reduce the incidence of infertility by mobilizing resources to provide health education and better access to health services. PID alone, which is often attributable to sexually transmitted infections, accounts for nearly 20% of female infertility.[29] Further, an increased understanding of environmental toxins known or suspected of being linked to infertility

would facilitate development of policies to mandate safer working and living environments.[30]

The problem of iatrogenic infertility also needs to be addressed. Surgical sterilization should be accompanied by strict informed consent requirements and counseling services to make clear to the patient whether the sterilization procedure is reversible or irreversible. Manufacturers of drugs and devices should be held more accountable for the potential reproductive harm that may result from the use of their products.[31]

Changes in basic societal structure may be necessary to reduce infertility significantly. The issue of the woman's age, for example, is linked to the difficulty of integrating work and family life, which has led a growing number of couples to delay childbearing. Shorter and more flexible work hours, more generous maternity and paternity leaves and higher quality child care options would help to reverse this trend.

Finally, cultural expectations also need to be re-examined if the plight of infertile people is to be mitigated. To the extent that the pain of infertility is due to a sense of failure, a sense of loss, or a sense of inadequacy, the pain of infertility can be alleviated by fostering a more expansive notion of parenthood and family. Adoption, foster care, step-parenthood and even less formal "family" arrangements involving aunts, uncles, friends, and others provide opportunities for adults to develop and maintain meaningful contact with children, and should be affirmed as alternative "parental" possibilities.[32]

Responses to Infertility

Just as there are many causes, there are also many responses to infertility. These responses differ not only in method but also in purpose. Whereas conventional surgical and drug therapies attempt to eliminate the underlying causes of infertility, the newer reproductive techniques, including artificial insemination (A.I.), *in vitro* fertilization (I.V.F.), gamete intra-fallopian transfer (G.I.F.T.), and tubal ovum transfer aim to produce pregnancies, not to alleviate the physiological problems that impair fertility. Adoption and surrogacy are in fact not medical treatments, but rather social arrangements designed to provide wanting couples with children.

Conventional Therapies

Conventional therapies can be grouped into two categories: drug and surgical. Drug therapies are indicated for ovulatory and spermatogenesis disorders. More than three quarters of women who undergo drug therapy later conceive.[33] These women often report multiple births.

Surgery is most often used to alleviate tubal problems. In the female, tubal surgery has been performed to remove adhesions, open blocked fallopian tubes and excise endometrial tissue. Surgical procedures for the male include varicocele repair, vasectomy reversal and the elimination of epididymis obstructions. The success of surgical interventions depends on the type of tubal disorder and the integrity of the tubes. Less than 20% of tubes damaged by infection can be repaired.[34] Women who undergo tubal surgery are more likely to have ectopic pregnancies.

Adoption

Until recently, infertile couples whose medical condition could not be assisted by conventional fertility therapies were left with only one course of action -- adoption. Adoption is still an option, but it is becoming an increasingly scarce one. Today, many more couples want to adopt children than there are children available. According to one estimate, some two million couples seek to adopt each year, but only 50,000 placements occur.[35] In 1985 in the United States, 25 couples were willing to wait 5 years for every one Caucasian newborn. By 1987, 40 couples were waiting for each child.[36] A number of factors account for the shortage of children to adopt in this country, including greater acceptance of single mothers, increased willingness of unwed mothers to raise their children alone, and greater accessibility of both birth control and abortion services. Finally, the recent recognition of the legal rights of prospective fathers in adoption cases and the subsequent requirement of notification of, and in many cases consent by, the biological father have further complicated adoption procedures.[37]

Because the number of couples who want to adopt exceeds the number of available infants, adoption requirements are very stringent. As a consequence many of today's infertile couples are not eligible to adopt. In New Jersey, most adoption agencies have set stringent criteria for selecting adoptive parents. For example, agencies typically refuse

couples who have a child (even from a previous marriage) or are of different religions, as well as couples in which one partner is over 40 years of age or is divorced.[38] In New Jersey, an extensive home study is carried out to assess the appropriateness of the family for adoption. This process consists of joint and individual interviews with the applicants and all members of their household. Employment and personal references are required, and state and federal criminal history background checks must also be completed. Extensive information is gathered on family background, philosophies on child rearing and discipline, family relationships, medical history, finances, and other matters. Typically, only infertile couples are eligible to adopt healthy, white infants. Once the home study is complete, the agency may then decide whether to approve or to reject the couple's application. As adoption becomes increasingly difficult, more and more people are turning to the "new reproductive practices."*

Artificial Insemination

The oldest of the new reproductive techniques is artificial insemination. First reported in the 1950's, this technique did not become widespread until the 1960's when adoption started to become a less viable option. At the same time, laws were passed to resolve the issues of paternity and legitimacy of babies conceived through artificial insemination.[39] Today, nearly 15,000 babies are conceived each year in the United States by artificial insemination.[40]

Artificial insemination is a relatively uncomplicated procedure, in which semen is inserted in the cervical canal by means of a syringe or catheter.[41] If the semen is from the woman's husband, the procedure is called artificial insemination by husband (A.I.H.). If the source of the semen is anyone other than the husband, the process is called artificial insemination by donor (A.I.D.).[42]

A.I.H. is indicated for a variety of male infertility problems, including low sperm density, poor sperm motility, ejaculatory problems

* Although there is a dramatic shortage of healthy Caucasian newborns to adopt, many other children are in need of parents. In 1985, 41% of the children in foster care remained without a permanent home for two or more years. Further, many "special needs children" are never adopted. Parents who adopt special needs children have a strong desire and ability to parent and are not necessarily infertile. Interagency Task Force on Adoption, Office of Personnel Management, *America's Waiting Children* (Washington, D.C. March 1988), pp.6-8.

and impotence. A.I.D. is used when the husband produces no sperm or has an inadequate sperm count, or when there is a risk of transmitting a genetic disorder carried by the husband. A.I.D. is also used to treat women with cervical hostility. In addition, A.I.H. and A.I.D. may be performed independently of an infertility diagnosis. Men scheduled to undergo chemotherapy, radiation or other potentially hazardous treatments sometimes choose to have some of their sperm frozen for future use. A.I.D. may also be considered an option for single women who choose to have a child.

Nearly 60% of the women who undergo A.I. become pregnant.[43] This percentage is expected to increase as doctors become more adept at the procedure and better able to predict ovulation and preserve sperm.

In Vitro Fertilization

Since the birth of the first baby born through *in vitro* fertilization (I.V.F.) in 1978, [44] some 5,000 I.V.F. babies have been born worldwide.[45] I.V.F. is a sophisticated technology in which the process of fertilization takes place outside the woman's body. Immediately prior to ovulation, mature eggs are removed from the ovary, either by a needle and suction apparatus or by laparoscopy. The recovered eggs are fertilized in a dish with a suitably prepared semen sample. These fertilized eggs are then permitted to divide and develop in a growth medium for 48-72 hours before they are transferred with a small catheter to the uterus for implantation and further development.

Between 15 and 20% of the fertilized eggs that are re-introduced into the woman are implanted,[46] but only a small percentage are actually carried to term. The principal determinants of the success of I.V.F. are the timing and synchronization of the steps. Before a woman undergoes I.V.F., she is treated with hormones to stimulate her ovaries to ripen several eggs simultaneously. This production of multiple eggs increases the probability of achieving a viable pregnancy and improves the accuracy of timing. The artificial stimulation of ovulation may also lead to multiple births. All the recovered eggs are fertilized, but only a few are transferred to the uterus. The embryos that are created but not implanted are usually frozen in a process known as cryopreservation to minimize the number of times eggs must be retrieved.

The most common indication for I.V.F. is damaged or diseased fallopian tubes. I.V.F., however, is a potential response for most couples with whom conventional therapies have failed. Indeed, I.V.F. has been used in cases of inadequate sperm count, pelvic endometriosis and adhesions, anomalies of the reproductive tract and cervical disorders. As long as the female and male produce eggs and sperm, respectively, and the female's uterus can maintain a pregnancy, I.V.F. is a possible response.

In Vivo Fertilization: G.I.F.T. and Tubal Ovum Transfer

Scientists have also begun to develop *in vivo* practices to relieve female infertility problems. Whereas *in vitro* fertilization takes place outside the woman's body, *in vivo* fertilization occurs within the woman's fallopian tube. The most promising *in vivo* techniques being pursued today are gamete intra-fallopian transfer (G.I.F.T.) and tubal ovum transfer.

G.I.F.T. involves the transfer of sperm and eggs into the fallopian tube for fertilization. After ovulation has been stimulated, the eggs are collected by aspiration and then loaded with semen into a catheter and deposited into the end of the fallopian tube closest to the uterus. Tubal ovum transfer is very similar to G.I.F.T., but differs in that only the eggs are transferred past the blocked or damaged section of the fallopian tube. The sperm is introduced independently by intercourse or by A.I. Although tubal ovum transfer is still in a developmental stage, G.I.F.T. has been used to treat unexplained infertility, endometriosis, low sperm count, premature ovarian failure, immunological disorders and fimbria adhesions. On average, about 30% of G.I.F.T. attempts result in clinical pregnancies, but there is a broad range of success rates. While only 10% of women with immunologically-based infertility responded to G.I.F.T., 56% of the women with primary ovarian failure who were "treated" with G.I.F.T. conceived.[47] New techniques of augmenting *in vivo* fertilization by combining intrauterine inseminations with ovarian hyperstimulation have been effective for women with unexplained infertility or low fecundity.[48]

Surrogacy

Between 1980 and 1987, an estimated 12,000 to 15,000 infertile couples contacted surrogate parenting clinics nationwide. One thousand of these couples were accepted into programs, and nearly 600 births were

reported by early 1987.[49] By 1989 an estimated 1200 surrogate births had occurred nationwide.[50] There are a number of reasons -- medical, social and psychological -- why couples pursue surrogacy arrangements as a response to infertility and childlessness.

Currently, most couples who seek surrogacy services are infertile.[51] Having tried unsuccessfully to remedy their infertility through conventional therapies and other new reproductive practices, these couples often turn to surrogacy as a last resort. Couples in which the woman cannot carry a child to term, because, for example, of a uterine malformation, may decide to contract with either gestational or genetic/gestational "surrogate mothers." Women who have ovarian disorders or have undergone premature menopause may also consider genetic/gestational surrogacy as an option.

Yet, female infertility is not the only medical indicator for surrogacy. Women who carry a defective gene and who do not want to pass on the genetic risk to their children may either seek an egg or embryo donation or contract with a genetic/gestational birth mother. Further, women with diseases such as hypertension or severe diabetes who fear the potentially harmful effects of a pregnancy may also be interested in surrogacy. It should be noted, however, that the extent of such health risks is not always clear. In the *Baby M* case, for example, Mrs. Stern decided to forego having children when she learned that she had multiple sclerosis and that a pregnancy could increase her risk of blindness, paraplegia or other forms of debilitation. Many current medical authorities, however, assess such a risk as minimal.[52]

Some infertile couples turn to surrogacy after attempting unsuccessfully to adopt a child. As noted above, the number of couples who wish to adopt infants today far exceeds the number of available, healthy white infants. Prospective parents must undergo close scrutiny by adoption agencies and satisfy demanding social and economic tests in order to qualify as adoptive parents. Even if applicants are able to successfully meet the stringent requirements, they often must wait several years to adopt an infant.

However, many couples who seek surrogacy services have chosen not to pursue adoption. For these couples surrogacy is seen as preferable to adoption for a number of reasons. First, the fact that surrogacy

enables the father (and with gestational surrogacy also the rearing mother) to have a genetic link with the child makes surrogacy a more attractive option than adoption for many couples.[53] Second, surrogacy often eliminates the years of waiting that generally accompany the adoption process, and in that sense may be seen as a less frustrating experience. Third, prospective parents may also favor the surrogacy screening process because it gives them access to the so-called "surrogate's" biological records and often even the opportunity to meet her.

Finally, since surrogacy is a social arrangement, it may also be used for non-medical reasons. Single men, homosexual couples, and women who for one reason or another do not want to become pregnant, may seek surrogacy services to build a family.[54]

Access and Financing for Fertility Services

With the growing number and increasing popularity of infertility services, issues of access and financing need to be addressed. Some of the questions confronting policymakers and the providers and payers of health care services are: Do couples have a right to fertility services? Which, if any, fertility services should be paid for by insurance? Should people be reimbursed for services which produce a pregnancy but do nothing to relieve the underlying causes of infertility? Should a limit be placed on the number of infertility service claims? Should restrictions be introduced concerning the parents-to-be?

In the 1982 NSFG survey, black couples were one and a half times more likely to be infertile than white couples.[55] Yet, a higher proportion of white women (15%) than black women (10%) report using infertility services.[56] In 1982, an estimated 200,000 women with primary infertility and 550,000 women with secondary infertility never sought fertility services although they wanted a baby. These women generally belonged to lower socio-economic classes and had less education and work experience than their counterparts who had sought fertility services.[57]

At least part of the reason for these discrepancies is the limited financing of infertility practices. Although insurance companies routinely cover surgical and chemical infertility treatments, they have been reluctant to finance more specialized and complex responses to infertility.

For example, in 1987 the Health Insurance Association of America (HIAA) surveyed member companies to determine their I.V.F. reimbursement policies. Only 23% of the companies surveyed covered I.V.F. procedures. Because the larger insurance companies were more likely to pay for I.V.F. than the smaller ones, 41% of the industry was covered.[58]

The newer reproductive practices such as I.V.F. are for the most part expensive and only somewhat successful. The median survey costs reported by the United States Office of Technology Assessment (OTA) in 1986 were $4688 per I.V.F. cycle, $3500 for G.I.F.T and $80 for A.I.[59] Although A.I. has a pregnancy rate of almost 60%, the other procedures succeed less than 30% of the time. The need to perform a standard infertility work-up followed by often more than one of the new reproductive practices to achieve a pregnancy compounds the costs.

The low success rate and non-trivial costs of many of the new reproductive practices are not the only factors that for some argue against more extensive insurance coverage. Three quarters of the HIAA companies who did not reimburse for I.V.F. maintained that I.V.F. is not a "treatment" for infertility. They argued that I.V.F. is neither medically required nor medically beneficial to the woman. Like I.V.F., A.I. and the various *in vivo* techniques produce pregnancies, but do nothing to relieve the underlying causes of infertility. As noted earlier, surrogacy is not even a medical procedure, but a social arrangement. Another quarter of the HIAA companies declined to pay because they considered I.V.F. to be an experimental procedure. Interestingly, however, in 1984 the Council of Medical Specialty Societal Health Care Delivery Committee, in consultation with the American College of Obstetricians and Gynecologists, rendered an opinion that I.V.F. is clinically applicable as a response to infertility.[60]

In November of 1987, Massachusetts became the first state to pass a law requiring insurance companies to pay for all "medical treatments" of infertility.[61] The bill did not include the still experimental procedure G.I.F.T., and it specifically excluded surrogacy, reversal of voluntary sterilization and procuring donor eggs and sperm. A number of other states, including Delaware, Maryland, Hawaii and Arkansas have

enacted legislation requiring insurers to cover some infertility procedures.[62] Although a few federal bills have been introduced,[63] none to date has become law.

NOTES

1. Public Hearing on Surrogate Motherhood, held jointly by the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care and the Task Force on New Reproductive Practices, Newark, New Jersey, May 11, 1988 (hereinafter "Joint Public Hearing").

2. United States Congress, Office of Technology Assessment, *Infertility: Medical and Social Choices* (Washington, D.C. United States Government Printing Office, May 1988), p. 37 (hereinafter "OTA Report").

3. Presentation by Steven E. Perkel, Doctor of Social Work, to the Task Force on New Reproductive Practices, June 1, 1988.

4. In the 1982 NSFG study and the subsequent OTA Report, the term "infertility" rather than "impaired fecundity" is used. The term "fecundity" refers to the potential of a couple to reproduce, while the term "fertility" refers to actual conception rates. Couples with impaired fecundity include those for whom it is difficult or dangerous for the woman to maintain a pregnancy, whereas infertility refers only to couples who have tried to conceive and failed. The percentage of couples with impaired fecundity is thus slightly higher than the percentage of infertile couples. OTA Report, *supra* note 2, p. 49.

5. OTA Report, *supra* note 2, pp. 49-51 (citing United States Department of Health and Human Services, National Center for Health Statistics, *National Survey of Family Growth*, Cycle III (1988)).

6. Excluding the surgically sterile, the percentage of infertile couples has risen from 13.3 to 13.9 percent. *See* OTA Report, *supra* note 2, p. 51.

7. Joint Public Hearing, *supra* note 1, testimony by Professor Nadine Taub.

8. OTA Report, *supra* note 2, p. 52.

9. In one unrandomized observational study of 1,145 infertile couples, 41% of those whose infertility problems were treated conceived at a later time; 35% of the untreated couples also conceived. OTA

Report, p. 52 (citing J. Bongaarts, "Infertility After Age 30: A False Alarm," *New England Journal of Medicine* 14 (1982): 75-7).

10. The increased accessibility and popularity of infertility services has probably shortened this delay. There is evidence that many couples now seek help within approximately six months of attempting to conceive. Personal communication, Dr. Lee Silver, May 15, 1990.

11. Joint Public Hearing, *supra* note 1, testimony by R. Alta Charo.

12. OTA Report, *supra* note 2, p. 55.

13. There is disagreement as to whether and to what extent female fertility decreases when a woman reaches age 30. *See, e.g.*, J. Bongaarts, "Infertility After Age 30: A False Alarm," *New England Journal of Medicine* 14 (1982): 75-78; A.H. DeCherney and G.S. Berkowitz, "Female Fecundity and Age," *New England Journal of Medicine* (1982): 424-25; G.E. Hendershot, W.D. Mosher, and W.F. Pratt, "Infertility and Age: An Unresolved Issue," *Family Planning Perspectives* 306 (1982): 287-89. Of the 2.4 million infertile couples reported in the 1982 NSFH, one half million of the married women were over 35 years.

14. Joint Public Hearing, testimony by Professor Nadine Taub (citing S.D. Aral and W. Cates, Jr., "The Increasing Concern with Infertility: Why Now?," *Journal of the American Medical Association* 78 (1983): 2327-31).

15. The American Fertility Society, a professional association of infertility specialists, grew in membership between 1975 and 1985 from 3,600 to 8,300. Lori B. Andrews, *New Conceptions: A Consumer's Guide to the Newest Infertility Treatments* (Ballantine Books 1985), p. 3 (hereinafter "Andrews").

16. The New York State Task Force on Life and the Law, *Surrogate Parenting: Analysis and Recommendations for Public Policy* (New York May 1988), p. 9 (hereinafter "New York State Task Force") (citing Barbara Eck Menning, "The Infertile Couple: A Plea for Advocacy," *Child Welfare* (June 1975), pp. 454-55).

17. New York State Task Force, *supra* note 16, p. 9 (citing J. Collins, W. Wrixon and L. James, et al., "Treatment-Independent Pregnancy Among Infertile Couples," *New England Journal of Medicine* 309 (1983): 1201-02).

18. Andrews, *supra* note 15, p. 40; Miriam D. Mazor and Harriet F. Simons, *Infertility: Medical, Emotional and Social Considerations* (Human Sciences Press 1984), p. 5 (hereinafter "Mazor and Simons").

19. Andrews, *supra* note 15, p. 40; Mazor and Simons, *supra* note 18, p. 5.

20. OTA Report, *supra* note 2, p. 65.

21. Andrews, *supra* note 15, p. 40; Mazor and Simons, *supra* note 18, p. 5.

22. Andrews, *supra* note 15, p. 39.

23. Mazor and Simons, *supra* note 18, p. 13.

24. *Id.*, p. 14.

25. New York State Task Force, *supra* note 16, p. 11 (citing Gertrude Svals Berkowitz, "Epidemiology of Infertility and Early Pregnancy Wastage," in *Reproductive Failure*, Alan Decherney ed. (Churchill Livingston 1986), pp. 17-18).

26. OTA Report, *supra* note 2, p. 69.

27. Joint Public Hearing, *supra* note 1, testimony by Professor Nadine Taub.

28. OTA Report, *supra* note 2, p. 52.

29. New York State Task Force, *supra* note 16, p.13.

30. Policies mandating safe working and living environments need to take into account the male's role in reproduction as well as the female's role. Moreover, there is a risk that some so-called "fetal protection" policies may be little more than thinly disguised attempts to exclude

women from the workplace. Joint Public Hearing, *supra* note 1, testimony by Professor Nadine Taub.

31. *Id.*

32. *Id.*

33. Mazor and Simons, *supra* note 18, p. 9.

34. Presentation by Dr. Gerson Weiss to the Task Force on New Reproductive Practices, April 27, 1988.

35. New York State Task Force, *supra* note 16, p. 14 (citing estimate by William Pierce, President of the National Committee for Adoption).

36. Joint Public Hearing, *supra* note 1, testimony by Dr. Elizabeth Aigen.

37. Interagency Task Force on Adoption, Office of Personnel Management, *America's Waiting Children* (Washington D.C. March 1988), p. 7.

38. *Id.*

39. Statutes regulating sperm donation exist in at least thirty states. At least eight of these statutes appear to be modeled on the Uniform Parentage Act. A table of state statutes addressing artificial insemination and identifying their major features is set forth in OTA Report, *supra* note 2, p. 243.

40. New York State Task Force, *supra* note 16, p. 19 (citing Barbara Menning, *Infertility: A Guide for the Childless Couple* (Prentice Hall 1977), p. 147).

41. In cases in which cervical mucus is hostile to sperm, the sperm may be placed directly in the uterine cavity in a process known as intrauterine insemination. *See* OTA Report, *supra* note 2, pp. 126-27.

42. The term "vendor" may be more accurate than "donor", since the so-called "donors" are often paid for their services.

43. New York State Task Force, *supra* note 16, p. 20.

44. The birth of Louise Brown in England in July, 1978, constituted the first full term delivery from the *in vitro* fertilization process.

45. OTA Report, *supra* note 2, p. 293.

46. *Id.*

47. *Id.*, p. 297.

48. Personal communication with Dr. Gerson Weiss, May 14, 1990.

49. Amy Zuckerman Overvold, *Surrogate Parenting* (Farrell Books 1988), p.79; OTA Report, *supra* note 2, p. 270.

50. Rebecca Powers and Sheila Gruber Belloli, "The Baby Business: A Five Part Series: Making Babies," *Detroit News* (September 21, 1989), p.1.

51. Herbert T. Krimmel, "Surrogate Mother Arrangements from the Perspective of the Child" (Written statement prepared for the California Senate Committee on Health and Human Services, April 1988), p. 11.

52. *Id.*

53. Such a genetic link was especially important, for example, to Mr. Stern in the *Baby M* case. The New Jersey Supreme Court stated in its decision that "most of [Mr. Stern's] family had been destroyed in the Holocaust. As the family's only survivor, he very much wanted to continue his bloodline." *In the Matter of Baby M,* 109 N.J. 396, 413, 537 A. 2d 1227, 1235 (1988).

54. According to the OTA Report, *supra* note 2, "[t]he number of homosexual couples who seek to hire a surrogate mother is consistently reported as no more than 1 percent, but three agencies have sought surrogates for a homosexual male couple, and one for a homosexual female couple." *Id.*, p. 268.

55. Margaret Fletcher Stack, "Who Should Pay for Infertility?," 17 *Hastings Center Report* 4 (December 1987) (hereinafter "Stack").

56. OTA Report, *supra* note 2, p. 145.

57. *Id.*

58. Health Insurance Association of America, "Reimbursement for *In Vitro* Fertilization: A Survey Of HIAA Companies," *Research and Statistical Bulletin* (August 14, 1987), p. 2 (hereinafter "HIAA Survey").

59. OTA Report, *supra* note 2, p. 141.

60. HIAA Survey, *supra* note 58, p.1. It should, however, be noted that only a few of the HIAA companies that did decide to pay for I.V.F. considered the Committee's statement. Many more assessed reports from health organizations, consulted medical researchers or gauged public opinion. *Id.*, p. 5.

61. *See* Stack, *supra* note 55, p. 3.

62. *See* OTA Report, *supra* note 2, pp. 149-51.

63. Stack, *supra* note 55, p. 4.

CHAPTER THREE

THE CURRENT PRACTICE OF SURROGACY

New Jersey and the nation received an extensive introduction to the phenomenon of surrogacy through the broad and varied media coverage of the case of *In the Matter of Baby M.*[1] In the past several years, radio and television talk shows and newspaper and magazine articles have featured the practice of surrogacy, through its supporters and opponents, including many of its participants. Popular written accounts tend to paint surrogacy as either a very positive arrangement bringing happiness to all involved or as an unmitigated disaster.[2] Although ethicists, lawyers, social critics, feminists, clergy, and many others have written copiously[3] on their attitudes toward the practice, there is scant available literature carefully describing the decade and a half of the practice as carried out by the dozen or so centers in this country acting as matching services.

Between 1976 and 1989, at least 33 separate broker/ intermediaries, from New England to the South, and from the Midwest to the West and Northwest, have facilitated surrogacy arrangements for a fee. Some centers report no births as a result of their efforts, while others report more than 100. As of 1989, 14 of the 33 brokers were still in operation, charging fees ranging from $8,000 to $42,000 per arrangement, with the average fee put at $29,000. At least 6 of the 14 still in business in the fall of 1989 had arranged 40 or more surrogate births, with a very small percentage of these being gestational surrogacy and the overwhelming majority being the conventional surrogacy of the *Baby M* case. It is estimated that as many as 1,200 children have been born through brokered arrangements and perhaps another 1,000 have been born in instances in which prospective parents located their own so-called "surrogates" without third-party assistance. As of 1989, reportedly at least 53 dissatisfied so-called "surrogates" had filed lawsuits and complaints, approximately 4.5 percent of the estimated 1,200 brokered arrangements. Most of these disputes have been settled out of court.[4]

This chapter describes the current practice of surrogacy in the United States, drawing largely on the site visits to selected commercial surrogacy programs conducted by members of the Bioethics Commission

staff, and partly on available literature.[5] After describing the nature of the site visits, the chapter discusses the operations of the four surrogacy centers visited and profiles contracting parties and so-called "surrogates", including their motivations for and reactions to participating in the programs. It concludes by highlighting similarities and differences among the centers, major findings, and some remaining questions."

Method of Site Visits

Four centers located outside New Jersey, in the East, Midwest, and West, were visited by members of the Bioethics Commission staff during 1988 and 1989. (The information presented about the centers may not fully reflect the practices of these organizations as of 1992.) The four centers vary in size, years of experience, methods of operation, and philosophy. They spanned the range of brokers in terms of size and characteristics of staff, numbers of births, and length of time in operation.

Visits varied in length and character. Two staff members visited three of the four programs; a third staff member participated in a portion of the visit to one program; and one staff member visited the fourth program. Visits lasted from one-half day to two days. In addition to taking notes at all visits, in three centers commission staff were permitted to tape record conversations. Although an attempt was made to obtain comparable information from all the programs, surrogacy center staff emphasized particular aspects of their work and de-emphasized others, and the interviews and data reflect these differences. The method of inquiry followed is summarized in Table 1 at the end of this chapter, which provides information about those interviewed, records requested, and records obtained from each center.

All cooperation on the part of center staff and participants was, of course, completely voluntary. Agency staff were free to make

[5] In a number of places throughout this chapter information obtained from the site visits is supplemented by or contrasted with that available from other sources. It should be noted, however, that current literature on the practice of commercial surrogacy tends to contain far more evaluation than it does description and rigorous analysis. Moreover, different sources give different information on even such apparently objective information as the number of programs in operation, the number of clients served, and the number of children born of surrogacy..

available as much or as little information and records regarding procedures as they chose. The Commission and Task Force are grateful to those at the four centers who shared their experiences with the practice of surrogacy. Their cooperation and good will have made an important contribution to a more informed understanding of the nature and practice of surrogacy in this country. Confidentiality played a key role in fostering center participation in the Commission's labors and requires that the identity of the four centers remain privileged and private."

Background on the Centers

Although programs share many common features, they differ in size, in philosophy, in the training and expertise of their staff, and in the type and comprehensiveness of service afforded to the clients and so-called "surrogates." Table II at the end of this chapter summarizes background data on the four centers concerning length of time in operation, size and qualifications of staff, numbers of people served, numbers of births, use of medical and psychological evaluation, legal representation, and criteria for selection.

Uniformly, time spent at the programs reveals a sense of mission on the part of program directors and a conviction by center staff, clients, and birth mothers that those involved derive great meaning and benefit from the arrangements. Currently unregulated by any social service agency in the states in which they operate, each program bears the imprint of the personality and philosophy of its founder and director. Directors are free to exercise a great deal of discretion and control over access to the services, essentially using their own standards to determine who will make an appropriate birth mother and appropriate rearing parents.

Center A. The largest and oldest of the four centers visited, this program focuses on giving clients and so-called "surrogates" a great deal of

" It must be noted, however, that all site visits occurred after the New Jersey Supreme Court decision in *Baby M*, at a time when not only had New Jersey's highest court taken a dim view of commercial surrogacy, but critical public scrutiny of the practice had grown dramatically. In addition, as discussed below, Commission staff was provided with very limited documentation of the surrogacy process for its review, and few interviews with participants in the process were conducted independently of involvement of surrogacy center staff. The findings and conclusions drawn from the site visits should be measured against this background.

autonomy in the matching process and in structuring the arrangements that govern the relationships among the parties. Staffed by attorneys, administrators, and clerical and secretarial personnel, and using the resources of outside mental health and medical practitioners, the center represents people seeking to have a child through surrogacy, recruits women to serve as so-called "surrogates" in conventional or gestational surrogacy, and expects that contracting parties will select one another and, within the guidelines of the standard contract, will negotiate the relationship. Espousing the view that people who seek assistance in procreation should have the same freedoms as those who procreate conventionally, this center does not require histories of infertility or medical problems of its clients as a precondition for those who seek surrogacy services. Center A serves couples who are not married, and also serves those who seek surrogacy for other than medical reasons. The Center refuses, however, to serve known homosexual singles or couples desiring to have a child through surrogacy.

Center B. With 57 births in its eight years of operation, this center is characterized by the strong commitment of its small staff to controlling the terms of the arrangements it facilitates. Among the criteria for acceptance of couples, for example, are marriage and a documented history of female infertility or serious medical problems threatening the health of the woman or the child. Center B is unique among the four centers in insisting upon nearly total anonymity for the so-called "surrogate" and the contracting couples. The parties never have face-to-face contact and know very little about each others' identities. In place of a "self-selection" process, the agency staff gathers information about the parties, matches couples and so-called "surrogates" based on staff and mental health consultant assessments, and mediates the nature and extent of contact between the parties from the beginning until about one year after the birth of the child. The agency's full-time staff keep in close contact with the so-called "surrogate" and the contracting couple, and it is they who seek to foster the formation of close relationships with couples and so-called "surrogates." Thus, successful arrangements rely in part on the confidence of couples and birth mothers that the agency staff is committed to their welfare and to the success of the venture in which they are engaged.

Center C. In its eleven years in operation, this center has assisted in more than one hundred births. Although more than ninety percent have

been through conventional surrogacy, the center is expanding its work to include gestational surrogacy and egg donation. Its nine professional staff members include two mental health practitioners, and an attorney who is also the program director and who represents the center's clients. This program emphasizes in-depth screening of would-be birth mothers and couples, devotes considerable attention to the matching process, and assists in forming strong relationships between the couples who will rear the child and the birth mother.

This center may be as committed to encouraging relationships between couples and so-called "surrogates" as Center B is committed to preventing them. Seeing the creation of a child as an intimate and special event, the psychologist who evaluates all applicants observed that: "If these people are not incredibly fond of each other, then why are they making a baby together? You shouldn't make a baby together unless there is a good deal of respect and warmth and fondness and comfort between the adults." Although couples come to Center C from throughout the country and the world, the agency insists that all birth mothers must live close enough to the center to attend monthly group counseling sessions. Consequently, virtually all birth mothers live within a two hour radius of the facility.

Center D. This center is the newest and had resulted in the fewest births as of the end of 1989. Like Center C, this center also emphasizes in-depth formal evaluation and counseling for all prospective birth mothers and couples, using the psychological training of its director and consulting psychologist to evaluate all those who work with the agency. In addition to seeking to foster ongoing contact between the couple and the so-called "surrogate" once the match is made, the agency staff keep in close touch with all the parties. As is the case with Center B, the staff frequently are physically present during labor and delivery, and they maintain considerable contact with all parties for months after the child is born.

Application and Evaluation Process

The four centers vary in the nature and extent of a formal application process for couples and birth mothers. In most centers the process requires that applicants complete written forms, undergo medical and psychological screening, and interviews with staff. The process can

be time-consuming. Centers vary in the amount of detail requested of applicants and in the verification of information provided.

The Birth Mother

All four centers ask prospective birth mothers to provide initial information about their own health, appearance, age, education, household income, pregnancy and childbirth histories, as well as data on any of their children. In addition to eliciting these basic demographic data, initial written forms and telephone interviews include questions on reasons for participating, and request information about such possibly sensitive matters as histories of psychological difficulties or substance abuse. Centers B, C, and D, which are more selective in their acceptance of prospective birth mothers into the program, eliminate many applicants based on unsatisfactory answers to questions about smoking, alcohol use, histories of psychological instability, or histories of health problems in applicants or their families. In contrast, Center A's philosophy is that the contracting clients and birth mothers should select one another without agency interference. Thus, Center A does not rule out applicants based on medical histories or behaviors. A review of applications of so-called "surrogates" in Center A (the only Center in which time permitted extensive examination of agency records), revealed that a sizable minority of candidates had some history of sexual abuse, substance abuse, or unhappy relationships with parents or partners. Many had less than a high school education, and several reported annual household incomes of less than twenty thousand dollars. Although many of those with such histories who applied to Center A were not rejected by the agency as unsuitable candidates, they might be passed over by couples for a variety of reasons. Aspiring "surrogates" generally remain in the pool of birth mothers until they match with a couple whose desires and expectations are compatible with their own.

Applicants who had been rejected as so-called "surrogates" in Centers B, C, and D included those with less than a high school education; those at, below, or just above poverty level; and those without a stable homelife and supportive partner, close family, or friends. Most of the women who sought to become birth mothers through these centers were rejected. Center B reported accepting only 5 percent of those who applied, and Centers C and D, respectively, accepted 18-20 and 30 percent of their applicants.

Those accepted by Centers B, C, and D resemble the women described in published information about the pool from which birth mothers are drawn.[6] Although some of the so-called "surrogates" have less than a high school education and some are living at the poverty level and receiving welfare benefits, the typical birth mother at the four centers and throughout the larger number surveyed elsewhere[7] has completed high school or beyond. Of the women who became birth mothers in Center C, fifty percent had attended college for some time, and all had finished high school. Reviews of the applications of Center A's pool of candidates showed that perhaps 20 had not completed high school and about half the remainder had had some formal education beyond high school. Center D noted that some of its birth mothers were teachers, nurses, and school administrators. The typical birth mother is married or is in a stable supportive relationship, and has borne at least one and often two or more healthy children. In Center C, for example, a woman serving as a birth mother typically was 27 years old, Christian, and married with two young children, with a year of education beyond high school, and a household income of just above $32,000 annually. Center B insisted that all birth mothers have completed high school, believing that a record of high school education indicated "an ability for the woman to make a commitment to herself" and to finish what she started.

The Couples

With respect to screening of couples, the "right to procreate" philosophy of Center A may be contrasted with the philosophical orientation of the other three centers -- an orientation that uses various criteria and methods of assessment to determine which people will make adequate parents for the children of surrogacy. Insisting upon a larger role for themselves in selecting and matching couples and so-called "surrogates", and placing greater weight on psychological and social characteristics, these centers have longer and more detailed application, screening, and matching processes. In contrast to Center A, where the time between the initial inquiry by couples or so-called "surrogates" and acceptance might be a matter of days, in Center B it was reported to be six months, and in the other centers intervals ranged from two months to a year. Whereas Center A appeared to be willing to work with almost any couple who applied, Centers B, C, and D reported deciding not to work with some couples who sought out their services.

Interviews and psychological assessment, rather than formal written application, constitute the major part of the evaluation process for those centers that seek to select among their potential clientele. Those centers reported ruling out many of the couples who applied based on psychological or social characteristics. Although Center B stated no formal criteria for rejecting couples, staff described disqualifying one couple in which there was a history of spousal abuse by the husband, and another in which the wife had a life-threatening illness and the husband indicated a lack of interest in raising the child if his wife were to die. The centers that stress in-depth staff knowledge of the couples focus on learning about the quality of the couple's relationship: how the couples deal with disagreement and conflict; how they have responded to the wife's infertility; reactions to the proposed surrogacy arrangement by the couple's family and friends; and the couple's plans for whether and how to inform the child of the circumstances of his or her conception and birth. This information is obtained either through in-house staff interviews (Centers C and D) or in psychological reports (Center B). In addition, Center D requires that couples complete a long and detailed personal history prior to interviews with staff and meetings with mental health practitioners. Because Center A takes a different approach to its task, viewing itself as a broker and facilitator of matches between couple and so-called "surrogate" and not as a gatekeeper, the application and screening process here is much shorter and less detailed. Center A indicated nothing in its written materials or interviews with Commission staff regarding criteria for refusing to work with a particular couple who could fulfill the terms of the contract (other than requiring that all couples be heterosexual).

Despite these differences in practice, couple profiles, like those of birth mothers, were similar across the surveyed agencies and in accord with the findings of published sources.[8] The overwhelming majority of clients (those people hiring so-called "surrogates") are in their late 30's or early 40's; nearly all are married couples. Those programs with data on religion noted that couples were of all the major religious groups in the nation. Virtually all were white, although a few African Americans, Hispanics, and Asians are found among the centers' clients.

One theme in the discussion of the *Baby M* case in particular, and surrogacy in general, has been the depiction of gross disparities in income and education between the contracting couples and the so-called

"surrogates." Frequently surrogacy is characterized as an instance in which affluent, well-educated men acquire children by hiring the labor of poor and unsophisticated women.[9] However, the disparities in income and education between couples and birth mothers may not be as great as these depictions have suggested. Although some of the women acting as birth mothers are known to have been financially desperate, poorly educated, and emotionally troubled,[10] the typical birth mother is not poverty-stricken and isolated. While nearly all the biological fathers and many of the infertile wives had college degrees, with substantial numbers having masters degrees, doctorates, or other advanced education, as noted above, educational attainment for the birth mothers varied by center. Generally, income and education of so-called "surrogates" and couples across the four centers is comparable to that described in sources surveying nearly all the centers in operation.[11] The selected birth mothers had earnings of approximately $30,000 annually, and the household income for contracting couples was likely to be twice or three times that amount. In a survey of couples using Center A, one psychologist noted that thirty percent had incomes over $100,000 a year and only four percent had incomes of less than $30,000.[12] The director of Center C reported the mean income of couples to be $80,000 annually, although some couples earned less and others were described as multi-millionaires.

Medical Screening

Centers that purport to be selective in the couples and the so-called "surrogates" give far more attention to physical and mental health and to character than to education or occupation. Centers varied in their emphasis upon and control exercised over medical screening of couples or of candidates for birth mother. Centers B, C, and D reported that they insisted upon receiving documentation of a couple's infertility or of a significant medical problem that precluded ordinary reproduction. These centers also obtained information about the medical history of the biological father. Center B refers all prospective fathers to a facility specializing in donor insemination for testing for sexually transmitted diseases and for genetic and medical histories. Center C obtains information on sexually transmitted diseases from both the biological father and his wife, and it asks the biological father to complete a medical and genetic history questionnaire kept on file at the agency.

All centers reported that prospective birth mothers were expected to pass medical examinations conducted by physicians selected by the

center or conforming to standards set by the center. Centers A, B, and C referred all prospective birth mothers to doctors independent of, but known to, the centers for preliminary examinations and inseminations. All centers reported that many women were rejected after medical evaluation, either because of potential risks to their health posed by pregnancy or because personal or family medical histories revealed possible risks to the fetus. The physician working closely with Center A, which screened out the fewest candidates, reported that at least ten percent of applicants failed the medical examination.

Although such examinations screened out some women, the examinations of biological fathers and of so-called "surrogates" did not make use of all possible medical testing. Physicians working with Centers A and B indicated that they relied on the accuracy and honesty of the women and men sent to them and did not always conduct extensive testing beyond what they would perform for other patients. Center C asks for medical histories of biological fathers and so-called "surrogates", but does not conduct in-depth examinations. The director of Center C pointed out that some of the "horror stories" attributed to careless medical practices of surrogacy centers could have occurred in any pregnancy if patients did not give complete and accurate information to physicians.[13]

Despite the fact that surrogacy could be selected as a reproductive alternative for reasons of fetal health or for obtaining particular fetal characteristics, detailed genetic screening and testing was not a significant component of medical evaluations of potential birth mothers or biological fathers. Centers that obtain genetic information about the biological parents do so through self-report and the taking of a genetic history questionnaire, not independent genetic testing. Some centers may insist upon testing for the presence of sexually transmitted diseases, and formal or informal understandings exist about medical testing for fetal impairments; however, information that might bear upon the genetic histories of applicants for so-called "surrogate" or biological father is obtained primarily through self-report and not through genetic testing. Thus, it appeared that as practiced to date, surrogacy has rarely been used to avoid transmittal of diagnosed genetic conditions.*

* The nature and extent of HIV/AIDS testing as a component of medical screening is an issue requiring further study.

Psychological Screening

The efficacy, appropriateness, and quality of psychological screening of candidates for so-called "surrogate" and of couples seeking surrogacy has engendered a good deal of speculation and media attention as a result of the *Baby M* case. During the trial it came to light that a psychological report had existed in the agency's files suggesting that Mary Beth Whitehead might experience distress and difficulty in relinquishing the baby after birth. This report was not requested by Mary Beth Whitehead herself or the Sterns, and for whatever reason, the matching service never communicated the findings to any of the participants.[14]

The four centers varied in their views on the relevance of psychological assessment of birth mothers, and consequently in the emphasis placed upon such evaluations. They also varied as to which participants they assessed, how they conducted their evaluations, and the weight placed upon psychological screening as a component of their activities. Centers B, C, and D claimed that the psychological screening they conducted would reduce appreciably the likelihood that women or couples with serious psychological problems become involved in a surrogacy arrangement through their centers. Center A put much less emphasis upon or faith in psychological assessment.

With full-time mental health practitioners on staff, Centers C and D not surprisingly rely heavily upon psychological evaluations of all couples and so-called "surrogates" who apply to their programs. The centers staffed with mental health professionals reported that the initial evaluations of birth mothers and couples are designed to take several months. Center D described a three-stage screening process for so-called "surrogates" and couples that included completion of an initial personal history form, an interview with the center director (who is a psychologist), tests given by a consulting psychologist, and further consultation with the center director. Couples and prospective birth mothers applying to Center D are given reading material for and against surrogacy and are asked to explain how they will describe surrogacy to family, friends, other children of the birth mother, and the child born of the surrogacy arrangement.

Although Centers C and D encourage contact and relationships between the couple and the birth mother and Center B operates with

strict anonymity, all three centers report similar concerns in their assessments of couples and birth mothers. These three centers stress their mission to provide a reproductive alternative for people with a deep longing for a child and those who will provide that child with a stable and loving environment. Public discussions of surrogacy have tended to focus more on the motives and responses of the birth mother than on those of the couple, but the center evaluations are very interested in the motives and responses of the couples as well. Moreover, interviews with agency personnel and participants themselves revealed agency interest in the needs and feelings of each partner. Center staff indicated that they wanted to make sure couples had a solid marital relationship and would be loving and committed parents. Their assessment included information on how the partners handled conflict in their own relationship; how the husband had responded to his wife's infertility; how the adopting mother felt about her infertility; how the wife expected to feel about another woman carrying her husband's child; and whether she was willing and eager to raise a child biologically connected to her husband but not to her. The centers also wanted to be confident of how couples expected their family and friends to react, and of how couples planned to help their child cope with the knowledge of his or her atypical origins. Agency directors indicated that they wanted to work with couples who sought a baby, but not couples who sought a "perfect baby."

The agencies did not believe that surrogacy should be tried only after all other infertility treatments and adoptive efforts had failed, and noted that most couples who sought them had already experienced many disappointments in their attempts to have children. Staff noted that the difficulties in current adoption combined with two features of surrogacy made it attractive to many couples: the genetic connection of the child to the husband, and the likelihood that the woman carrying the child would be in good health and would receive competent and thorough prenatal and obstetrical care.

While it is not known how many couples are rejected by these three centers or for what reasons some are disqualified, it is noteworthy that all of the adoptive mothers interviewed professed satisfaction with the choice of surrogacy. Several couples were tired of the long waiting periods they had already experienced in the adoption queue; others had been rejected by adoption agencies because they were too old, had been previously married, were of different religions, or had children from a

previous marriage. Still others preferred surrogacy to adoption because of the genetic connection to the husband, and some were concerned about the circumstances surrounding the pregnancy of a woman relinquishing an unwanted child for adoption.

All but Center A indicated that to varying degrees they were interested in exploring the motives of prospective birth mothers as well. The staff psychologist at Center C believed that the woman had to be gaining something important from the experience beyond money. The psychologist who had interviewed five women for Center B believed at least two or three would have served as so-called "surrogates" even if they had received no fee, provided pregnancy-related expenses were paid. In fact, women seeking to become birth mothers revealed a mix of motives in addition to monetary compensation. These descriptions, as well as the comments of the women interviewed by Commission staff, corroborate published findings about motivation of so-called "surrogates": an enjoyment of their own children; appreciation of the role of motherhood in their own lives; contact with and empathy for infertile people; a desire to give in an unusual and special way; an enjoyment of the experience of pregnancy and of the attention they receive while pregnant; and for some, the desire to resolve problems stemming from a previous abortion or relinquishment of an unwanted child.[15]

With regard to the birth mother, each of the programs wants, of course, to accept women who will not have difficulty relinquishing the child upon birth. Assessments focus on how the woman makes decisions in her life, whether impulsively or after thinking things out; how she has handled loss and depression in her past; how she responds to pregnancy and to the post-partum period; and how she intends to use the money obtained from the transaction. The psychologist at Center C, for example, said that she is interested in a woman's thought process, whether it is clear or confused, whether it appears clouded by denial. The psychologist at Center C described the birth mother's experience as "a demanding and a complex process", and said that the center works only with people who can think in an abstract manner and can project their feelings into the future. The center prefers to work with someone who recognizes that the pregnancy and birth will be an experience that may engender strong and powerful feelings. This psychologist claimed that it was better to work with a woman who had concerns and questions than with one who did not acknowledge them. Only Center D routinely

brings husband and children of the so-called "surrogate" into the screening process; the other centers rely on the psychological evaluation of the so-called "surrogate." Centers B, C and D indicated that they would work with women only if they appeared to have strong and supportive relationships in their lives with spouse or partner, parents or friends, and their own children. Center D, for example, stated that it would never work with a prospective birth mother in the midst of a divorce. The centers stated that they would be wary of taking someone who seemed coerced by a spouse, seemed to want a child of her own, or could not talk about her feelings nor reflect upon how the process might affect her marriage and her children.

The several month screening process described by Centers C and D may appear to differ more from the much shorter mental health assessments conducted by Center B than is in fact the case. Although Center B's standard exam for a couple is normally three hours and that for the so-called "surrogate" is 90 minutes, the independent practitioner's psychological assessment is supplemented by the staff's ongoing contact with and relationship to the parties involved. The director and assistant rely on their own judgment of the couples and prospective birth mothers to determine whether these people could work successfully in the program. Because of Center B's policy of anonymity, the staff are the only link between the couple and the birth mother; thus, psychological assessment by and rapport with center staff are considered crucial to acceptance into the program. Since the psychological assessments in Centers C and D are conducted largely by mental health practitioners on staff, those who meet the criteria of psychological health are also those with whom the staff is prepared to maintain an intense and ongoing relationship.

In sum, regardless of the time taken or whether standard personality or intelligence tests are given to augment clinical impressions, Centers B, C, and D believe it their task to learn a great deal about the participants' stability, character, motives, and relationships. It is through this knowledge that the centers decide whether their program will work for those who seek its services, and they believe it both prudent and appropriate to their understanding of their mission to exclude people from participating in a process that may be harmful to them, to the children, or to the future of commercial surrogacy as an enterprise. Those centers emphasizing psychological characteristics of couples and birth mothers do

so for several reasons. They observe that because surrogacy is new and somewhat controversial, couples, so-called "surrogates", and the resulting children might encounter a range of psychological problems. Hence, they felt that surrogacy is not appropriate for everyone and that it is acceptable to screen out participants in the process. Also of critical importance to the centers was establishing greater legitimacy for surrogacy as a reproductive alternative by avoiding adverse publicity that might surround unsuccessful and contested arrangements. In addition, the centers were committed to preventing the kind of difficulties and negative public perceptions that might encourage states to seek excessive regulation, or perhaps prohibit, their work.

In contrast, Center A, guided by the philosophy that people who wish to procreate by surrogacy should encounter no greater obstacles than those who can do so conventionally, adopted a very different approach to the scope and importance of psychological assessment. Center A does not require screening for single individuals or couples who seek a so-called "surrogate." A ninety-minute interview is conducted with women who apply to be birth mothers, but the assessment is limited to a determination of medical and legal competence to sign an agreement to undertake a pregnancy and to relinquish the child after its birth. Throughout discussions with Commission staff, the two consulting mental health practitioners who screened prospective birth mothers insisted that no clinical exam could reliably predict future stress or difficulty for a woman entering into a surrogacy agreement. Although each practitioner reported instances of deciding that a prospective birth mother was not medically or legally competent to understand the consequences of a surrogacy agreement and to give a knowing and informed consent to the agreement, they believed that the vast majority of people could do so and felt there were rarely reasons to exclude an individual based upon a psychological examination.

After Acceptance to The Program: Negotiating The Relationship

The Matching Process

After a center decides that all parties have met the established criteria, the process of matching birth mother and couple begins. Here again, the centers varied in their philosophy and approach. Center A leaves the matching process to the parties themselves. After reviewing applications, photographs, and biographical histories of prospective birth

mothers (sometimes called "catalogues" by staff and participants), couples select those women they wish to meet. Alternatively, couples and birth mothers can attend a gathering at the agency and can meet one another during group sessions. For some participants these group sessions felt like "cattle calls." One adoptive mother, delightedly raising two children born through the Center A program, nonetheless described the matching process as "a little like looking for wallpaper." Although she and her husband were very happy with the surrogacy program that had given them the children they were raising, she said the group meetings were not entirely comfortable. "They were a little impersonal. We didn't like them very much." She and others interviewed said that selecting someone to work with involved meeting several people before finding someone whose personality, appearance, and expectations of the surrogacy relationship conformed to their own. A psychologist from Center A who had surveyed couples about their experiences noted that it usually took meetings with four possible birth mothers before a couple finally selected one with whom to work.[16]

The other three centers aim to spare couples and birth mothers unsuccessful meetings by learning about the applicants through the interviewing and screening process. In contrast to the approach of Center A, the other three centers saw an active role in screening, matching, and assisting in the forming of relationships as critical to the success of their operations. While meetings between prospective couples and so-called "surrogates" in Center A might take place on or off the agency premises and usually without agency staff present, all initial meetings among the parties in Center C were conducted at the agency in the presence of the staff psychologist. Center D did not have a set policy on how the initial encounter should be arranged.

Centers B, C, and D stressed that physical characteristics of the so-called "surrogate" were only a part of the matching process. More important was whether couples and so-called "surrogates" had similar needs and expectations. Since Center B's policy of annonymity and limited contact prevented meetings and interactions among the parties, the staff, in its matching process, considered personality, similarity in values and hopes for the child, and a commonality of understanding about how the pregnancy should be conducted. For example, couples who would want amniocentesis and would choose abortion in case of detected fetal impairment would not be matched with a woman who was unwilling to

undergo such a test or to have an abortion in that circumstance. At Centers C and D, where couples and birth mothers could have varied relationships with one another, those who wanted relatively little contact with birth mothers during the pregnancy and after the child's birth were matched with women who themselves did not seek close relationships. Some couples and so-called "surrogates", on the other hand, looked forward to forming a close and special relationship. While the staffs in Centers C and D personally favored more rather than less contact between so-called "surrogate" and couple, they indicated that their clients varied and that they honored individual differences. Referring to views about the conduct of the pregnancy, one of the attorneys who represents couples and so-called "surrogates" for Center D said: "A lot of these things don't become major issues if you talk to the surrogate up front and pick one who is in sync with you." The Center director commented: "That's part of the matching. The relationship with the surrogate is of vital importance for it to be okay for both the surrogate and the adoptive mother." Center C, however, said that it would not work with people who wanted no contact at all. To them it suggested denial about the reality of the situation of surrogacy.

Psychological Counseling

The centers also vary in the importance placed upon counseling during the surrogacy process as well as after the birth of the child. Center A has no policy regarding counseling for so-called "surrogates" or couples, and the fees charged to couples do not include expenses for psychological counseling of the birth mother during pregnancy. Center B's screening requirements for birth mothers and couples are confined to the initial assessment, and an interview with a so-called "surrogate" does not include her spouse, children, or other significant people in her life. Nor does the agency require ongoing psychological counseling of either the so-called "surrogate" or the couple, although the frequent contact with agency staff is intended to serve a supportive and problem-solving function for everyone involved. Relying heavily on psychological orientation that stresses applicant assessment and staff expertise, Centers C and D include a formal component of psychological counseling for the so-called "surrogate" throughout the pregnancy and for some months after the child is born and surrendered to the couple. Center C also requires monthly group meetings for birth mothers led by the agency mental health staff, supplementing appointments with agency staff. It is worth noting however, that since the counseling in both Centers C and D is

conducted by agency staff who also screen candidates and serve as intermediaries or problem-solvers in any phase of the birth mother-couple relationship, there is no way to assess how independent psychological counseling is from other staff involvement. As the psychologists doing the counseling are also staff people for Centers C and D, it is open to serious question whether the psychological counselor can properly separate fiduciary responsibilities to the couple or birth mother as patient from responsibilities to the center in case of any serious conflict that might threaten the surrogacy arrangement.

Medical Care

The issue of supervision of the medical care of the birth mother has occasioned considerable comment and concern by people both supportive of and opposed to the practice of surrogacy. Couples often choose surrogacy over adoption desiring to know the biological mother and to be confident that she is taking care of herself and of the fetus during her pregnancy. Some of the contracts that have come to public attention have made mandatory medical tests and medical care of the woman integral to the arrangement. Consequently, Commission staff attempted to determine the centers' policies toward medical care for the woman and the interpretations and experiences of those policies by couples, so-called "surrogates", and involved physicians.

Physicians working with Centers A and B, staff of all centers, and participants interviewed from Centers A, B, and D all declared that medical care followed standard protocols used for any other obstetrical patient and did not include any stipulations made by the agency or the couple. The physician who was part of the group working with birth mothers in Center B reiterated that he and his colleagues had no contact with the couple and did not wish to do so. "She is my patient," said the doctor, referring to the woman who was carrying the child. "I care for her as I would care for any other patient. I don't have any reason to deal with the couple." The independent physician who worked with many of the so-called "surrogates" in Center A expressed the same view. Center C did not require that so-called "surrogates" use specified physicians during pregnancy, labor, or delivery. To assure standard care, the agency requires that so-called "surrogates" be seen by licensed obstetricians rather than midwives, and gives the woman and the physician guidelines regarding its expectations. Center C's protocols

proscribe drinking, drugs, and smoking. (Some couples waive any stipulations about smoking if they themselves smoke.)

Center C also tries to use medical expectations for the pregnancy as part of the criteria for matching, but leaves a great deal to the woman and her physician. Limitations on such activities as caffeine consumption, travel, or working are found in neither the contract nor the medical protocol but are left to the woman and her doctor. "I can't say that a woman shouldn't travel to see her parents for Christmas just because a couple is paranoid about traveling," said the psychologist. "That is up to the woman and her doctor." In contrast, Center D spells out all requirements for medical care in its 50-page contract, but attempts to limit involvement in the matter of lifestyle of the pregnant woman by matching the so-called "surrogate" only with a couple whose expectations are compatible with hers. All personnel expressed the view that they had confidence in the women they selected and that the women, not agencies or couples, were in charge of their pregnancies. Many of the wives of the couples took great interest in the medical care received by the woman carrying the child. Sometimes prospective adoptive mothers who lived near the so-called "surrogates" used medical appointments as occasions to spend time with the so-called "surrogate"; how much informal negotiation about testing, diet, exercise, and daily activities occurred in this way is impossible to determine.

Legal Representation

Centers A and C, which have staff lawyers, handled legal matters for the contracting parties and often referred the so-called "surrogates" to attorneys familiar with the practice of surrogacy. Center A had one attorney in its office who handled many of the negotiations for so-called "surrogates", and Center C had trained a group of local attorneys to work with so-called "surrogates" in negotiations. In contrast, Centers B and D insisted upon independent legal representation for all parties, and sometimes referred them to independent outside attorneys. Since many couples and so-called "surrogates" sought counsel from those familiar with surrogacy, and since few people unconnected with an agency are familiar with legal issues surrounding surrogacy, it is uncertain in practice how "independent" of the agency any local legal counsel may be.

The Contract

The only contracts seen by Commission staff were the standard contracts used by Center A; none of the other agencies provided examples of their contracts. The centers were reluctant to discuss contracts in detail and Commission staff did not examine any completed written contract. However, agency directors provided some information regarding the nature of the contract, particularly on the topics of fees, duties of the so-called "surrogate", and remedies in cases of dispute. Some general conclusions about the nature of surrogacy contracts emerged from these discussions. It is worth noting that although a number of contract terms appeared to be standard, the terms of a contract were also said to vary within centers depending upon the particular wishes of couples or so-called "surrogates."

Since Centers A, C, and D sought to assure that matched birth mothers and couples held compatible views on pregnancy, it was assumed that most specifications of testing, lifestyle, and behavior of the birth mother could be worked out between the parties and therefore did not need to be included in the written contract. Similarly, since Center B matched only people whose views on these issues were thought to be compatible, these topics remained outside the written agreement. All post-*Baby M* contracts, however, assured that the birth mother herself would decide whether or not to have an abortion.

The agreements described by the four centers were similar with respect to fees paid to the so-called "surrogate" and expenses to be paid by the couples. Agency C charged the highest fees, believing that its in-depth counseling and its requirements for ongoing contact with the so-called "surrogate" and couple after the child's birth warranted additional expenditures. The fee paid to the so-called "surrogate" was reported to be $10, 000 in all cases, but payment schedules varied. All agencies stressed that the payment was to be understood as compensation for services, not for the relinquishment of a child, but only Center C stated that the woman would be paid the same fee regardless of whether or not she surrendered the child after birth. All others expected that failure to relinquish would affect fee payment. While some contracts from prior years had called for only partial payment in the event of stillbirth or disability, all centers stated that post-*Baby M* their contracts had been changed to require payment based solely on the duration, not the outcome, of the pregnancy. A full-term pregnancy resulting in a

stillbirth or a disabled child would warrant payment of the full $10, 000. All indicated, however, that payments might be reduced if it could be shown that death or disability was attributable to gross misconduct on the part of the birth mother.

Final Observations

Several additional findings emerged from the site visits conducted by Commission staff. First, regardless of the size of the program or the composition of the center staff, those working at the center and the participants in the program showed dedication and a strong sense of mission about the importance of surrogacy. When asked what directions for future policy they would favor, all center directors acknowledged that more regulation of the business was needed, but insisted (for obvious reasons) that prohibition of the practice would be wrong. Centers B and D stressed the need for standards to govern agency practice, including qualifications of staff, and background checks of prospective participants. The director of Center B, for example, indicated that criminal and credit checks would be possible with regulation and state licensure, but were impossible because surrogacy was a fringe and unregulated industry. Center C did conduct such checks. (It is unclear what accounts for the differing abilities of the two programs to do a thorough background investigation.) Couples and so-called "surrogates" interviewed (including some who spoke with Commission staff by chance and were not selected by the center), evidenced great satisfaction with what they were doing. Couples and birth mothers at three of the four programs had gone through the process for a second time.

Second, when birth mothers form a deep relationship during their surrogacy experience, it is usually with the agency staff, with the couple, and especially with the infertile wife. For most, it is not a psychological relationship with the developing fetus. One birth mother explained that she always felt she was carrying someone else's child. Her husband, she said, would not put his hand on her belly during the pregnancy to maintain a distance from the child-to-be that was not his own. Two birth mothers from Center B said that they felt no connection to the developing fetus because it would not be the child of them and their husbands; they were taking care of someone else's child. Birth mothers with young children were careful to explain to their own children that the fetus they were carrying was not going to live with them, was not going to be their

sister or brother, but was "Tom and Ginny's child" being carried by them because Ginny's body would not let her carry a fetus.

Contrasted with the lack of connection felt between the birth mother and the child was a strong and close involvement with the couple. In many instances intense relationships were formed between the birth mother and couple, particularly between the women. This was found to be true in all three centers, A, C, and D, that permitted contact between birth mother and couple. In fact it was with the infertile wives that so-called "surrogates" often maintained the greatest contact. In such cases, the husband often remained more distant. It appeared that for the infertile women, who often desired a close relationship with the birth mother and involvement in the pregnancy, the birth mother was truly a "surrogate" standing in for them. Birth mothers spoke with great appreciation of the attention and affection they received from the couples, especially the women, and some stressed that diminution of contact with the couple following the child's birth had been their greatest problem with the surrogacy experience. Emphasis upon the relationship between the two women corresponds with the finding reported in one of the few studies conducted by researchers unconnected with any of the surrogacy agencies -- that grief for the so-called "surrogate", when experienced after the surrender of the child, is due primarily to the loss of contact with the woman or the couple, not the loss of the relationship with the child itself.[17] A so-called "surrogate" in Center A said of her experience: "This child is born of your love and my body." To her, and to the other birth mothers interviewed, including some who were serving for a second time, their psychological relationship existed with the woman or the couple for whom they were carrying the child-to-be, and not with the fetus. Many referred to their surrogacy experience as "like babysitting."

Further, as noted earlier, more important than size, qualifications of staff, or numbers of clients, it is the personality, views, and philosophy of the agency staff that give the program its character. Irrespective of their professional orientation, staff members who want oversight and control of the process are very involved with the couples and the birth mothers. Center C, one of the largest programs, reported involvement with participants that appeared as intense as the smallest of the centers.

It is important to iterate the caveat expressed at the beginning of this chapter. Very little of the information obtained from agency staff could be independently verified. Written records were rarely provided. Contracts and psychological and medical reports offered scant verification of the information provided by the parties about themselves. Of the participants interviewed at Centers A, B, and D nearly all were selected by agency staff in advance of the interviews. There is no way to know the extent to which they may have been "coached." In Centers B and D, agency staff were present during almost all of the interviews with participants, which may have inhibited what was said. (In some instances, however, telephone interviews were conducted when center staff were not present, and these did not yield different information.) In Center C, no participants were interviewed.

Additionally, in the post-*Baby M* period several of the participants had become involved in speaking to media and to lawmakers in support of surrogacy. Thus, a number of those who provided personal accounts to the Commission staff had become public figures of sorts, and appeared to have become practiced at communicating their views about surrogacy to skeptical, curious, or probing questioners. At the same time, it should be noted that their accounts of contentment and appreciation did not differ significantly from those interviewed who had not had previous experience talking about surrogacy in the public eye. Nonetheless, it is at best unclear how representative the views and experiences of the participants at the centers are of those involved in surrogacy nationwide.

TABLE I
SITE VISITS TO SURROGACY CENTERS: METHODOLOGY

Interviews with	Center A	Center B	Center C	Center D
Director	+	+	+	+
Coordinator			+	+
Secretary	+			
Staff Psychologists			+	
Outside Psychologists	+	+		
Staff Attorney	+			
Outside Attorney		+		+
Staff Physician				
Outside Physician	+	+		
Contracting Couples	+			+
Rearing Mothers	+	+		+
Birth Mothers	+	+		+

Interview Methods	A	B	C	D
In Person (Appointment)	+	+	+	+
By Phone		+		+
Taped	+	+		+
Random		+		

Documents Reviewed	A	B	C	D
Applications	+			
Screening Forms				
Psychological Forms	+	+		
Agency Information			+	
Sample Contracts	+			
Data on Clients	+	+	+	
Medical Forms		+		

TABLE II
SUMMARY DATA ON SURROGACY CENTERS
(as of end of 1989)

	Center A	Center B	Center C	Center D
Established	1976	1981	1980	1985
Number of Births	253	57	100	8

Staff Composition	A	B	C	D
Size of Staff	18	2	9	5
Administration	+	+		+
Attorneys	+		+	
Psychologists			+	+
Other Professionals			+	
Clerical	+		+	+

Birth Mothers	A	B	C	D
Medical Screening	+	+	+	+
Psychological Screening	+	+	+	+
Legal Representation	*/**	*	*	*
Acceptance Rate	N/A	5%	18-20%	30%

Contracting Couples	A	B	C	D
Medical Screening (Biological Father)		+	+	+
Psychological Screening		+	+	+
Legal Representation	**	*	**	*

Criteria for Acceptance	A	B	C	D
Heterosexual Couple	+			
Married (documented)		+		
Infertility/Medical Problem		+	+	+
Acceptance Rate	100%	40%	N/A	N/A

* Independent Counsel
** In-House Counsel
N/A means no data available

NOTES

1. 109 N.J. 396, 537 A.2d 1227 (1988).

2. For an illustrative sample of the extensive media coverage, *see* Martha A. Field, *Surrogate Motherhood: The Legal and Human Issues* (Harvard Univ. Press 1988), chapters 1 and 2 and sources cited therein.

3. *See* sources cited in chapters 4 and 5.

4. Rebecca Powers and Sheila Gruber Belloli, "The Baby Business: A Five Part Series," *Detroit News* (September 17-21, 1989) (hereinafter "Detriot News").

5. Lori B. Andrews, *Between Strangers: Surrogate Mothers, Expectant Fathers, and Brave New Babies* (Harper and Row 1988) (hereinafter "Andrews"); Office of Technology Assessment, *Infertility: Medical and Social Choices* (United States Government Printing Office May 1988) chapter 14 and Appendix G (hereinafter "OTA Report"); Amy Zuckerman Overvold, *Surrogate Parenting* (Farrell Books 1988); Susan Ince, "Inside the Surrogate Industry," in *Test Tube Women: What Future for Motherhood?*, Rita Arditti, Renate Duelli Klein, and Shelley Minden, eds. (Pandora Press 1984), pp. 99-116. The most recent information is provided in the September 1989 series of five articles in the *Detroit News*, *supra* note 4.

6. *See* OTA Report, *supra* note 5, chapter A and Appendix G.

7. *Id.*

8. *Id.*

9. Michelle Harrison, "The Social Construction of Mary Beth Whitehead," *Gender and Society* (September 1987): 300-11.

10. *See* Andrews, *supra* note 5; Detroit News, *supra* note 4; Testimony Presented by the National Coalition Against Surrogacy at the Joint Public Hearing of the Assembly Judiciary Committee and the Assembly Task Force on Women's Issues (New York, December 8, 1988).

11. *See* OTA Report, *supra* note 5; *Detroit News*, *supra* note 4.

12. Joan Einwohner, "Characteristics of Parents of Surrogate Children," paper presented at the New York State Psychological Association Annual Convention, Kiamesha Lake, New York (April 30, 1988) (hereinafter "Einwohner").

13. "Women Who Experienced Surrogacy Speak Out: Mary Beth Whitehead, Alejandra Munoz, Patricia Foster, and Nancy Barrass," in *Infertility: Women Who Speak Out About Their Experiences of Reproductive Medicine*, Renate D. Klein, ed. (Pandora Press 1989), pp. 139-58; Detroit News, *supra* note 4.

14. 109 N.J. at 437, 537 A.2d at 1247.

15. Hilary Hanafin, "Surrogate Parenting: Reassessing Human Bonding," paper presented at the American Psychological Association (New York August 1987); Philip J. Parker, "Surrogate Motherhood, Psychiatric Screening, and Informed Consent: Baby-Selling and Public Policy," *Bulletin of the American Academy of Psychiatry and Law* 12 (1984): 21-39; Donald D. Franks, "Psychiatric Evaluation of Women in a Surrogate Mother Program," *American Journal of Psychiatry* 138 (10) (1981): 1378-79.

16. Einwohner, *supra* note 12.

17. Kathy Forest and David McPhee, "Surrogate Mothers' Grief Experiences and Social Support Networks," Department of Development and Family Studies, Colorado State University (Fort Collins, Colorado, 1989) (unpublished Monograph 1988).

CHAPTER FOUR

THE LEGAL CONTEXT

Public Policy Options for Surrogacy

Formulating public policy for surrogacy raises the fundamental question of the extent to which the state, through its laws, ought to be involved in decisionmaking in this area. Should the law take a permissive approach, allowing people to arrange their affairs as they see fit? Or should the law proceed on the premise that in certain circumstances protection and promotion of social values takes precedence over the desires and wishes of some individuals, warranting prohibition, or perhaps regulation, of surrogacy arrangements?

Natural reproduction and adoption provide two contrasting examples of the role of law in procreative issues.[1] In natural reproduction, the state does not screen potential parents to ascertain their "fitness to parent", but takes a non-interventionist approach that gives precedence to private decisionmaking. In adoption, on the other hand, the state plays a very active role, applying strict standards of eligibility which involve detailed scrutiny of the applicants' physical, emotional, economic, and psychological profiles. Since surrogacy has some similarities to and some differences from both natural reproduction and adoption, neither approach is completely applicable; public policy development should draw on both models for guidance.

In defining the role that the state should play with regard to surrogacy, a number of potential approaches can be identified. At one extreme is *prohibition*. A prohibitory approach might entail a comprehensive ban on all forms of surrogacy, enforced by criminal or quasi-criminal penalties on some or all knowing participants (for example, broker/intermediaries, so-called "surrogates", the potential rearing couple, or professionals such as physicians, attorneys, and psychologists). At the other extreme is an *enabling* or *promoting* model. Under this approach, the state promotes surrogacy by enforcing a wide spectrum of private contractual arrangements, subject only to traditional legal protections against fraud and duress that would void the agreement. For example, the state might enforce contractual agreements regarding

payment to the so-called "surrogate" and to the broker/intermediary, as well as contractual provisions intended to control the so-called "surrogate's" conduct during pregnancy and to govern the transfer of custody and the termination of parental rights.

A third, less absolutist strategy is a *regulatory* approach, which would set forth legal requirements for some fundamental matters and provide minimum standards of conduct for broker/intermediaries, professionals, and familial participants. A regulatory model might reflect either a "facilitating" or a "discouraging" policy orientation toward surrogacy. A facilitating model entails a strong commitment to surrogacy as an important option in dealing with female infertility, and would thus accept surrogacy, within defined limits, as a socially legitimated activity. This approach would be intended to maintain certain public policy standards, to provide necessary protection to the participants, and to curb potential abuses, by seeking to regulate some fundamental matters, such as payment, determinations of custody and other parental rights, and control over medical and lifestyle decisions during pregnancy. A facilitating scheme could provide for licensing or minimum standards to govern the behavior of broker/intermediaries and professionals, such as psychological, medical, and genetic screening, as well as counselling. Grounded on norms of individual autonomy and respect for private contractual agreements, a regulatory scheme to foster surrogacy arrangements with proper safeguards would essentially rely on the parties to protect themselves within the context of the contractual agreement, and would view the state's role (beyond the setting of minimum standards) primarily as enforcing the contract, intervening only to protect the parties from overreaching.

A discouraging regulatory model embodies the view that society will allow the practice of surrogacy only on condition that certain stringent safeguards are met. This model might set forth a series of regulatory measures aimed at protecting the parties from exploitation, such as by prohibiting certain activities and/or refusing to recognize or enforce certain contractual arrangements. A discouraging approach might thus refuse to enforce contractual provisions for commercial payments to so-called "surrogates" or to broker/intermediaries, conditions limiting the right of the so-called "surrogate" to control fundamental medical and lifestyle decisions during pregnancy, and irrevocable waivers of parental rights or claims to custody prior to the expiration of a fixed period

following the birth of the child. As with the facilitating approach, a discouraging model may take a variety of forms, and may allocate the risks differently, depending on whose interests it most wishes to protect (*e.g.*, the so-called "surrogate" or the resulting child). The core feature of the discouraging model, whatever variation it takes, is its basic concern to protect parties from potential abuse and exploitation, and its consequent demand for compliance with stringent protective standards.

The question whether and to what extent the state can or should intervene in personal procreative decisions like surrogacy also raises important constitutional issues. Although the Commission and Task Force did not seek to reach ultimate conclusions of constitutional law, relevant judicial decisions and commentary were reviewed for guidance concerning the possible constitutional limits applicable to a policy response to surrogacy.

Briefly, a number of decisions of the Supreme Court of the United States have held that the due process clause of the Fourteenth Amendment to the United States Constitution protects certain fundamental rights relating to personal and familial privacy.[2] Generally, the state may limit these fundamental rights only if it is shown that there are "compelling state interests." Looking to these precedents, some have argued that if there is a fundamental right to procreate by means of natural reproduction, this right is broad enough to encompass procreation by assisted means; consequently, state statutes prohibiting commercial surrogacy amount to an interference with that fundamental right and may be unconstitutional.[3] In *Baby M*, the New Jersey Supreme Court considered and rejected the argument that procreation through commercial surrogacy, including the right to custody of the child, is a constitutionally protected right. The Court held that:

> The right to procreate very simply is the right to have natural children, whether through sexual intercourse or artificial insemination. It is no more than that. Mr. Stern has not been deprived of that right. Through artificial insemination of Mrs. Whitehead, Baby M is his child. The custody, care, companionship, and nurturing that follow birth are not parts of the right to procreate; they are rights that may also be constitutionally protected,

but that involve considerations other than the right of procreation.[4]

Thus, the *Baby M* Court specifically declined to rest its decision on federal or state constitutional grounds. The Court's central holdings were rooted in statutory and common law, allowing that public policy governing surrogacy is subject to potential modification by legislative action. In fact, the Court was quite explicit in inviting legislative action if the legislature should reach different conclusions on fundamental policy issues, stating that "...the Legislature remains free to deal with this most sensitive issue as it sees fit, subject only to constitutional constraints."[5] It is within the legislature's prerogative to address surrogacy in a manner it believes to be sound public policy for the citizens of New Jersey. (The Court did not set forth the constitutional limits on this authority in its opinion.)"

The array of approaches to dealing with surrogacy reflect different philosophies about the extent to which government should intervene in the private lives of its citizens, and seek to respond to speculative but highly significant concerns as to the consequences of the surrogacy arrangement on the particular parties involved and upon broader public policy concerns. Thus, it is not surprising that the several legislatures, courts and study committees that have addressed the issue have not taken a uniform approach. To the contrary, all four models (and variations on them) reflect a rich diversity of values and policy goals. This chapter discusses the highlights of the key judicial decisions, statutes and policy studies that have responded to the issue of surrogacy, beginning with the *Baby M* case.

" As noted below, those few courts elsewhere to address this issue have similarly rejected the claim that surrogacy arrangements are constitutionally protected. This view is most strongly stated by the New York State Task Force, which concluded that it is arguable the constitutional considerations relevant in natural reproduction are simply inapplicable in surrogacy. In the view of the New York State Task Force, the constitutional right claimed by the intended parents relates not to their bodily integrity, but rather is an asserted right to use *another* person's body. Given the necessary involvement of a third party (the so-called "surrogate"), the interests of the intended parents can not be said to amount to a "privacy" interest. Further, to protect the procreative rights of the intended parents necessarily involves disregarding the procreative rights of the so-called "surrogate." The Task Force also suggested that the payment involved in commercial surrogacy may remove any constitutional protections. New York State Task Force on Life and the Law, *Surrogate Parenting: Analysis and Recommendations for Public Policy* (May 1988), pp. 61-62.

Current Law in New Jersey: The *Baby M* Case

National and international attention was focused on the practice of surrogacy with the widely publicized New Jersey case of *In the Matter of Baby M*. In that case, Mary Beth Whitehead and William Stern entered into a surrogacy arrangement whereby Mrs. Whitehead was to be artificially inseminated with Mr. Stern's sperm, carry the fetus to term, and immediately after birth surrender the child to Mr. Stern. The contract contemplated that Mrs. Whitehead's parental rights would be voluntarily terminated, thus allowing for the adoption of the child by Mr. Stern's wife. Mrs. Whitehead was to receive $10,000 upon surrender of the child. After the birth of the child, however, Mrs. Whitehead refused to surrender her parental rights and contested custody.

The trial court held that the surrogacy contract was valid and enforceable, and that it would be in the best interests of the child to be placed with and raised by the Sterns. The court terminated Mrs. Whitehead's parental rights, and awarded sole custody of the child to Mr. Stern. It then immediately granted Mrs. Stern an order for adoption to make her the legal mother of the child.[6]

The New Jersey Supreme Court reversed much of the trial court's opinion, holding the contract to be invalid and reinstating Mrs. Whitehead's parental rights. The Court also affirmed that portion of the opinion that awarded custody to the Sterns. The Court ruled that the contract violated New Jersey's adoption statutes and that it was contrary to New Jersey public policy, as expressed in both statutory and decisional law. There was no basis on which to justify termination of Mrs. Whitehead's parental rights, nor thereby to permit adoption by Mrs. Stern. In deciding the issue of custody, however, the Court affirmed the finding of the trial court that it was in the "best interests" of the child to be placed with the Sterns. Having awarded custody to the Sterns and reinstated Mrs. Whitehead's parental rights, the Court ruled that Mrs. Whitehead was entitled to visitation "at some point." This limited issue was remanded for further hearings before an alternate trial judge.[7]

The New Jersey Supreme Court's ruling that the surrogacy contract conflicted with existing adoption statutes was based on the grounds that the contract 1) violated statutory prohibitions against certain uses of money in connection with an adoption; 2) conflicted with laws

requiring proof of parental unfitness or abandonment as a prerequisite to termination of parental rights; and 3) was inconsistent with statutory provisions making surrender of custody and consent to adoption revocable in private placement adoptions.[8]

Finding that the surrogacy contract was invalid because contrary to New Jersey public policy, the court emphasized that 1) the basic premise of the surrogacy contract, namely, that the contracting natural parents would decide prior to the birth of the child which parent would have custody, is contrary to the policy that custody is to be determined by a court in accordance with the child's best interests; 2) the contract contravened the policy that a child should be protected from unnecessary separation from her or his natural parents, since "[t]he surrogacy contract guarantees permanent separation of the child from one of its natural parents;"[9] and 3) the contract was inconsistent with the policy that the rights of the natural parents are equal at birth -- in the words of the court, "[t]he whole purpose and effect of the surrogacy contract was to give the father the exclusive right to the child by destroying the rights of the mother."[10]

The Court also noted its apprehension regarding the potential for exploitation of the so-called "surrogate" inherent in such arrangements. In the Court's view, surrogacy is a practice likely to be used by the wealthy at the expense of the poor. While noting the lack of definitive empirical evidence on this point, the Court stated: "[W]e doubt that infertile couples in the low-income bracket will find upper income surrogates."[11]

Addressing the argument that the so-called "surrogate" has knowingly agreed to the arrangement and should be bound by its terms (*i.e.*, that she has given informed consent), the Court expressed concern that the natural mother "never makes a totally voluntary, informed decision, for quite clearly any decision prior to the baby's birth is, in the most important sense, uninformed, and any decision after that, compelled by a pre-existing contractual commitment, the threat of a lawsuit, and the inducement of a $10,000 payment, is less than totally voluntary."[12] Furthermore, the Court maintained that even if the natural mother's consent were informed, money could not purchase Mrs. Whitehead's consent, because "[t]here are, in a civilized society, some things that money cannot buy."[13]

The Court went on to describe the following potentially harmful long-term effects of commercial surrogacy on all the participants involved: "the impact on the child who learns her life was bought...; the impact on the natural mother as the full weight of her isolation is felt along with the full reality of the sale of her body and her child; the impact on the natural father and adoptive mother once they realize the consequences of their conduct";[14] and the "potential degradation of some women that may result from this arrangement."[15]

Several other noteworthy considerations were identified by the Court as relevant to its decision. Among them was the lack of protection afforded to the so-called "surrogate", who received "no counseling, independent or otherwise...no evaluation, no warning."[16] Further, there was insufficient protection for the contracting couple, who were given only scant information concerning the genetic make-up and psychological and medical history of the natural mother.[17] And, "worst of all", the contract totally disregarded the best interests of the child by failing to contemplate any inquiry as to the fitness (or "superiority") of the contracting couple as parents, or as to the effect on the child of not living with her natural mother.[18]

On the issue of custody (discussed at greater length in chapter six), the New Jersey Supreme Court's approach was complex. As noted earlier, the Court rejected the argument that procreation by means of surrogacy is a constitutionally protected right, concluding that "[t]here is nothing in our culture or society that even begins to suggest a fundamental right on the part of the father to the custody of the child as part of his right to procreate when opposed by the claim of the mother to the same child."[19] The Court also considered, and rejected, the argument that Mr. Stern had been denied equal protection because state statutes grant full parental rights to a husband whose wife has conceived a child by means of A.I.D. with his consent. Distinguishing surrogacy from A.I.D., the Court stated that "[a] sperm donor simply cannot be equated with a surrogate mother...even if the only difference is between the time it takes to provide sperm for artificial insemination and the time invested in a nine-month pregnancy."[20]

Rather, the Court turned to analysis of the best interests of the child, stating that it was applying a best interests standard, with no presumption or rule favoring either parent on the basis of gender.[21] On

the particular facts of the case the Court accepted the trial court's conclusion that the child's best interests were served by awarding custody to the biological father. However, the Court's strong directive to trial court judges to make the initial (theoretically temporary) custody order in favor of the birth mother[22] barring a substantial likelihood that the life or health of the child would thereby be endangered, coupled with the Court's emphasis on continuity of care, achieves indirectly a result that the Court declined to adopt more explicitly. Under this approach, in many cases the initial order and the consequent opportunity for the birth mother to establish a strong psychological relationship with the child will largely determine the final custody award, virtually by default, unless there is a very large disparity in parenting capacities between the birth mother and the adoptive parents. In other words, although on its face articulating a gender-neutral best interests test for contested custody cases, in practice the decision makes it likely that, absent extraordinary factors, in any future cases the birth mother, not the biological father, will likely be awarded custody.

With regard to termination of parental rights, the Court applied the same standard in the surrogacy context as in private placement adoption proceedings, which require a showing of "unfitness" on the part of the birth mother. "Unfitness" requires a finding of "a course of conduct amounting to intended abandonment or very substantial neglect of both parental duties and claims, with no reasonable expectation of any reversal of that conduct in the near future."[23] In *Baby M* the Court held that there were no facts to support a finding of unfitness and therefore no justification for terminating Mrs. Whitehead's parental rights.[24] As with custody, the Court gave no weight to the contractual provisions of the surrogacy agreement. Parental rights cannot be terminated by a surrogacy contract.[25]

As discussed below, a number of courts and legislatures in other states have had occasion to address some aspects of surrogacy arrangements and have reached several different conclusions.

The Law of Other States

With the recent enactment of New York's surrogacy law,[26] as of early 1992, fifteen states have enacted legislation addressing surrogacy.[27] A large number of bills have been introduced in many states across the

nation[28], including New Jersey.[29] State laws differ considerably, and several courts have confronted the issue, producing a range of opinions. The following section briefly examines the legislative activity and decisional law that has thus far evolved in states across the nation.

Legislative activity

The legislative schemes now in existence portray an array of approaches. Commercial surrogacy is prohibited, with criminal penalties attaching, in Florida, Kentucky, Michigan, New Hampshire, Utah, and Washington.[30] It is also a criminal offense in Michigan (with respect to commercial and non-commercial agreements) and in Washington (regarding commercial agreements alone) for a person "to enter into, induce, arrange, procure or otherwise assist" in the formation of a surrogacy contract where the so-called "surrogate" is a minor or is diagnosed as mentally retarded or as having a mental illness or mental disability.[31] In Arizona commercial surrogacy is prohibited, but no penalty is specified in the legislation.[32] In Nebraska commercial agreements are void and unenforceable,[33] and in Indiana,* Michigan, North Dakota and Utah, non-commercial contracts (as well as commercial contracts) are void and/or unenforceable as contrary to public policy.[34]

Some statutes adopting a prohibitory or discouraging approach to surrogacy nevertheless address the issue of custody, anticipating that the goal of deterrence will not be achieved in all cases. For example, both the Michigan and the Washington laws provide that in the event of a custody dispute in a surrogacy arrangement, the party having physical custody may retain custody until the court orders otherwise.[35] The court's final decision concerning custody should be based on the best interests of the child, looking to factors identified in the relevant child custody statutes. Under Utah law the court is not bound by the terms of the agreement but is to make its custody decision based solely on the best interests of the child.[36] In Indiana, the court may not consider evidence

* The Indiana statute provides that it is against public policy to enforce a term of an agreement requiring a so-called "surrogate" to undergo, *inter alia*, an abortion, medical or psychological treatment or examination, or to waive parental rights or duties to a child, terminate care, custody or control of a child, or to consent to a step-parent adoption. The statute voids any surrogacy agreement containing these terms formed after March 14, 1988.

of a surrogacy agreement in deciding the best interests of the child, absent duress, fraud or misrepresentation.[37]

In contrast to these restrictive laws, the Nevada surrogacy legislation consists only of a provision in Nevada's adoption law specifically exempting surrogacy from the prohibition against payments in adoption. This prohibition does not apply "if a woman enters into lawful contract to act as a surrogate, be inseminated and give birth to the child of a man who is not her husband."[38] There have been no court decisions to date in Nevada concerning what constitutes "a lawful contract to act as a surrogate", and no determinations as to whether such contracts can be enforced. The status of surrogacy contracts is also unclear in Arkansas. The relevant Arkansas provision states that the presumption that a child born of artificial insemination is the child of the woman giving birth and her husband (if he has consented to the procedure) does not apply in the case of surrogacy, where the child is presumed to be that of the biological father and intended social mother.[39] The law does not give any indication, however, of the legal validity or enforceability of surrogacy contracts.

Two states, Florida and New Hampshire, have adopted a regulatory approach for *non-commercial* surrogacy arrangements. (As noted above, both states prohibit commercial arrangements.) The Florida law provides that the parties may enter into a non-binding (*i.e.*, the agreement can be terminated at any time by either party) pre-planned adoption agreement, which must contain a number of specific terms. The so-called "surrogate" must agree to become pregnant by the fertility method specified in the agreement and to terminate her parental rights through a written consent executed at the time the pre-planned adoption agreement is signed. She has a right to rescind this contract at any time within seven days of the birth of the child, and she must agree to submit to a reasonable medical evaluation and treatment and to adhere to reasonable medical instructions about her prenatal health. In addition, the statute sets forth the rights and responsibilities of both biological parents, as well as the obligations of the intended parents. Specifically, the law requires the so-called "surrogate" to acknowledge that she is aware that she will assume parental rights and responsibilities for the child if the intended father and mother terminate the agreement before final transfer of custody, if it is determined that the intended father is not the biological father, or if the pre-planned adoption is not approved by

the court. The contract must also specify that an intended father is aware that he will assume parental rights and responsibilities for the child if the agreement is terminated by any party before the final transfer of custody, or if the planned adoption is not approved by the court. The intended parents must also agree to accept full parental responsibilities for the child upon its birth, regardless of any impairment the child may have. All reasonable legal, medical psychological or psychiatric expenses of the so-called "surrogate" must be paid by the intended parents, who may also agree to pay her reasonable living expenses. However, the payment of these expenses may not be conditioned on the transfer of parental rights, and no other form of compensation may be paid. The Florida law goes on to state that the agreement may not contain any terms requiring termination of the pregnancy, reducing the amount payable to the so-called "surrogate" if the child is stillborn or born alive but impaired, or offering a bonus or supplement for any reason. Consistent with Florida's ban on commercial surrogacy, payments to agents, finders, and intermediaries, including, attorneys and physicians, as a finder's fee for locating volunteer mothers or for matching a volunteer mother with an intended couple are prohibited. Final transfer of the child or final adoption can be effected only with the review and approval of the state's department of Health and Rehabilitation Services and the court.[40]

The New Hampshire act provides a detailed regulatory scheme for non-commercial surrogacy agreements, setting forth a number of legal and procedural requirements. These requirements relate to, *inter alia*, medical evaluations of the parties to the arrangement, including in particular, genetic counseling for all the parties if the so-called "surrogate" is 35 years or older; non-medical evaluations performed on each party by a psychiatrist, psychologist, pastoral counselor or social worker; and a home study of each party, conducted by a licensed child placement agency or the division of children and youth services. A copy of the findings of the non-medical evaluations must be filed with the court. Mandatory terms of the surrogacy agreement relate to the consent of the so-called "surrogate" and her husband to surrender custody of the child, and the consent of the intended parents to accept the obligations of parenthood, unless the so-called "surrogate" has given written notice of her intention to keep the child within 72 hours of childbirth. The statute also sets specific terms for fee arrangements to cover medical expenses

and related costs." In New Hampshire a surrogacy arrangement is lawful only when the court has issued a judicial pre-authorization order finding that the agreement conforms to all the requirements set forth in the statute. The court must hold a hearing within 90 days after the filing of a petition for pre-authorization, and will grant the order validating the surrogacy contract only after making the following findings: that all parties to the contract have given their informed consent; that the contract conforms to all the statutory requirements; that the evaluations and counseling have been completed and the petitioners have been determined qualified; and that the surrogacy contract is in the best interests of the child. No specific performance will be enforced against a so-called "surrogate" for breach of a contract term that requires her to become impregnated, or that either requires or forbids her to have an abortion.[41]

Court Decisions in Other States

While *Baby M* is to date the leading case on surrogacy, a number of other state courts have had occasion over the past decade to consider this subject. This section highlights selected cases, focusing on those that have explicitly addressed public policy considerations.

Whether surrogacy arrangements violate state adoption laws has been considered by courts in New York, Michigan, and Kentucky. In New York, two courts have arrived at different conclusions. In *In the Matter of Baby Girl L.J.*,[42] a 1986 case involving an uncontested adoption petition, the Surrogate's Court held that surrogacy arrangements had not been contemplated by the New York legislature when it enacted the prohibition against payments in connection with adoptions. The court found that although contractual provisions regarding custody and termination of parental rights are voidable if in violation of the state's adoption statutes,[43] "[c]urrent legislation does not expressly foreclose the

Fees received by a so-called "surrogate" must be limited to:

Pregnancy-related medical expenses, including expenses related to any complications occurring within 6 weeks after delivery and expenses related to the medical evaluation; actual lost wages related to pregnancy, delivery and postpartum recovery, if absence from employment is recommended in writing by the attending physician; health, disability and life insurance during the term of pregnancy and 6 weeks thereafter; reasonable attorney's fees and court costs; and counseling fees and costs associated with the non-medical evaluations, and home studies for the surrogate and her husband, if any.

use of surrogate mothers or the paying of compensation to them under parenting agreements."[44]

In contrast, several years later (and subsequent to *Baby M*), the Family Court in New York was presented with an uncontested adoption application pursuant to a surrogacy arrangement in *In the Matter of the Adoption of Paul*.[45] Guided by the growing legal and public discussion, the *Paul* court held that a surrogacy contract involving a fee to the so-called "surrogate" is void, as it violates New York adoption statutes. Under New York adoption law an application for termination of parental rights can only be granted upon the submission of sworn affidavits from the so-called "surrogate" that she has not and will not request, accept, or receive any payment provided by the intended rearing parents in exchange for termination of parental rights, and from the intended parents that no such compensation has been promised.[46] It was also argued in *Paul* that since sperm donation is allowed by law, to prohibit surrogacy constitutes a denial of equal protection. Like the *Baby M* court, the *Paul* court did not find this argument convincing, and concluded:

> The very significant difference between these two methods of procreation is that a sperm is merely a gamete, potentially capable, if successfully joined with an egg, of creating an embryo which must then survive gestation to birth, while the "surrogate" mother is supplying a life-in-being, having provided, not only the egg, but protection and nourishment during gestation and having delivered a human child capable of independent survival.[47]

In Kentucky, the surrogacy issue was brought to the judicial forum by the State's Attorney General, who charged a clinic arranging surrogacy agreements with "abuse and misuse of its corporate powers detrimental to the interest and welfare of the state and its citizens."[48] In *Surrogate Parenting Associates, Inc. v. Kentucky*,[49] the Kentucky Supreme Court held that baby-selling laws designed to prevent baby brokers from employing financial inducements to coerce expectant mothers to part with their children should not apply to surrogacy. The Court found that the purpose of surrogacy arrangements differed in that the essential consideration is to assist an infertile person or couple to

have a biologically-related child. Consequently, Kentucky's existing legislative scheme did not prohibit surrogacy.[50] Nonetheless, the contractual provisions concerning custody and termination of parental rights were held voidable, with custody to be determined in accordance with the best interests of the child. The court also held that the so-called "surrogate" should have five days following birth to decide whether or not to consent to the surrender of custody and termination of parental rights (a five day waiting period).[51]

In *Doe v. Kelley*,[52] a husband and wife who had planned a surrogacy arrangement but had not yet entered into it brought an action against the State of Michigan Attorney General to declare unconstitutional provisions of the state's adoption law prohibiting the exchange of money or other consideration in adoption and related cases. The Court of Appeals was confronted with the argument that the right to procreate through surrogacy is a fundamental constitutional right. The Michigan court arrived at the same conclusion on this point as the *Baby M* opinion, although on different grounds. It stated:

> While the decision to bear or beget a child has thus been found to be a fundamental interest protected by the right of privacy...we do not view this right as a valid prohibition to state interference in the plaintiff's contractual arrangement. The statute in question does not directly prohibit [plaintiffs] from having the child as planned. It acts instead to preclude plaintiffs from paying consideration in conjunction with their use of the state's adoption procedures. In effect, the plaintiffs' contractual agreement discloses a desire to use the adoption code to change the legal status of the child —*i.e.*, its right to support, intestate succession, etc. We do not perceive this goal as within the realm of fundamental interests protected by the right to privacy from reasonable governmental regulation.[53]

In addition to *Paul*, two post-*Baby M* surrogacy cases involving custody and parental rights disputes have reached the courts, each a case of first impression in jurisdictions without applicable statutory law. In Ohio, the case of *In re Adoption of Reams*[54] involved a surrogacy arrangement in which neither of the two intended social parents were

genetically related to the child. In *Reams*, a contracting married couple entered into an oral surrogacy agreement with a woman who agreed to bear a child for $10,000. When insemination attempts failed to produce a pregnancy, the so-called "surrogate" obtained sperm from a third party. After the baby was born, the contracting couple delivered the $10,000 payment along with payment of medical expenses, in accordance with the oral agreement, and physical custody of the child was given to the couple. The intended rearing father acknowledged paternity and was granted legal custody, pursuant to (incorrectly prepared) court papers. In the year following the birth of the child, the couple separated and commenced divorce proceedings, and both filed petitions for adoption. The case was remanded for further hearings.

Finally, in California, the issue of custody and parental rights arose recently in the context of gestational surrogacy. In *Anna J. v. Mark C.*,[55] a married couple, Crispina and Mark Calvert, entered into an agreement with a so-called "surrogate," Anna Johnson, whereby Mrs. Calvert's egg would be fertilized *in vitro* with Mr. Calvert's sperm and the resulting embryo would be transferred to Ms. Johnson, who would bear the child and relinquish it upon birth to the Calverts in exchange for $10,000. During the pregnancy, however, Ms. Johnson decided that she wished to retain custody. The trial court held not only that the gestational "surrogate" was not entitled to custody, but that she had no parental rights whatsoever. The court held that "...surrogacy contracts in the *in vitro* fertilization cases are not void nor against public policy" and that the contractual provision regarding relinquishment "is enforceable by either specific performance, arguably even by habeas corpus if necessary..."[56]

The Court of Appeal affirmed the lower court's decision. That court found that under a provision of the California Parentage Act, Crispina Calvert was the "natural" mother of the child[57] and Mark Calvert was not precluded from being the legal father.[58] The court rejected the so-called "surrogate's" constitutional claims that she had a liberty interest in her relationship with the child[59] and that the Parentage Act infringed on the equal protection clauses of the federal and state constitutions.[60] Since the court found that the Calverts were entitled to parental rights on the basis of the state statute, it declined to decide whether the contract was enforceable.[61] The petition for review of the case has been granted by the Supreme Court of California.[62]

In sum, as evidenced by the cases discussed here, judicial responses to certain aspects of surrogacy arrangements, such as their conflict with adoption and other statutory schemes, are diverse. Although greater uniformity exists regarding other issues, such as rejection of the assertion that surrogacy is a constitutionally protected right, only a few courts have reached these questions. However, one theme does appear to represent an emerging consensus: in custody disputes the best interests of the child should be the governing standard.

Representative Commissioned Reports and Policy Positions

The legal, ethical, and social problems spawned by the use of the new reproductive practices, and in particular surrogacy, have generated reports from at least twenty-five countries, including the United States, Canada, the United Kingdom, Australia, Israel, West Germany, France, the Netherlands, Spain, East Germany, Japan, and New Zealand.[63] This section describes the recommendations of some of the most prominent reports, representative of a range of perspectives.

Not surprisingly, the three American medical organizations to adopt official policy statements on surrogacy have taken different positions. The American Fertility Society ("AFS")[64] report recommends neither prohibition nor prior judicial approval of surrogacy arrangements. Stating that it had "serious ethical reservations about surrogacy that cannot be fully resolved until appropriate data are available for assessment of the risks and possible benefits of this alternative,"[65] the AFS Committee recommended that surrogacy should at this time be pursued only as a clinical experiment. Among the key issues it listed as requiring further research were the following: the psychological effects on all the participants; appropriate screening of the biological father and the birth mother; effects of surrogacy on the birth mother's own family; and effects of disclosure or non-disclosure of the birth mother's identity to the resulting child. Although expressing concern about the possible risks surrogacy may entail for the birth mother and the intended social parents, the Committee concluded that prohibition of surrogacy on the ground of risk to the adults may be unduly paternalistic, given that we as a society generally allow competent adults a good deal of autonomy to choose (possibly) risky behaviors. However, the AFS emphasized the critical importance of ensuring that voluntary, informed consent is obtained from the adult participants. It also limited the use of surrogacy

to medical cases, stating that the risks to which a woman must expose herself in undergoing a pregnancy would not be justified if the reason for surrogacy was convenience alone. As to the potential psychological risks to the child stemming from confused genealogy, the AFS Committee was of the view that these risks might be outweighed by possible benefits to the child of having parents who very much wanted him or her. Regarding the issue of commercialization, the Committee did not view the exchange of money as being for the possession of the child, but characterized it rather as paying for assistance in creating a child. The Committee was troubled, however, by the potential for exploitation by brokers, and recommended that professionals involved in surrogacy arrangements should receive only their customary fee for services and no finder's fee.[66]

Like the approach of the AFS, the American College of Obstetricians and Gynecologists ("ACOG") did not adopt a prohibitory model. Although acknowledging some of the conceivable detriments of surrogacy, including the possible harms to the parties to the arrangement and other children of the so-called "surrogate"; the perception that surrogacy trivializes reproduction; and discomfort regarding payment to many so-called "surrogates," ACOG concluded that on balance the benefits of a surrogacy arrangement can outweigh the detriments. Specifically, the ACOG Committee opinion focused on the benefits to the contracting parents, to the so-called "surrogates" who enjoy pregnancy or derive pleasure from helping others, and to the children whose lives are intensely desired. The report also found the existence of significant liberty interests on the part of the so-called "surrogate" and the contracting couple. ACOG concluded that surrogacy arrangements, including compensated arrangements, are ethically justifiable as long as seven general guidelines are followed: (1) Such arrangements should be permitted only in cases of infertility; (2) the so-called "surrogate" and the contracting couple should each be represented by independent doctors and lawyers; (3) the so-called "surrogate" should be regarded as the mother and should be entitled to a waiting period after birth during which she can decide whether to place the infant for adoption; (4) surrogate parenting arrangements should be overseen by private non-profit agencies licensed and regulated in a similar manner to adoption agencies; (5) written advance planning should take place by all the parties to the arrangement in the event certain contingencies should arise during the pregnancy or after the child is born; (6) medical decisions concerning

pregnancy and childbirth should be left to the surrogate; and (7) the basis for any compensation to the surrogate should be for her services, not for the successful delivery of a healthy child.[67]

The American Medical Association, also recognizing the host of potential problems still unresolved in surrogacy, has taken a more negative stance toward the practice than the AFS or ACOG. The report of its Judicial Council briefly listed several particular concerns, including ensuring protection for the welfare of the child; the possibility that neither the so-called "surrogate" nor the intended rearing parents will want custody of a baby born with disabilities; a decision by the so-called "surrogate" to abort or to refuse to relinquish custody; and the psychological effects on a woman who conceives with the intent of giving up the child she bears. The report concluded: "The Judicial Council believes that surrogate motherhood presents many ethical, legal, psychological, societal and financial concerns and does not represent a satisfactory reproductive alternative for people who wish to become parents."[68]

In its comprehensive policy analysis, the New York State Task Force on Life and the Law recommends that public policy should discourage surrogacy, and that legislation should be enacted declaring surrogacy contracts void and prohibiting fees for women acting as so-called "surrogates" and for brokers.[69] While the report states that "divergent and sometimes competing views form the basis for this conclusion", there was unanimous agreement by New York State Task Force members on several points. "First, when surrogate parenting involves the payment of fees and a contractual obligation to relinquish the child at birth, it places children at risk and is not in their best interests. Second, the practice has the potential to undermine the dignity of women, children and human reproduction."[70] The New York State Task Force concluded that "state enforcement of the contracts and the commercial aspects of surrogate parenting pose the greatest potential for harm to individuals and to social attitudes and practices."[71] Regarding undisputed non-commercial surrogacy arrangements, the New York State Task Force concluded that such arrangements should not be prohibited, finding that "society should not interfere with the voluntary, non-coerced choices of adults in these circumstances."[72] With respect to custody disputes arising out of surrogacy arrangements, it was further recommended that "the birth mother should be awarded custody unless the court finds, based on

clear and convincing evidence, that the child's best interests would be served by an award of custody to the father and/or genetic mother."[73]

A prohibitory approach has also been adopted by Study Commissions in Great Britain[74] and Victoria, Australia.[75] The British Committee of Inquiry into Human Fertilization and Embryology considered arguments for and against surrogacy and concluded that the risk of commercial exploitation was a serious concern:

> Even in compelling medical circumstances the danger of exploitation of one human being by another appears to the majority of us far to outweigh the potential benefits, in almost every case. That people should treat each other as a means to their own ends, however desirable the consequences, must always be liable to moral objection. Such treatment of one person by another becomes positively exploitative when financial interests are involved.[76]

The Committee was of the view that the criminal law was required to prevent this risk of commercial exploitation, and recommended "that legislation be introduced to render criminal the creation or the operation in the United Kingdom of agencies whose purposes include the recruitment of women for surrogate pregnancy or making arrangements for individuals or couples who wish to utilize the services of a carrying mother; such legislation should be wide enough to include both for profit and non-profit organizations." Further, this legislation should be "sufficiently wide to render criminally liable the actions of professionals and others who knowingly assist in the establishment of a surrogate pregnancy."[77] However, the Committee did not recommend imposition of criminal penalties upon private parties entering surrogacy arrangements, fearing that criminal liability might stigmatize the children born of these arrangements. The Committee added that in its view surrogacy undertaken not for medical reasons but for convenience alone is "totally ethically unacceptable."[78] Recognizing the possibility that there may continue to be privately arranged surrogacy agreements, the Committee recommended that legislation be enacted to

provide that "all surrogacy agreements are illegal contracts and therefore unenforceable in the courts."[79]

A similar approach was taken in Victoria, Australia, by the Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilisation (the Waller Committee).[80] This Committee concluded that "surrogate mother arrangements where fees are paid are, in reality, agreements for the purchase of a child, and should not be countenanced."[81] In its examination of commercial surrogacy arrangements as part of an *in vitro* fertilization program, the Waller Committee found such arrangements unacceptable because "[i]f the sale of human gametes is characterised as inhuman, then these agreements to bear and then convey a child for a fee are the more so. Whatever terms are employed it seems clear ... that it is the buying and selling of a baby which is really the core of the arrangement."[82] Discussing non-commercial surrogacy arrangements as part of an *in vitro* fertilization program, the Committee noted that while surrogacy may be performed for reasons of family duty or affection or as an altruistic service and may in certain circumstances be considered by some as appropriate, there was nevertheless concern about possible negative consequences -- in particular, the potential for "grave harm" that might be caused to a child born of surrogacy; difficulties that the birth mother may experience in relinquishing the child; and problems of custody disputes, either where there are competing claims for custody or conversely, where none of the adult participants wishes to take custody.[83] In addition to these concerns, the Committee had "grave doubts" as to whether any surrogacy arrangement, whether commercial or not, was in the best interests of the resulting child, given that surrogacy involves the "deliberate manufacture of a child for others."[84]

A contrary approach is posited by the Ontario Law Reform Commission.[85] The basic view of the Ontario Commission was that "prohibitory action is warranted only when there is an extremely powerful justification; the onus should be on those who would advocate such action, not on those whose conduct is to be the subject of legislative

Two members of the Committee dissented from this recommendation, claiming that it was premature to "close the door completely on surrogacy." These members suggested that non-commercial agencies should be licensed to arrange surrogate births and that a form of adoption procedure should be made available.

or other interference."[86] The Ontario Commission rejected the Warnock Committee's argument that surrogacy represents an offensive utilitarian approach in that people are treated as a means to an end. Rather, the Commission felt that the principle that people ought not be treated as a means to an end is not regarded as an absolute one in our society, illustrating this proposition with the example of organ donations by live donors. While sensitive to some of the concerns regarding potential psychological dangers to the biological mother or to the resulting child, the Commission was of the view that these dangers were at the present time too speculative to justify prohibition of surrogacy. It also rejected the view that acceptance of surrogacy necessarily foreshadows the dissolution of the family, and suggested that surrogacy may indeed be seen as a positive affirmation of the value placed on family life for those who would otherwise remain childless. Further, the Commission believed that prohibition of surrogacy would not end the practice, but would result instead in clandestine private arrangements, with very real dangers of exploitation of the adult parties and an absence of any protection afforded to the child.[87]

In recommending a regulatory scheme, the Ontario Commission noted that there were two possible approaches that could be adopted. The first involves the court *ex post facto*, *i.e.*, court intervention takes place after the agreement has been implemented. The alternative approach involves judicial screening prior to the implementation of the agreement. The Commission favored the latter approach on the ground that earlier intervention would provide greater opportunity for ensuring the protection of all the parties involved. Under the Commission's proposed scheme, the parties to a surrogacy arrangement would submit to the court a written agreement which would be required to conform to specified legislative criteria. The documents would be approved at a hearing, where the court would also determine the suitability of the parties. The report sets forth further details of a regulatory scheme including, *inter alia*, the criteria to be used in assessing the suitability of the prospective parents and the prospective birth mother, payment to the prospective birth mother, resolution of paternity disputes, resolution of custody disputes, responsibility for the birth of a disabled child, and confidentiality of court proceedings and records.[88]

It is not surprising that these representative reports from around the world reflect the same divergent views about surrogacy found in the

various enactments and judicial decisions in this country. Due to the relative infancy of the practice, no position is firmly grounded in empirical evidence. Policy statements, legislation and judicial opinions rest on different philosophies about the appropriate extent of government intervention into the private lives of citizens as well as concerns for the best interests of all the parties, and the potential for exploitation, coercion, and commodification in commerical surrogacy arrangements.

NOTES

1. An interesting discussion of these two models is provided in Ontario Law Reform Commission, *Report on Human Artificial Reproduction and Related Matters*, pp. 105-210 (1985).

2. *Carey v. Population Services International*, 431 U.S. 678 (1977) (contraceptives for minors); *Roe v. Wade*, 410 U.S. 113 (1973) (abortion); *Stanley v. Illinois*, 405 U.S. 645 (1972) (parental rights); *Eisenstadt v. Baird*, 405 U.S. 432 (1972) (contraceptives for single people); *Loving v. Virginia*, 388 U.S. 1 (1967) (marriage); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (contraceptives for married couples); *Skinner v. Oklahoma*, 316 U.S. 535 (1942) (sterilization); *Meyer v. Nebraska*, 262 U.S. 390 (1923) (child rearing).

3. *See* John A. Robertson, "Embryos, Families, and Procreative Liberty: The Legal Structure of the New Reproduction," *Southern California Law Review* 59 (1986): 958-67; John A. Robertson, "Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth," *Virginia Law Review* 69 (1983): 403-36; Note, "Prohibiting Payments to Surrogate Mothers: Love's Labor Lost and the Constitutional Right of Privacy," *John Marshall Law Review* 20 (1987): 725-45.

4. *In the Matter of Baby M*, 109 N.J. 396, 448, 537 A.2d 1227, 1253-54 (1988).

5. *Id.* at 469, 537 A.2d at 1264.

6. 217 N.J. Super. 313, 525 A.2d 1128 (1987), *aff'd in part, rev'd in part*, 109 N.J. 396, 537 A.2d 1227 (1988).

7. 109 N.J. at 463-68, 537 A.2d at 1261-64.

8. *Id.* at 422-34, 537 A.2d at 1240-46.

9. *Id.* at 435, 537 A.2d at 1246.

10. *Id.* at 436, 537 A.2d at 1247.

11. *Id.* at 440, 537 A.2d at 1249.

12. *Id.* at 437, 537 A.2d at 1248.

13. *Id.* at 440, 537 A.2d at 1249.

14. *Id.* at 441, 537 A.2d at 1250.

15. *Id.* at 442, 537 A.2d at 1250.

16. *Id.* at 436, 537 A.2d at 1247.

17. *Id.* at 437, 537 A.2d at 1248.

18. *Id.*

19. *Id.* at 449, 537 A.2d at 1254.

20. *Id.* at 450, 537 A.2d at 1254.

21. *Id.* at 454, 537 A.2d at 1257.

22. *Id.* at 462, 537 A.2d at 1261.

23. *J. and E. v. M. and F.*, 157 N.J. Super. 478, 488-89, 385 A.2d 240, 246 (1978) (quoting *In re Adoption of Children by D*, 61 N.J. 89, 94-95, 293 A.2d 171, 173 (1972)); *see also N.J. Div. of Youth and Family Services v. A.W.*, 103 N.J. 591, 512 A.2d 438 (1986).

24. 109 N.J. at 444-47, 537 A.2d at 1251-53.

25. *Id.* at 425-29, 537 A.2d at 1242-44.

26. S.1906 214th Leg., 1991-92 Sess.; A.7367, 214th Leg., 1991-92 Sess., enacted July 22, 1992.

27. ARIZ. REV. STAT. ANN. sec. 25-218 (1989); ARK. STAT. ANN. sec. 9-10-201 (1989); FLA. STAT. sec. 63.212(1) (1988); IND. CODE sec. 31-8-2-1 *et. seq.* (1988); KY. REV. STAT. ANN. sec. 199.590 (1988); LA. REV. STAT. ANN. sec. 9:2713 (West 1987); MICH. COMP. LAWS sec. 722.851 *et. seq* (1988); NEB. REV. STAT. sec. 25-21,200 (1988); NEV. REV. STAT. sec. 127.303.5 (1987); N.H. REV. STAT. ANN. sec. 168B: 1 *et. seq.* (Supp. 1991); N.D. CENT. CODE sec. 14-18-0 *et. seq.* (1989); UTAH CODE ANN. sec.

76-7-204 (1988); VA. CODE sec. 20-156 (1992); WASH. REV. CODE ANN. sec. 26.26.210 *et. seq.* (1989).

28. Following the pattern of divergent responses reflected in the statutes, the bills collectively express no uniform reaction to the practice. Some would permit and regulate surrogacy contracts, others would prohibit these arrangements entirely or partially or render them judicially unenforceable, and still others would establish study committees or task forces. Detailed information on these bills as well as updates on bills and legislation concerning surrogacy is available from the National Conference of State Legislatures in Denver, Colorado. As discussed below, recommendations of study committees run the gamut of responses to surrogacy.

Federal legislation has also been proposed on surrogacy. For example, the Commercialized Childbearing Prevention Act of 1989 (H.R. 1188, 101st Cong., 1st Sess.), seeks to render commercial surrogacy agreements unenforceable and provides criminal penalties for brokers violating this prohibition. The Surrogacy Arrangements Act of 1989 (H.R. 275, 101st Cong., 1st Sess.) would criminalize participation in commercial surrogacy arrangements, while the Anti-Surrogate-Mother Act of 1989 (H.R. 576, 101st Cong., 1st Sess.) would provide criminal penalties for any person who, *inter alia*, procures a woman to engage in surrogacy, provides medical assistance in carrying out a surrogacy agreement, or sells for a profit the right to adopt a child.

29. A variety of bills on surrogacy had been introduced in the late 1980's; all but one died in committee. In the 1992 session, A-172, introduced by Assemblyman Kavanaugh, seeks to amend existing law to include surrogate parenting agreements within the prohibition against "babyselling" found in the New Jersey adoption statutes, and provides that any person who violates this prohibition shall be guilty of a third degree crime.

30. FLA. STAT. sec. 63.212(1) (1988); KY. REV. STAT. sec. 199.590 (1988); MICH. COMP. LAWS sec. 722.851 *et. seq.* (1988); N.H. REV. STAT. ANN. sec. 168.B:1 *et. seq.* (1990).

31. MICH. COMP. LAWS sec. 722.859(1) (1988); WASH. REV. CODE ANN. sec. 26.26.230 (1989).

32. ARIZ. REV. STAT. ANN. sec. 25-218 (1989).

33. NEB. REV. STAT. sec. 25-21,200 (1988).

34. IND. CODE sec. 31-8-2-2 (1988); MICH. COMP. LAWS sec. 722.855 (1988); N.D. CENT. CODE sec. 14-18-05 (1991); UTAH CODE. ANN. sec. 76-7-204(1)(c)(1989).

35. MICH. COMP. LAWS sec. 722.861 (1988); WASH. REV. CODE ANN sec. 26.26.260 (1989).

36. UTAH CODE ANN. sec. 76-7-204(3)(b) (1989).

37. IND. CODE sec.31-8-2-3 (1988).

38. NEV. REV. STAT. sec. 63.212(1) (1987).

39. ARK. STAT. ANN. sec. 9-10-201(b) (1989).

40. FLA. STAT. sec. 63-212(1) (1988).

41. N.H. REV. STAT. ANN. sec. 168B:1 *et. seq.* (Supp. 1991).

42. 132 Misc. 2d 972, 505 N.Y.S.2d 813 (Surr. Ct. 1986).

43. *Id.* at 977, 505 N.Y.S.2d at 817.

44. *Id.* at 978, 505 N.Y.S.2d at 818.

45. 146 Misc. 2d 379, 550 N.Y.S.2d 815 (Fam. Ct. 1990).

46. *Id.* at 385, 550 N.Y.S.2d at 818-19. The *Paul* court noted the several bills then pending before the New York State Legislature.

47. *Id.* at 384, 550 N.Y.S.2d at 818.

48. *Surrogate Parenting Associates, Inc. v. Ky.*, 704 S.W.2d 209, 210 (Ky. Sup. Ct. 1986).

49. 704 S.W.2d 209 (Ky. Sup. Ct. 1986).

50. *Id.* at 211-12.

51. *Id.* at 212-13.

52. 106 Mich. App. 169, 307 N.W.2d 438 (1981), *cert. denied*, 459 U.S. 1183 (1983).

53. *Id.* at 173-74, 307 N.W.2d at 441.

54. 52 Ohio App. 3d 52, 557 N.E.2d 159 (1989).

55. Nos. X-633190 and AD-576, slip op. (Cal. App. Dep't. Super. Ct. Oct. 22, 1990), *aff'd*, 234 Cal. App. 3d 1557, 286 Cal. Rptr. 369 (Cal. Ct. App. 1991), *review petition granted*, 4 Cal. Rptr. 2d 170, 822 P.2d 1317 (Cal. Sup. Ct. 1992).

56. *Id.*

57. 234 Cal. App. 3d 1557, 1569, 286 Cal. Rptr. 369, 379 (Cal. Ct. App. 1991), *review petition granted*, 4 Cal. Rptr. 2d 170, 822 P.2d 1317 (Cal. Sup. Ct. 1992).

58. 234 Cal. App. 3d at 1571-72, 286 Cal. Rptr. at 377-78.

59. *Id.* at 1573-75, 286 Cal. Rptr. at 378-80.

60. *Id.* at 1575-76, 286 Cal. Rptr. at 380-81.

61. *Id.* at 1577, 286 Cal. Rptr. at 381.

62. 4 Cal. Rptr. 2d 170, 822 P.2d 1317 (Cal. Sup. Ct. 1992).

63. An overview of the major features of some of these reports is set forth in LeRoy Walters, "Ethics and New Reproductive Technologies: An International Review of Committee Statements," *Hastings Center Report* 17(3) (June 1987), pp. 3-9.

64. "Ethical Considerations of the New Reproductive Technologies," The Ethics Committee of the American Fertility Society, *Fertility and Sterility*, 46 Supplement 1 (Sept. 1986). In contrast to the reports of the New York State Task Force, the Warnock Committee, the Waller Committee, and the Ontraio Law Reform Commission, which were all

publicly chartered Government study commissions, the report of the American Fertility Society was commissioned by a professional group.

65. *Id.* at 67S.

66. *See* chapter 25, pp. 62S-68S of the AFS report.

67. American College of Obstetricians and Gynecologists (ACOG) Committee Opinion, "Ethical Issues in Surrogate Motherhood," No. 88 (November 1990).

68. American Medical Association, "Report of the Judicial Council: Surrogate Mothers," reprinted in *Surrogate Motherhood: Politics and Privacy*, L.Gostin, ed. (Indiana Univ. Press 1990), pp. 304-06.

69. The recommendations of the New York State Task Force were largely adopted in recent enacted legislation, S.1906, 214th Leg., 1991-2 Sess. and A. 7367, 214th. Leg., 1991-2 Sess. A number of other bills on surrogacy were also introduced in New York, reflecting a range of approaches.

70. New York State Task Force on Life and the Law, *Surrogate Parenting: Analyses and Recommendations for Public Policy* (May 1988), p. 18.

71. *Id.*

72. *Id.* at 126.

73. *Id.* at 136.

74. Department of Health and Social Security, *Report of the Committee of Inquiry into Human Fertilisation and Embryology* (July 1984) (hereinafter "Warnock Committee Report"). This committee's recommendations on surrogacy form the basis of the Surrogacy Arrangements Act of 1985.

75. Committee to Consider the Social, Ethical and Legal Issues Arising From In Vitro Fertilisation, *Report on the Disposition of Embroyos Produced by In Vitro Fertilisation* (August 1984) (hereinafter "The Waller Committee Report").

76. Warnock Committee Report at 46.

77. *Id.* at 47.

78. *Id.* at 46.

79. *Id.* at 47.

80. Waller Committee Report, *supra* note 75. Pursuant to the Waller Committee's recommendations, the Victorian legislature enacted the Infertility (Medical Procedures) Act 1984, Part V of which deals with surrogacy. The Act prohibits the publication of any advertisement for either commercial or non-commercial surrogacy; makes it an offence for a so-called "surrogate", a contracting couple, or a broker to engage in commercial surrogacy; and renders any surrogacy agreement (commercial or non-commercial) void.

81. *Id.* at 50.

82. *Id.* at 52.

83. *Id.* at 53-54.

84. *Id.* at 54. Several other Australian reports have also been issued on the subject of surrogacy. *See* Family Law Council, *Creating Children: A Uniform Approach to the Law and Practice of Reproductive Technology in Australia* (1985); New South Wales Law Reform Commission, *Artificial Conception: Surrogate Motherhood Report* (1988); Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, *In Vitro Fertilisation and other Related Matters*, Report (1984); Select Committee of the S.A. Legislative Council, *Report on Artificial Insemination by Donor In-Vitro Fertilisation and Embryo Transfer Procedures and Related Matters in South Australia* (1987); Committee of Inquiry, *Report of the Committee Appointed by the Western Australian Government to Enquire into the Social, Legal and Ethical Issues Relating to In-Vitro Fertilisation and its Supervision* (1986); Committee of Inquiry to Investigate Artificial Conception and Related Matters in Tasmania, *Final Report* (1985); National Bioethics Consultative Committee, *Surrogacy*, Report 1 (1990).

85. Ontario Law Reform Commission, *Report on Human Artificial Reproduction and Related Matters* (1985).

86. *Id.* at 16.

87. *Id.*

88. *Id.* at 17-19.

CHAPTER FIVE

SURROGACY: THE ETHICAL AND SOCIAL ISSUES

This chapter discusses the ethical and social issues raised by surrogacy in both its commercial and non-commercial form, and presents the underlying rationale for the central recommendations of the Commission and Task Force. The first section discusses the major arguments advanced by proponents and opponents of surrogacy arrangements. While the predominant focus of the scholarly literature and public discussion has been on commercial surrogacy arrangements, many of the arguments apply to non-commercial arrangements as well. Building on this analysis, the next section presents the specific rationale for the Commission and Task Force conclusions and recommendations that public policy should prohibit commercial surrogacy and, among other things, visit criminal penalties upon those who act as broker/intermediaries to arrange surrogacy agreements for a fee. The last section provides the rationale for the conclusion and recommendation that non-commercial surrogacy should be discouraged, but not prohibited, in law and policy.

As discussed in chapter three, surrogacy matching services differ in their approach and, of course, not all surrogacy occurs under the aegis of a formal program. People seek surrogacy for both medical and social reasons. Participants in a surrogacy arrangement may or may not have a previous relationship with one another and may have a range of expectations of future contact after the child's birth. Whether commercial or non-commercial, the arrangement may be the more common genetic/gestational form or the less frequent, but increasingly sought, gestational form. This chapter seeks to take account of these variations in the practice of surrogacy. It is important to recognize that since surrogacy (particularly in its commercial guise) is relatively recent, there is little available information about its lasting effects upon the children of surrogacy, birth mothers or others, or upon public sensibilities. Thus, the ensuing assessment of the practice places the available information in the context of the values on which there is perceived to be broad societal consensus, drawing more on prudential judgment about the potential implications of surrogacy for society than on hard evidence about the actual experiences of couples, birth mothers, families, or the children of surrogacy.

Policymakers, commentators and the public have reached divergent conclusions as to whether surrogacy arrangements ought to be criminalized, legalized, discouraged, facilitated, or regulated. Whatever one's ultimate conclusions, the major issues remain essentially the same, namely, whether surrogacy is consistent or inconsistent with important societal values and institutions, and whether the practice will likely bring greater harm or benefit to the parties to a surrogacy arrangement, the children of surrogacy, and others. Conceptually, arguments about surrogacy take two distinct yet related paths. One asks whether surrogacy is intrinsically morally wrong, *i.e.*, whether something inherent in the nature of surrogacy itself is immoral or violates an important and shared ethical principle. The other asks whether the consequences of permitting surrogacy arrangements produce greater harm than good. Analysis of surrogacy often does not proffer a rigid distinction between these two approaches. Similarly, the discussion here takes these two lines of argument as organizing principles, but recognizes as well the interrelatedness of concerns relevant to crafting a public policy response to surrogacy. Conclusions about the first inquiry--whether surrogacy is intrinsically wrong--are often the basis for distinguishing commercial and non-commercial surrogacy.

The Commission and Task Force firmly believe that there is a need to do more to respond to the problem of infertility, and to the heartfelt and laudable efforts of infertile couples to raise a family. While sensitive to the promise of surrogacy as a reproductive option, the Commission and Task Force also believe that the nature and practice of surrogacy, particularly in its commercial form, threaten to erode long-established societal values concerning women, children, reproduction, and the family. Further, surrogacy, again particularly commercial surrogacy, likely will cause psychological and emotional harm to the children of surrogacy and to so-called "surrogates." In arriving at this conclusion, the Commission and Task Force supplemented the limited existing data on the effects of surrogacy by looking to the lessons of our experience with adoption and donor insemination. Although the character and practice of surrogacy differ from both adoption and donor insemination in certain significant respects, the experiences of those involved in the older practices suggest problems as well as benefits that could apply to the newer practice of surrogacy.

It should be noted that Commission and Task Force members are not unanimous in their support of the several policy recommendations made here. For example, several Commission members favor a more permissive regulatory approach such as was described in chapter four. All recognize, however, that any social and policy response is likely to have its costs as well as its benefits, particularly where, as here, there is limited historical experience or reliable empirical research regarding the practice of surrogacy.

Women, Pregnancy and Reproduction

Typically, the physical experience of pregnancy is imbued with powerful and deeply felt psychological, social, emotional and cognitive content.[1] While much remains to be understood about the psychological and social aspects of pregnancy, it is clear that for many women acts of physically nurturing and bearing a child are profoundly meaningful and intimate experiences that engender an intense sense of relationship and connection with the developing fetus. Such responses maintain the nexus of mind and emotion with physical experience and are at the core of the evolving self-understanding a woman experiences during pregnancy. Significantly, total personal involvement is seen as preparation for the next and more complex stage of nurturing the child after birth. Pregnancy is the beginning of a lifelong loving commitment to parenting."

Central to deep concerns about surrogacy is the likelihood that widespread resort to publicly sanctioned surrogacy arrangements (commercial or non-commercial) may radically transform the social meaning accorded to reproduction and pregnancy. Women who agree to bear children for others redefine this traditional understanding of pregnancy. Instead of experiencing pregnancy as the first phase of their connection to and relationship with their future child, so-called "surrogates" undertake pregnancy as an act in itself, as an experience that will generally have limited implications for their social and emotional lives during gestation, and none after the child is born and surrendered to others to parent. Put another way, the practice of surrogacy is the deliberate separation of physical gestation from social parenthood. It contemplates a nine month pregnancy without forming a significant

[1] The meaning of pregnancy as preparation for social parenthood is discussed at greater length in chapter six.

emotional bond with the developing fetus. Indeed, as illustrated by the *Baby M* contract, typical provisions in commercial surrogacy contracts idealize and seek to ensure the separation of the birth mother's emotional and social self from her physical self: "Mary Beth Whitehead understands and agrees that, in the best interest of the child, she will not form or attempt to form a parent-child relationship with any child or children she may conceive, carry to term, and give birth to pursuant to the provisions of this agreement ..."[2] Separating the physical experience of pregnancy from its usual social and emotional components suggests that pregnancy is not, and ought not be understood as, an intimate and personal event, central to women's self-understanding and self-definition. Rather, whether or not undertaken for money, pregnancy is viewed as an activity divorced from full self-involvement.[3]

Most major religious groups that have addressed surrogacy also focus on the intrinsic nature of the practice, though with lesser emphasis on the meaning of pregnancy. According to a 1988 survey conducted by the U.S. Office of Technology Assessment, most major religions view surrogacy as morally illicit.[4]

In the Catholic tradition, for example, it is procreation with artificial assistance outside the context of a marital union that makes surrogacy morally offensive. It is the opinion of the Catholic Church that scientific research and technology must be morally evaluated with reference to the dignity of the human person.[5] Scientific advances assume a positive aspect when they aid individuals who are ill.[6] However, when they are used to intervene in the process of procreation, the Church does not regard them as morally acceptable.

Pursuant to Catholic doctrine, as set forth in the 1987 Vatican statement of the Congregation for the Doctrine of the Faith, "[h]uman procreation requires on the part of the spouses responsible collaboration with the fruitful love of God; the gift of human life must be actualized in marriage through the specific and exclusive acts of husband and wife, in accordance with the laws inscribed in their persons and in their union."[7] Furthermore, it is taught that human life must be respected from the moment of conception.[8] Since surrogacy contravenes the union of conception, pregnancy and marriage, it is viewed as an offense to the child's right to be conceived, gestated, born and brought up by his or her

own natural parents. Thus, the official Catholic position finds the practice to be morally unacceptable.[9]

Other religious faiths generally do not stress to this extent the sanctity of marital conjugal union, but base objections to surrogacy more firmly on other grounds.[10] In general, religious objections focus on such themes as introduction of a third party into the reproductive process; confusion of lineage; dehumanization of the reproductive process; and exploitation and commercialization involved in commercial surrogacy.[11]

Most rabbis and scholars who have considered the question in accordance with Orthodox Jewish law find it to be an unacceptable solution to the problem of infertility. Many of the analyses begin with God's blessing to people soon after creation: "Be fruitful and multiply, fill the earth and master it." This statement is seen as imparting two imperatives: procreation and active participation in improving mankind. Thus, at least one commentator has concluded that when the natural means of procreation are inhibited, artificial means such as surrogacy that will bring about the positive goal of parenthood should be looked upon with favor.[12] Most of the writers on the subject, however, believe that the potential negative effects of surrogacy outweigh the benefits. Specific concerns include the risks in pregnancy undertaken by the birth mother;[13] the use of surrogacy as an alternative to adoption when there are many infants in need of adoptive parents;[14] the potential exploitation of so-called "surrogates";[15] and the possible shattering of family bonds.[16] At least one rabbi has suggested that society legislate against the practice of surrogacy.[17] (This is not necessarily the position, however, of Conservative and Reform Judaism.[18])

While not endorsing the view of any particular religious faith (and recognizing the diversity of opinions that may exist even among individuals of particular faiths), the Commission and Task Force feel strongly that pregnancy is and should remain a central and integrated self-expressive experience for women that serves as a prelude to the further self-expressive activity of loving and raising a child. This view applies with equal force to both genetic/gestational and gestational surrogacy. The separation of pregnancy and parenting inherent in the nature of surrogacy also raises serious concerns about our perceptions of and attitudes towards the role of women in reproduction.

Reproductive Autonomy

The practice of surrogacy, both commercial and non-commercial, emphasizes women's reproductive capacities as distinct from, rather than as an integrated part of, their lives, available for gift or sale. Surrogacy encourages equating women with their reproductive capacities, appropriate solely for childbearing, but not for other of life's labors.[19] Such a perception is even more likely if gestational surrogacy increases, and if, as some suggest, some women will be expected to do the difficult work of bearing children while others reap the rewards of loving them and raising them.[20] Some critics of surrogacy (indulging rhetorical metaphor) suggest the evolution of a "breeder class" of women serving as "incubators" with "wombs for rent."[21]

The question whether surrogacy expresses or imperils reproductive autonomy for women has strong voices on both sides. Some proponents of surrogacy, including many feminists and advocates of women's rights, argue that a commitment to women's rights and reproductive autonomy must include the right to control all aspects of one's reproductive capacities. To allow so-called "surrogates" to enter into contracts for the use of their reproductive capacities is to respect women's decisions about their bodies and to enhance the dignity of women. To restrict or deny this right is to sanction state interference with very personal decisions and to diminish women's rights to exercise a full range of reproductive options.[22*]

Many who take this position argue further that having exercised the right to enter into a surrogacy agreement, the birth mother should be bound by her agreement. "Waiving" the right to raise the child to which she gives birth is an essential component of the constellation of reproductive rights belonging to the birth mother. Some feel that not to enforce the agreement--not to hold a woman to her promise--would fail to respect women as responsible autonomous agents, and would

* A similar argument about full recognition of reproductive rights has been made on behalf of men who seek traditional surrogacy by providing their own sperm with the intention of raising a genetically related child. As an argument for surrogacy, however, this claim is unpersuasive. The right to procreate does not and should not include the right to obligate third parties as reproductive collaborators. Further, as a reproductive choice sperm donation is qualitatively distinct from gestation and pregnancy. (*See* the discussion of reproductive rights in chapter four.)

perpetuate unfavorable stereotypes of women as emotional, indecisive and likely to change their minds, or as subject to the "biological destiny" of maternal-fetal bonding. It also follows from this line of reasoning that the negative consequences of holding the birth mother to her promise to relinquish custody are viewed as both minimal and manageable. Changes of mind will be rare; serious psychological and emotional harm to the birth mother is unlikely.[23]

In contrast, others who argue for women's rights to freely make agreements about the use of their own bodies also contend that full respect for reproductive choice must acknowledge the woman's right to change her mind. Pursuant to this view, women are fully capable of entering into agreements to become pregnant and carry a fetus to term, and most will fulfill their promise to relinquish custody after birth without difficulty. But changing one's mind is not indicative of inability to reason or make decisions. To enforce this promise over the birth mother's objection falls short of full respect for women as autonomous agents.[24]

Whatever the variation on the argument, proponents of surrogacy on the grounds of reproductive freedom view the practice as involving a woman's freely given agreement to use her reproductive capacities to bear a child for another. Surrogacy's inherent distinction between pregnancy and parenthood enhances, rather than diminishes, respect for women. With respect to commercial arrangements, this position rejects the notion that surrogacy involves baby-selling or that the contract is for sale of a product. What is for sale (or rent) is reproductive services, and decisions ought to be made by the provider of those services.

A number of commentators frame the issue of freedom to contract in terms of informed consent. Can a woman give informed consent at the time of the surrogacy agreement (a pre-conception agreement) to relinquish custody of the child more than nine months later upon birth?[25] Some opponents of surrogacy claim that a woman cannot make an informed choice to relinquish custody (and other parental rights) prior to the actual experience of pregnancy and birth. In contrast to the usual situation, the powerful experience of pregnancy and birth is coupled with the unusual obligation to give up the child to others. That a woman will understand, more than nine months in advance, the nature and likely risks of this event (both necessary elements of informed consent) is at

best unlikely, and to some impossible. Consequently, the agreement should not be binding. For some this means there is no agreement at all; for others a non-binding agreement recognizes the realities of a unique and deeply personal event."

The opposite view of informed consent is taken by proponents of the practice. To suggest that women are not capable of understanding the meaning of a surrogacy agreement and of weighing the risks, burdens and benefits of pregnancy, birth, and relinquishing custody and parental rights demeans women, portraying them as emotional and biologically driven. That surrogacy does not involve a contemporaneous consent to deliver custody, *i.e.*, one formed at or near the time of birth, does not diminish the quality of consent, nor detract from the ability of women to make informed decisions about their bodies across a spectrum of personal and medical choices.

Arguments on these grounds make significant contributions to the debate. The notions of voluntariness, consent, and free choice are further explored below in connection with exploitation in commercial arrangements. However, as arguments for permitting or prohibiting surrogacy, arguments from reproductive autonomy fail to account for important differences between surrogacy and other reproductive practices and choices, chiefly that surrogacy involves a third party reproductive collaborator who is called upon to embark upon a psychological and emotional separation of pregnancy and parenthood. This approach to the problem of surrogacy also tends not to fully address the larger concerns for societal values and for the consequences of surrogacy for children that were prominent in the Commission and Task Force deliberations. In the view of the Commission and Task Force the surrogacy agreement should be unenforceable and the contracting couple should not be able to rely on the birth mother's promise to deliver custody; thus, whether the birth

" Carried to its logical extreme, a rigorous informed consent objection leads to the strange conclusion that only women who have previously given birth and then given up custody could anticipate and understand the true consequences of surrogacy, and only they would be appropriate candidates. This actual prior experience standard for informed consent is also out of keeping with our ordinary understanding of informed consent. There is no good reason to impose a higher standard here than is used when women make a host of other important medical decisions. *See* Ruth Macklin, "Is There Anything Wrong With Surrogate Motherhood?: An Ethical Analysis," in *Surrogate Motherhood: Politics and Privacy*, L. Gostin, ed. (Indiana Univ. Press 1990), pp. 142-43.

mother freely entered the agreement with informed consent is ultimately beside the point. Furthermore, to strictly enforce the birth mother's promise to relinquish custody and parental rights, a position that follows from emphasis on a contract model, would be contrary to accepted legal and ethical norms against specific performance of personal service agreements."

Anticipating the Consequences of Surrogacy

Any approach to surrogacy must account for the potential benefits, risks and harms of the practice. The Commission and Task Force share a number of concerns about the potential harm surrogacy arrangements may cause to birth mothers and, most importantly, to the children of surrogacy. It is important to emphasize that although existing data about the surrogacy experience, as well as studies of our experience with adoption and donor insemination, support the conclusions reached, given the relative infancy of the practice of surrogacy the data itself is inconclusive.

The So-called "Surrogate"

Clearly the so-called "surrogate" may obtain both tangible and intangible rewards from helping to create a child. As discussed earlier, so-called "surrogates" are often moved by their love of children and empathy for infertile couples, even when money offers a financial incentive. Proponents of surrogacy contend that women generally come to surrogacy voluntarily, and exercise important rights to make agreements with others and to decide how, under what conditions, and with whom they will reproduce. So-called "surrogates" typically enter surrogacy without the pressures of an unwanted pregnancy; thus their offer to bear children for others is very different from the confusion and panic that may lead to some women's reluctant surrender of children to adoption. Further, the financial rewards may be more satisfying than other endeavors in life for which money is earned.

" It should be emphasized that the conclusions here are in no way intended to diminish the importance of reproductive freedom, a principle valued highly by nearly all members of the Commission and Task Force. Nor does this report conclude that women are incapable of giving informed consent to a surrogacy agreement. In fact, the large proportion of "successful" surrogacy arrangements suggests the contrary.

Though in one sense benevolent and large-spirited, surrogacy may also take advantage of human (and perhaps especially women's) impulses toward self-sacrifice. Some evidence suggests that many so-called "surrogates" may have unfulfilled emotional and financial needs. Surrogacy may seem to them an appealing solution to problems, but in fact such pre-existing difficulties may remain long after the child is surrendered and the relationship with the couple has ended.[26] Once the so-called "surrogate" becomes pregnant, the agreement to which she has become a party may compound her burdens. By entering the agreement, she has agreed to separate the physical experience of pregnancy from her emotional involvement with the developing fetus. Yet, no piece of paper can govern a person's feelings. Quite understandably, a woman's desire to sever the relationship may change markedly during the course of a pregnancy, as she comes to realize more clearly that fulfilling her promise risks severe loss, and psychological and emotional trauma. The conflicting commitment to keep her promise to give up the child could cause tremendous inner strife. The Commission and Task Force believe that the potential adverse consequences for birth mothers are real harms and real risks that should not be sanctioned.

A further central theme is the threat to the human dignity of women when identified with their reproductive capacities. As discussed below, this concern is most serious with commercial surrogacy, when women's reproductive capacities are monetarily valued, purchased, and sold. It is important to note here that as individuals, birth mothers need not (and often do not) feel degraded to be degraded in the eyes of others, nor for surrogacy to subtly foster societal perceptions and attitudes that depersonalize women and affront human dignity.

The Children of Surrogacy

The Commission and Task Force are particularly concerned with the question whether surrogacy (commercial or non-commercial) is in the child's best interests. Will the practice bring more harm than good to the children of surrogacy?

Some believe that part of the specialness and value traditionally accorded to children is threatened by an arrangement which creates them outside the context of an adult relationship in which both biological parents are committed to one another as well as to the child. Not all children are valued and wanted by their parents, and not all children

result from such a long-term parental relationship. Appreciating children as unique, precious beings and loving them because they are tangible symbols of their parents' love for one another remain cultural ideals and aspirations.

Yet, the parents of the children of surrogacy are likely to have motives for parenthood and expectations for children no different, and no more problematic, than those who become parents through ordinary reproduction. If anything, children born of surrogacy might view themselves fortunate indeed. Not only have their parents gone to significant and unusual efforts to bring them into the world, but they come into homes in which they can expect to receive a high degree of care, love, and appreciation. The very fact that their creation may have been unconventional and may have required more from their parents than is necessary in ordinary reproduction may translate into the children's sense of being particularly wanted and cherished. Moreover, those who come to know their birth mothers and their special role in their origins, may experience an intense attachment to an adult beyond their immediate family. In fact, for some commentators surrogacy is a positive expression of what is possible and beneficial in alternative forms of family arrangements, and broadens our understanding of "family."[27]

While recognizing that a child's response to being of atypical origins will be an individual one, the Commission and Task Force are concerned that this knowledge could adversely affect a child's psychological and emotional development. Many believe that the knowledge that one is the product of assisted reproduction and of atypical origins will be harmful to the child of surrogacy. Though no data

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The potential effects of surrogacy on other family members should not be overlooked. The other children of the so-called "surrogate" are at special risk for anxious, bewildered, adverse reactions, as have been reported in at least a few instances. After realizing that the baby has not come home from the hospital with mom but has gone to others, a child could become fearful and insecure about his or her own relationship with his or her mother. *See* Martha A. Field, *Surrogate Motherhood: The Legal and Human Issues* (Harvard Univ. Press 1988), p. 33 ("[Surrogacy] must inevitably harm the older children whom most surrogates have. How can a mother explain to her children that she is giving away or selling their newborn sister? How can she make them believe that they do not also have a pricetag?"). It is worth noting that some centers attempt to anticipate these concerns by working with birth mothers on how to explain pregnancies and to prepare children for the fact that their new sister or brother will not be coming home. There is no way to know how successful these efforts have been.

specifically addressing surrogacy is yet available, here our experience with adoption and with donor insemination is instructive.

Lessons from Adoption? Studies suggest that traditional adoption is not without attendant psychological and social problems for adopted children.[28] Children of adoption reportedly face added stress handling the customary tasks of establishing a sense of identity, particularly during school age years and adolescence.[29] This stress may be heightened if associated with individuated features of some people's adoption experiences, such as the way the adoptions were revealed to them; lack of knowledge about their mothers and fathers; fear that the birth parents are in some way undesirable people; or the feeling that the parents who are raising them are unhappy about having had to adopt.[30] The studies also suggest though, that the strain experienced by many young adoptees does not dominate (though it is not entirely absent from) early childhood or adulthood.[31] Further, although considered more vulnerable to stress than non-adopted children, adoptees generally do not indicate dissatisfaction with relationships with adoptive parents or overall unhappiness with their lives.[32] For the past few decades, many adoptees have shown considerable interest in obtaining information about or having contact with one or both of their natural parents.[33] Studies comparing those who do and do not seek out information yield no clear findings about the implications of the search for the overall well-being of adoptees.[34]

Important dissimilarities between adoption and surrogacy limit the ability to draw definite conclusions about how children of surrogacy will fare in the future. First, the child of surrogacy usually will know more about his or her birth mother than will the adopted child. As currently practiced, many rearing parents maintain some contact with the birth mother after the child's birth. This is especially true in non-commercial arrangements involving family members or close friends. In some surrogacy cases children may know a great deal about the birth mother, including that she was chosen because of characteristics the child's parents valued. For those programs that maintain anonymity, or for those couples who cut off contact with the birth mother after taking custody of the child, surrogacy agencies generally report that they maintain records that can be made available to the child at the age of eighteen or older.[35] Thus, the child of surrogacy need not live a lifetime

with unanswered and unanswerable questions and the resulting underlying anxiety that may be experienced in the lives of many adoptees.

Second, adopted children most often feel that their rearing parents who wanted them have provided love, care and support superior to that available in alternative situations, such as state institutions or foster homes.[36] Some adopted children may feel rescued. In contrast, the child of surrogacy will come to know that he or she was conceived with the deliberate intent to be given to others to raise. Although the resulting child may well view her or his existence as demonstrating great love and commitment, it is also reasonable to conclude that in confronting inevitable comparisons to traditional families the child may resent rather than appreciate his or her unique origins. In short, the adoption experience supports the view that psychological and emotional harm to the children of surrogacy is a realistic possibility, but offers little evidence of how serious or common such harm might be.

Lessons from donor insemination? Insofar as surrogacy deliberately creates children with atypical origins, analogies to donor insemination may be useful. Yet very little is known about the experiences and responses of children of donor insemination. Lack of information may be attributable to the way in which donor insemination has been practiced for the past fifty years. Unlike professionals involved in arranging surrogacy, those assisting in donor insemination have generally counseled parents against revealing its use to the child. Also unlike much of current surrogacy practice, sperm donors in professionally-assisted insemination usually remain anonymous to all concerned. Typically, a married couple using donor insemination experiences an ordinary pregnancy. If they choose, no one but the couple and the assisting physician need know that the child is not genetically related to its father. Medical professionals often do not keep records of donors that could lead a searching child to a genetic father. Norms of confidentiality could prevent the child from gaining access to any records even where they are maintained.[37] For these reasons it is rare for children to discover that they are the offspring of donor insemination.[38]

The few reports of children's reactions to learning of their A.I.D. origins are not uniform. Some report that they suspected something was "different" about them all along and were relieved finally to learn as adolescents or adults just what that "difference" was.[39] Others have felt

gratitude that their parents made such special efforts. Still others, however, reported a sense of betrayal, deception, and resentment.[40] Existing research does not indicate whether these responses were to learning of their origins or to learning that the truth had been hidden from them for many years (or to other factors).[41] Some recent accounts highlight a further consequence of anonymity -- the possibility of unknowing intimate involvement with a half-sister or half-brother. This otherwise remote prospect becomes more likely when the same man fathers multiple offspring through A.I.D.

With some exceptions, the secrecy and anonymity surrounding A.I.D. and adoption that may contribute to children's anxiety and distress is absent from surrogacy. Thus, the reactions of children of surrogacy are unlikely to focus on misrepresentation of their origins. However, to the extent that apparent negative reactions by children of A.I.D. have been to learning of their atypical origins, these emotional repercussions may sound a warning signal.*

Interestingly, some studies of donor insemination suggest that the effect on the intended rearing parents may not be as positive as many believe. With A.I.D., like most surrogacy (but unlike adoption), only one spouse is genetically connected to the child. This asymmetry in genetic or biological connection may disrupt marital harmony, and in turn may produce an imbalance in the parent-child relationship. A.I.D. researchers are not of one mind on this issue. Some contend that couples who use donor insemination have particularly strong and close marriages and that social fathers are often more involved with their children than are other men. Other researchers maintain that the men withdraw from active participation in their marriage and are more distant from their children than are other fathers.[42] Absent a consensus no firm conclusion arises, but it seems that marital relationships in which only one partner

* Comparison of surrogacy to artificial insemination has also been made by groups favoring commercial surrogacy. They argue that equal protection counsels that surrogacy should be permitted just as payment for sperm is allowed. While it is true that in both cases a third party's gametes are employed to create a child, the analogy falls short, as it does not take account of the process of gestation and the much greater degree of investment that pregnancy represents. As one writer notes: "Both males and females can donate gametes; males cannot become pregnant. Pregnancy is, so to speak, an extended event. An involvement of nine months duration, inevitably characterized by interactions between animate beings, differs qualitatively from masturbation and donation of the ejaculate." David H. Smith, "Wombs For Rent, Selves For Sale?," *Journal of Contemporary Health Law and Policy* 4 (1988): 23-36.

is genetically connected to a child, as in surrogacy, may be more at risk than a marital relationship in which both or neither of the spouses are biologically linked to their offspring.

In sum, surrogacy is factually distinguishable from both adoption and A.I.D., and the limited available research on the effects of adoption and A.I.D. on children suggests inconclusive results. Nonetheless, the real possibility remains that future behavior and development will be adversely affected. As suggested by experience with A.I.D., some children may feel that the surrogacy arrangement destroyed their chances of an attachment to their natural mothers. Some children born through surrogacy may experience bitterness and loss of self-esteem knowing they were conceived for the purpose of being given away, similarly to some experience with adoption. Current data on surrogacy (though sparse), together with lessons from our experience with adoption and donor insemination, supports the prudential judgment that the risk of harm resulting from surrogacy is of sufficient magnitude to cause significant concern. The majority of the Task Force and Commission fear that no matter how lovingly children might be treated, or how carefully they are told about the reasons for the surrogacy arrangement, these potential psychological and emotional harms are real ones we have a responsibility to address.

Preventing Future Harm

In crafting an approach to surrogacy, preventing possible future harm to the children of surrogacy, to birth mothers, and to others is an important policy consideration. It has been argued that surrogacy produces more good than harm for the child because absent the agreement, the child would never have been born. Existence, even if miserable, is preferable to non-existence.[43] To rest the argument here, however, would beg the question. Potential harm to the children of surrogacy is an important policy concern.[44] The real issue is whether surrogacy risks bringing children into the world in conditions they will find harmful. Are the children of surrogacy somehow "wronged" by being brought into the world in a harmful condition (or one they will come to find harmful)? Do we have a responsibility to prevent practices that create children in harmful conditions?[45] Our felt obligations to future generations counsel that surrogacy poses risks of psychological and emotional harm, particularly to children, that our public policy ought to aspire to prevent.

Absent stronger evidence than currently exists of the potential harms of surrogacy, preventing future harm does not, in itself, provide sufficient jusification for banning the practice. Conclusions about the potential consequences are, however, consistent with the deeper concerns of the Commission and Task Force about the nature of surrogacy, in particular commercial surrogacy. As noted throughout this report, the Commission and Task Force draw an important policy distinction between commercial and non-commercial surrogacy. When a woman's reproductive capacities are available for sale in the marketplace, serious concerns about exploitation and commodification come to the fore. In contrast, non-commercial surrogacy involves predominantly private arrangements between family or close friends with no "purchase." Commercial and non-commercial surrogacy arrangements, respectively, are further explored below.

Commercial Surrogacy Arrangements

For many legislatures, policymakers, and commentators, as well as the New Jersey Supreme Court in *Baby M*, commerce in surrogacy embodies the most troubling features of the practice. The commercial aspect has been seen by many as one of the most critical determinants as to whether the practice of surrogacy should be prohibited or tolerated. For example, the New Jersey Supreme Court in *Baby M* concluded that commercial surrogacy arrangements were illegal and unenforceable both on statutory and public policy grounds; however, the Court found "no offense to our present laws" in non-commercial surrogacy arrangements provided the birth mother "is not subject to a binding agreement to surrender her child."[46]

The question of how we as a society should define the limits of the market in this area of procreation may be viewed in a number of ways.[47] The New Jersey Supreme Court's statement in *Baby M* that "[t]here are in a civilized society, some things that money cannot buy,"[48] reflects a particular view of market theory, which recognizes social interactions as falling basically within two broad categories -- those which may be ordered or mediated through the market and those which should not be for sale in the market. Although the vast majority of our societal "transactions" occur to varying degrees within the ambit of the marketplace, we regard a small number of specific activities such as the

right to vote or the transfer of organs for transplantation as being outside the appropriate scope of commerce. Some things are "not for sale."

The position that certain goods, including childbearing and childbirth, because of their meaning to us in our culture, should not be distributed on the basis of ability to pay is forcefully articulated by Michael Walzer.[49] He contends that before we can understand how (distributive) justice works in a particular society, we must understand the value placed on certain goods by that society and how those goods are distributed. Put another way, it is from our understanding of the meaning that specific goods have for people in a society that we derive moral principles as to how those goods ought to be distributed in that society. Therefore, we place limitations on the exchanges of goods. Because money is the universal medium of exchange in our society, the most important limits are restrictions imposed on what money can buy. Most goods and services are exchangeable through the marketplace; they are "market alienable." But in some areas we adopt rules to prohibit market exchanges, making particular goods, services or relationships "market inalienable." (Walzer calls these "blocked exchanges.") Friendship, love, marriage, and procreation exemplify some of the intangible "goods" of life that, because of their special character, should be outside the sphere of the market.[50] Similarly, for many pregnancy is understood as a very intimate, highly emotional experience, and as such should not be "distributed" in accordance with rules of sale and purchase.

A vividly contrasting view of the role of the market is that of some "free market libertarian" theorists who would recognize and legitimate virtually all consensual exchanges among competent adults. According to this approach, sometimes referred to as "universal commodification,"[51] the market is potentially all-encompassing. All interactions can be thought of in market terms; the only limits imposed on buying and selling are those of the market itself. Anything that can be desired or valued is thought of as a commodity subject to trade. This includes not only tangible objects, but also intangibles such as personal relationships or justice.

An interesting version of this free market libertarian approach is found in the writings of Judge Richard Posner and Elisabeth Landes on markets in babies,[52] and in Posner's more recent writings on surrogacy.[53] The Posner/Landes thesis is that legal restrictions currently imposed on

the baby market are undesirable and should be eliminated. In their view, interference with the free operation of the market leads to inefficient results, with negative consequences for all parties concerned.[54] Posner points out the irony that "those who attack surrogate motherhood out of a general hostility to free markets do not realize that surrogate motherhood is itself a product, in part, of the interference with a market -- the market in adoption."[55] The basis for this claim is that the demand for surrogacy stems in large measure from the shortage of healthy, white infants available for adoption -- a shortage to a great extent generated by legal restrictions that prevent the market from operating freely in the sale of babies.[56]

This brief account of these contrasting positions regarding the marketability of certain social arrangements is by no means exhaustive of the authors' views nor of the range of opinions and theories on this issue.[57] This account is intended to illustrate that the way we think about the market is not a given, but is a choice reflective of important societal values. In attempting to define the appropriate role of the market with respect to the practice of surrogacy, the Task Force and Commission considered a range of arguments for and against commercial surrogacy. Attention and concern focused in particular on two major areas: First, the likelihood that commercial surrogacy will foster "exploitation" of women, and second, the likelihood that it will foster "commodification" of women, children, and the procreative process.

Exploitation

Opponents of commercial surrogacy frequently maintain that surrogacy for sale is exploitative of so-called "surrogates" in particular, and of women in general. The central posit of the exploitation argument is that the practice will lead to the exploitation of poor or less advantaged women by richer and more advantaged women (and couples). Where women are driven by perhaps desperate economic or social circumstances to act as so-called "surrogates", perceiving that they have no other real "choice," they cannot be said to be acting voluntarily and autonomously. A practice which unduly influences women to sell such an intimate personal service devalues and degrades women, and affronts human dignity.

This is, of course, an oversimplification of the argument. The key question is whether so-called "surrogates" are coerced or unduly

induced by the offer of money to enter the surrogacy agreement. It is difficult at best to objectively distinguish voluntary and considered choices to be a birth mother from those based on "undue" inducement. Personal and subjective beliefs about undertaking certain risks for a given sum of money can vary considerably. In short, "[w]hat is merely an incentive for some would constitute a coercive offer for others."[58] Furthermore, as noted above, available data suggests that birth mothers often have mixed motives, and do not generally believe they are "doing it for the money." Disparities in wealth, education and social status between contracting couples and birth mothers are often not as great as opponents of surrogacy suggest, and many birth mothers receive professional counseling prior to entering the arrangement.[59]

Despite these caveats, the Commission and Task Force believe that the offer of money is likely to be an undue and morally offensive influence upon women who are poor and uneducated, and those who may also be unemployed, receiving welfare, and with few or no alternative sources of financial support in sight. A number of Task Force and Commission members believe that in many cases it is difficult to regard the so-called "surrogate" as being "exploited" in the sense of being coerced by economic circumstances; but nonetheless the "degradation" involved in her role, whether or not she feels personally degraded, constitutes an equally offensive form of exploitation which should not be legally sanctioned. As the New Jersey Supreme Court noted in *Baby M*, "the essential evil [in commercial surrogacy and in payments in adoptions] is the same, taking advantage of a woman's circumstances (the unwanted pregnancy or the need for money) in order to take away her child, the difference being one of degree."[60] With the advent of gestational surrogacy, the specter of a wealthy class hiring a "breeder" class of poor women to bear children for them is increasingly possible, and to many, particularly offensive.

Several analogous societal practices and prohibited activities offer further insight into the ways in which we think about exploitation of individuals and groups, and the state's role in banning exploitative commercial transactions. Among the analogies considered by the Commission and Task Force were those between surrogacy and slavery, organ sales, ordinary wage labor, and prostitution. While these analogies offer useful constructs for thinking about surrogacy and the state's role

in "blocking" certain transactions from the marketplace, each differs in relevant respects from the practice of surrogacy.

Slavery. One such prohibited practice is slavery, banned by the Thirteenth Amendment to the U.S. Constitution. Broadly defined as the sale of a person's body (or the use of that person's body) by a third party who has somehow obtained control over another's body or the sale of another's body, slavery violates inalienable rights of life and liberty. Some argue that commercial surrogacy is morally equivalent to slavery and should therefore be banned. Slavery and surrogacy are, it is said, both in essence practices in which human lives are regarded as property to be sold and purchased. Both involve the control, disposition and sale exercised by another of not only one's own body, but of one's offspring as well. (Historically, slave owners also owned the sons and daughters of adult slaves.) Similarities between surrogacy and slavery are thoughtfully explored, for example, by David Smith. He observes:

> There are two intuitive points of contact. One is that control over progeny, the ability to separate the parents and children, has always been thought to be among the most repugnant features of slavery ... Totalitarian control is ratcheted to a new height when, going beyond depriving me of my freedom, it deprives me of my offspring. That is to say, a freedom lost in surrogating and in slavery is widely perceived to be important, touching an intimate side of the soul.[61]

In short, though slavery differs conceptually and in practice from surrogacy, both share a kind of degradation of the body and spirit that speaks to our universally shared moral repugnance and to the illegality of slavery. Both, it is argued, put a monetary value on human lives, denigrating human dignity.

Yet this argument cannot be pressed too far, as there are also important dissimilarities between surrogacy and slavery. As Smith also notes, in contrast to slavery, "the surrogate's status is not hereditary, and the bondage period is brief. She assumes the status by a seemingly free contract and in nine months she is freed."[62] Clearly, however one views the power of money in today's world, the so-called "surrogate" is free to engage in a market transaction for her body and labor in a way that

slaves were not. Nor is the child of surrogacy deprived of freedom, forced into manual labor for the benefit of others, or subject to being resold as a chattel in the marketplace.

Organ selling. Another paradigm of legal prohibition of the exploitation of poor people is found in the analog of organ sales by live "donors." It is well-established that the sale of organs by live "donors" is not permitted in this country. (Nor is the sale of cadaver organs.) Intervention by the state to prohibit the sale of organs is justified by some on the ground that these sales are generally "desperate exchanges" in which the seller is coerced to act because of his or her highly constrained circumstances. Although supporters of an organ market contend that forbidding the sale deprives the would-be seller of a potential source of income, thus leaving him or her in a worse position than if the sale had been permitted, powerful reasons justify prohibition. Perhaps the most compelling is based on an appeal to the higher ideals of our society. A society which allows people to take advantage of those in desperate positions by permitting the sale of organs is arguably not the kind of society to which we wish to aspire. As Samuel Gorovitz observes: "...one appropriate standard for judging the greatness of a society is that of how it treats those whom it treats least well."[63] Discussing the issue of organ sales, Professor Gorovitz expresses a hope which may be equally applicable in the context of surrogacy:

> that history will be able to judge us as a society that never abandoned its struggle to eliminate ... poverty, that strove ever to enhance and enrich its respect both for individuals and for their capacity for mutual aid, and that faced the problems of an awesome new technology with humanity and efficiency both, rather than as merely another commercial opportunity.[64]

Prohibition of organ sales is one of a number of precedents for laws designed to proscribe particularly offensive practices where the threat of exploitation, degradation, and coercion of poor, disadvantaged or vulnerable members of our society looms.

Wage labor. Some commentators argue that surrogacy is more properly thought of as a job which lasts for a nine-month period, and analogize the practice to wage labor. Pursuant to this view, the birth mother's sale of

reproductive services is not the sale of her body (nor of a baby), as in slavery, but rather is the sale of the use of her body for a specified purpose and time (along with the attendant risks and sacrifices of pregnancy), subject to certain constraints. In a sense, the birth mother is "renting" her womb. The essence of a surrogacy arrangement is a voluntary contractual agreement between consenting parties for the sale of reproductive services. Certainly, surrogacy brokers and most of the parties to such arrangements would agree with this premise. This approach, often advanced within the larger context of arguments about reproductive autonomy, leads to a free market conception pursuant to which outright prohibition or legal restrictions upon allowable compensation constitute an unwarranted interference with the parties' freedom to contract.

However, this contention ignores the fact that in our society the freedom to contract is by no means unqualified. As the New Jersey Supreme Court stated in *Baby M*:

> In America, we decided long ago that merely because conduct purchased by money was "voluntary" did not mean that it was good or beyond regulation and prohibition. Employers can no longer buy labor at the lowest price they can bargain for, even though that labor is "voluntary", or buy women's labor for less money than paid to men for the same job, or purchase the agreement of children to perform oppressive labor, or purchase the agreement of workers to subject themselves to unsafe or unhealthful working conditions. (Citations omitted.)[65]

The wage labor model ignores key features of surrogacy and argues for a free market approach which is unpersuasive when weighed against the state's established authority to limit certain marketplace and contractual liberties in the interest of protecting legitimate societal values.*

* Some point to a variant of the wage model, namely, wages paid for ultra-hazardous work, such as stunt performers in the entertainment industry. Factually this construct may be slightly closer than the "job" analogy, because what is being sold here is the seller's capacity deliberately to place his or her health or body at risk—physical and psychological risks which many may consider place the activity outside the parameters traditionally defining wage labor. If we permit individuals to voluntarily contract to jump from airplanes or to work with explosives, why not to bear a child?

Prostitution. Not infrequently, comparison is drawn between surrogacy and prostitution.[66] The sale of sexual services raises serious ethical objections for most of us, in part because it dehumanizes sexuality, one of the elements most intimately and essentially connected to a person's humanity. As Marx Wartofsky writes:

> What is characteristic of the ethical objections to prostitution is that the intimacy, dignity, or love which sexual relations are supposed to express...has been translated into the terms of an economic exchange of money for services...[T]he monetary relation appears to underscore and make fully articulate the quality of the act as a degradation of human relations. But again, why? Because it is believed that payment robs the relation of the voluntary character which it presumably should have, if it is to be fully human... Insofar as the seller alienates the disposition over the use of her body, and the buyer possesses this alienated use, prostitution becomes a paradigm of alienation.[67]

Opponents of commercial surrogacy sometimes refer to the practice as "reproductive prostitution," claiming that prostitution and commercial surrogacy both involve the sale of a highly intimate service with the woman being seen as detached and alienated from the services she provides.[68] Both practices, it is claimed, subvert human dignity. In neither situation is it necessary for the woman to feel humiliation, embarrassment or degradation in order to be degraded.

While it is true that in both prostitution and in commercial surrogacy a woman's body is being used, for a fee, in order to fulfill another person's desires, the analogy obscures important moral and factual distinctions. First, sexual intercourse is generally not involved in surrogacy, and thus surrogacy does not involve free trade in sexuality in the way that prostitution does. Second, in contrast to prostitution, surrogacy involves the life of a third person, the resulting child. Third, prostitution is often condemned because of a fear that the woman has been economically coerced into her role as a prostitute. However, as

As a case for commercial surrogacy, the analog to ultra-hazardous work for hire fails for the same reasons as the wage labor argument.

discussed earlier, while in some cases desperate economic circumstances may lead some women to be so-called "surrogates", there is evidence that in many cases money is only one of a number of complex motivations. It is difficult to conclude that many so-called "surrogates" have been "coerced." Furthermore, for the so-called "surrogate", surrogacy is a short-term contract, rarely entered into a second time, not a profession.

In sum, analogies between commercial surrogacy and slavery, organ sales, wage labor, and prostitution offer useful thought constructs, each helping to illuminate the concepts of exploitation, coercion, degradation and consent that are crucial to understanding surrogacy. Yet none provides a clear answer to whether commercial surrogacy is inherently exploitative, coercive, or degrading."

Commodification

The Commission and Task Force harbor serious concern that a free market in surrogacy may lead to a shared perception of women, children, and the parent-child relationship as "commodities" subject to trade in the market.[69] Societal or legal acceptance of commercial surrogacy may adversely affect certain social attitudes, causing us to come over time to think about women, children, and procreation in terms of marketability, advertising, pricing, and packaging, thereby devaluing their inherent human worth. The Commission and Task Force believe strongly that a society in which very personal aspects of our lives and human relationships are for sale is not the kind of society to which we wish to aspire.

" Another analogy which further illuminates notions of "consent" and "coercion", is that of paid research subjects. In the context of human subjects research, such as clinical drug trials, the effects of the regimen are often unknown or at least uncertain, and the purpose is to test certain hypotheses. Thus, the person (subject) assumes a number of risks in undergoing the research protocol in exchange for potential, but unproven benefits. As with surrogacy, part of what is being "sold" here is the subject's capacity and willingness to assume a (possibly unforeseen) risk to her body and health. Our laws allow payment to research subjects, but attempt at the same time to protect against exploitation and other harms by specifying carefully the guidelines for participation and for the conduct of ethical research. For example, requiring informed consent, ensuring that the agreement has been entered into freely, allowing the research subject to withdraw at any time, and limiting the degree of risk to which subjects may be exposed, are established criteria for human subjects research. The difficulties with approaching surrogacy as a question of informed consent are discussed above. However, those interested in regulating the practice of surrogacy may find this analogy more useful.

As discussed above, surrogacy promotes excessive identification of women with their biological and reproductive capacities, perhaps even to the point at which these functions are seen as detached from other personal attributes, able to be monetized and exchanged on the market as "commodities." The so-called "surrogate's" labor is converted into a commercial "production process" in which she is expected to form no emotional ties with the "product" she is creating. Her role is devalued and reduced to that of a "surrogate uterus," an "incubator," a "hatchery."[70] The offensiveness of this terminology itself speaks loudly to the denigration of the so-called "surrogate's" dignity and to the trivialization of the pregnancy process.

Children, too, may come to be viewed, and may be taught to view themselves, as "commodities" -- as luxury items available to consumers who can afford them, rather than as a natural consequence of intimate adult relationships. As one writer has noted:

> Commercial surrogacy substitutes market norms for some of the norms of parental love. Most importantly, it requires us to understand parental rights no longer as trusts but as things more like property rights -- that is, rights of use and disposal over the things owned...[The natural mother] and the couple who pay her to give up her parental rights over her child thus treat her rights as a kind of property right. They thereby treat the child itself as a kind of commodity, which may be properly bought and sold.[71]

Treating parental rights as marketable property rights fosters a perception of children as "objects" created or "manufactured" in order to satisfy the needs and desires of the contracting parties. The unusual effort involved in surrogacy, the fact that a person was sought out to supply the genes, gestation, or both, the controls that may be exercised over the pregnancy to ensure a healthy child, and the payment of a large sum of money, may all contribute to thinking of the child as a "product." Children born of surrogacy may be valued not for themselves as totalities with individual traits, but rather as the embodiments of certain characteristics viewed as highly desirable by their intended parents. Treated as means to an end, rather than as ends in themselves, the

children of surrogacy (and perhaps children in general) are not accorded full human dignity and worth.

Some opponents of commercial surrogacy also argue that once women are paid to act as so-called "surrogates," it may be very difficult, if not impossible, to prevent differential pricing arrangements in the market. A practice by which the birth mother's fee is based upon attributes such as race, intelligence, or physical appearance would be a particularly offensive form of commodification, especially if legitimated by legal or social approval. Children born of these arrangements may also come to be "priced" according to their characteristics, such as race, national origin, gender or freedom from disability. Not only might such a system of payments foster a view of women and children as packaged "products", but it also would be deeply destructive in terms of the potential for overt racial, sexual, and other forms of discrimination.

Finally, implicit in the problem of commodification is the concern that the effects of commodification may extend well beyond the immediate participants in the surrogacy arrangement to an unknown number of other societal values and practices. Once some women and some children are known to be "worth" a certain amount of money, putting price-tags on people and on human relationships may well extend to other areas of life, depersonalizing and dehumanizing persons and relationships, and demeaning our sense of what it means for all to be equal and respected members of a community.

In sum, for all of the above reasons, the Task Force and Commission conclude that commercial surrogacy should be prohibited by law. Commercial surrogacy agreements should be both illegal and unenforceable. Some are concerned about the potential for exploitation and coercion of poor women; some fear that commercialism will lead to a view of women, children, and of procreation as "commodities" to be bought and sold; others feel that the practice is intrinsically morally wrong because it involves the sale and purchase of a human being; and still others feel that even if there is no compelling moral argument against commercial payments in themselves, a ban on monetary exchange would limit and discourage the growth of surrogacy, thereby addressing the worst potential abuses, while allowing for the possibility that some good might be associated with surrogacy in the non-commercial context.

Sanctions[n]

In order to make commercial surrogacy illegal and to strongly deter its practice, the Commission and Task Force also recommend that statutory law impose penalties for engaging in commercial arrangements. Criminal sanctions should be imposed upon broker/intermediaries who orchestrate and derive financial benefit from surrogacy agreements, with the possibility of incarceration (in the court's discretion) as well as substantial fines.[oo] Making illegal and criminal payments to broker/intermediaries will discourage and likely deter the growth of a surrogacy "industry", and will also protect against improper incentives or careless practices which have sometimes placed the lure of profits ahead of the well-being of the participants involved in the surrogacy arrangement.[72]

A more complex situation is presented regarding the role of *professionals* as participants in commercial surrogacy.[73] Medical, psychological or legal screening and counseling of the parties is often an essential undertaking of the surrogacy agreement. Professionals who screen women and couples not infrequently do so with an understanding that they are facilitating a commercial arrangement. Physicians, psychologists, and attorneys who receive financial compensation for providing services with full knowledge of the likelihood that their patients or clients are entering into an illegal surrogacy arrangement are facilitators, if not participants, in an illegal activity. They should therefore be subject to the criminal law. Effective deterrence should

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[n] The Commission and Task Force would like to acknowledge the contribution of Professor Walter P. Loughlin of Rutgers University School of Law, on the issue of penalties. Professor Loughlin prepared two memoranda for the Task Force, the first entitled "Application of Criminal Sanctions to Surrogacy Agreements" (dated June 22, 1989), and the second entitled "Legal Responses to Surrogacy" (dated July 7, 1989).

[oo] In arriving at this recommendation, the penalties set forth in the New Jersey adoption code were considered. Under the adoption code, any person who assists in placing a child for adoption, whether or not for money (or other consideration), is guilty of a misdemeanor, which constitutes a fourth degree crime. *N.J.S.A.* 9: 3-39. When money is involved, the crime is a high misdemeanor, which constitutes a third degree crime. *N.J.S.A.* 9: 3-54. The fine for a third or fourth degree crime may not exceed $7,500.00 (unless otherwise specified by statute). *N.J.S.A.* 2C: 43-3. The jail sentence for third degree crimes may be three to five years, and for fourth degree crimes may not exceed eighteen months. *N.J.S.A.* 2C: 43-6. The Commission and Task Force's view is that the penalties set forth in the adoption code are an insufficient deterrent to broker/intermediaries engaged in commercial surrogacy.

include the possibility of incarceration, although there should be a presumption in favor of non-incarceration for those who are not acting as broker/intermediaries. In addition, facilitating professionals should be subject to fines, and their participation should be deemed to constitute unprofessional conduct if the matter is referred to a licensing board.

It is important to understand, however, that this type of medical or psychological screening differs from counseling and professional services provided to participants after they have become involved in a surrogacy arrangement. Counseling after the fact should not be criminalized nor otherwise subject to legal sanction. Nor should a physician's provision of care during the so-called "surrogate's" pregnancy, labor and delivery, be characterized as illegal. Any such restrictions imposed after the participants are already involved in a surrogacy arrangement would violate understandings of the nature of the professional-patient relationship, including the duty of confidentiality, and would deprive people of professional assistance where it might be needed.

Finally, the Commission and Task Force conclude that criminal penalties should not be imposed upon the contracting couple (the biological father and his wife), or upon the birth mother. Civil fines may be appropriate, in the discretion of the court. While some believe that the goal of deterrence would be better achieved by the prospect of a criminal record, the majority maintain that deterrence could be achieved more effectively in other ways, notably through the maternal custody presumption and the obligation of support by the non-custodial parent in case of a dispute. (*See* chapter six.) A further consideration is that the child might be socially and psychologically injured by the knowledge that the circumstances of his or her birth caused his or her parents to be labelled "criminals." Prudence counsels that the contracting couple and the birth mother who knowingly participate in a commercial surrogacy arrangement should be subject to civil penalties, in the form of a fine, but not to criminal sanctions."

These recommendations are intended to advise the Legislature of the severity of sanctions believed necessary to provide an appropriately

" It should be noted that several Task Force members strongly favored mandatory imposition of community service for the parties to a commercial arrangement.

strong deterrent to the practice. They also express the view shared by many Task Force and Commission members that those who act as broker/intermediaries or as facilitators in commercial surrogacy arrangements deserve punishment on retributive grounds, as they are engaged in a morally offensive practice.

Based on the foregoing, the Commission and Task Force make the following policy recommendations with regard to commercial surrogacy:

The practice of commercial surrogacy should be illegal.

Any commercial surrogacy arrangement or any contractual provisions in connection with a commercial surrogacy arrangement should be both illegal and unenforceable.

Those who knowingly participate in a commercial surrogacy arrangement should be subject to penalties, as follows:

(a) A broker/intermediary should be subject to criminal penalty, including the possibility of incarceration, and a fine.

(b) A professional should be subject to criminal penalty, with a fine imposed. There should be a presumption in favor of non-incarceration. Where the matter is referred to a licensing board, there should be a presumption that the conduct constitutes unprofessional conduct.

(c) The biological father and his spouse should be subject to civil penalties, with a fine.

(d) The birth mother should be subject to civil penalties, with a fine.

Non-Commercial Surrogacy Arrangements

Though less common than commercial arrangements, there are several known instances of non-commercial surrogacy (sometimes termed "altruistic" surrogacy) in the United States and abroad.[70] As discussed above, non-commercial arrangements raise many of the same questions and concerns as commercial arrangements. However, in the absense of a financial transaction and the consequent potential for exploitation and commodification public policy should not be prohibitive or punitive.

Generally, non-commercial surrogacy occurs when family or close friends agree to collaborate in creating a child for a couple in which the woman is unable to conceive or to carry the pregnancy to term. Such altruistic surrogacy has occurred when a fertile sister, cousin, mother, or friend of an infertile woman has been inseminated with the sperm of the infertile woman's partner, or has carried an embryo containing the genes of both the intended rearing parents (non-commercial gestational surrogacy). The most dramatic case of non-commercial gestational surrogacy in this country occurred this past year in South Dakota, when a 42 year old woman gave birth to her daughter's twins, becoming mother and grandmother at the same time.[75] Non-commercial surrogacy could also occur between strangers, although there is no known evidence of how frequently this occurs. There is much less available reliable information about non-commercial arrangements than is the case with commercial surrogacy, due largely to the fact that no broker/intermediary is involved. Nonetheless, it is clear that birth mothers' motives are complex. It appears that social and psychological desires for children, a desire to help others, and giving "the gift of life" are the principal motivating factors for those who undertake non-commercial surrogacy. (*See* the discussion in chapter three.)

Empirical data on the impact of non-commercial arrangements on the affected parties is as sparse as in the commercial context. Consequently, the views of the Commission and Task Force concerning the best approach to non-commercial surrogacy are necessarily speculative, while driven by a desire to ensure the best outcome for everyone involved.

For the majority of the Commission and Task Force, many of the concerns underlying commercial surrogacy are felt as well with respect to non-commercial arrangements. In both cases a woman becomes impregnated with the intent to surrender the resulting child. Even the non-commercial practice of surrogacy might diminish, rather than enhance, societal values and perceptions regarding the reproductive process and the role of women. A subtle yet real transformation of society's view of the roles of children, women and reproduction is possible whether or not the surrogacy arrangement is based on the exchange of money. Like its commercial counterpart, "altruistic" surrogacy proceeds on the premise that physical gestation can be separated from the emotional and social bonds that characterize pregnancy, birth, and the ensuing relationship between mother and child; it thereby fosters a divided selfhood.

Further, the absence of financial compensation does not guarantee an informed and voluntary decision free of potential grief, stress, and disruption to the families and children whose lives the practice is designed to enrich. In fact, non-commercial intra-family arrangements may involve more complicated and possibly harmful social relationships. While the child likely will not experience resentment arising from a lack of knowledge about his or her birth mother, negative emotional consequences may nevertheless flow from learning of his or her atypical origins and realizing that he or she was conceived with the intent to be given away. When the birth mother is a close family member or friend who will maintain ongoing contact with the family, a blurring of social and perhaps physical identity for the child may arise. Constant contact with two "mothers" might prove to be a source of distress, confusion and destabilization interfering with the child's formation of a sense of identity and belonging. (For the other children of the birth mother and of the rearing couple the hard reality to be confronted is that a sibling was conceived for the purpose of being given away.)

Whether or not money is exchanged, the possibility exists that during the course of gestation the birth mother will develop feelings for the fetus that might make her ambivalent about her promise to relinquish the resulting child. The inner discord which she experiences is likely to be exacerbated when she is a close family member or friend who will have ongoing contact with the child, and who might have different opinions than the rearing parents about childbearing and fundamental

decisions in the child's life. It may be more difficult to "put the trauma behind her" when she is related to the child's social parents.

Family members or close friends often believe they know and trust each other well. Consequently, they likely will engage in the practice with little or no assistance from medical, legal or other professionals, and without a written agreement spelling out their full and mutual understandings. Medical, psychological or genetic screening may be overlooked, to the possible detriment of the rearing couple, the birth mother, and the future child. In one known case the birth mother did not disclose that she had been a user of intravenous drugs, resulting in the birth of a child with the HIV virus who was subsequently abandoned by all the adults in the family.[76] Thus, the completely private nature of an intra-family arrangement could occasion problems that likely would be prevented, or at least minimized, by professional involvement typical of commercial arrangements. Additionally, non-commercial intra-family surrogacy could set in motion other demands or expectations of a psychological or material nature. For example, a fertile family member (or friend) could be manipulated (some might say "blackmailed") emotionally and psychologically into bearing children for the infertile woman. The reverse may occur as well. The birth mother might subject the couple to unceasing demands for attention or help portrayed as their obligatory expression of appreciation for such a wonderful gift.

For all of these reasons, the majority of the Commission and Task Force conclude that non-commercial surrogacy raises sufficient concerns to warrant a public policy that discourages the practice.* At the same time, the Commission and Task Force believe that the State should not intervene in the private emotional, sexual, and reproductive lives of those wishing to collaborate in creating a child, just as it should not

* A number of Commissioners and Task Force members feel that the chief difficulties with surrogacy are confined to those involving payment of money to brokers and to women for their reproductive services. A woman who bears a child for a beloved friend or family member is giving a precious, unique gift. Like blood, bone marrow, or organ donation, giving one's gametes and gestational services as a birth mother is a praiseworthy endeavor that speaks to our higher human aspirations. Rather than wishing to discourage these arrangements, several members of the Commission and Task Force suggested creating a policy framework that might assist them. One specific approach was to permit licensed adoption or other special service agencies to locate women willing to serve as so-called "surrogates" in non-commercial arrangements. The agencies would also provide psychological evaluations and counseling for the parties, whether the so-called "surrogate" is a family member, friend, or stranger.

intervene in the lives of people who procreate naturally. This principled objection to State intervention is buttressed by a realistic assessment of the limits of the State's resources for helping already existing troubled families and children, and the conviction that the state could never adequately supervise a scheme of medical, psychological, or legal counseling. While recognizing the potential benefits to families (including the children) of mandated or recommended professional assistance in those arrangements, the state should neither endorse nor aid developing such assistance. Many feel strongly that any governmental program that regulates professional assistance in non-commercial arrangements may thereby legitimate the practice, rather than discourage it.

Consequently, the Commission and Task Force have concluded that non-commercial surrogacy should not be declared illegal nor should the practice be condemned. Rather, the chief vehicle for discouraging the practice should be the unenforceability of the agreements if disputes arise, and the maternal custody presumption (discussed in the next chapter) which puts all on notice that the birth mother is likely to prevail if she decides to retain the child. This policy response accomplishes the goals of discouraging the practice without legitimizing it; respecting the especially strong privacy interests of families and close friends; and recognizing that in some circumstances the genuine love and intimacy reflected in altruistic reproductive collaboration may indeed provide the participants great joy without harm to society's larger beliefs and values.

Therefore, the Commission and Task Force make the following policy recommendation with regard to non-commercial surrogacy:

> **Any non-commercial surrogacy arrangement or any contractual provisions in association with a non-commercial surrogacy arrangement should be unenforceable.**

Conclusion

After long and careful deliberation the Commission and Task Force conclude that surrogacy could erode the significance we attach to a number of fundamental values and policies. The Commission and Task Force fear a subtle yet real transformation of societal attitudes toward the

roles of children, women and reproduction, particularly when surrogacy takes the form of commercial contracts mediated through the marketplace. Commercial surrogacy violates basic commitments to preventing practices that exploit and commodify women and children, and to ordering social practices, institutions and relationships in ways that promote, rather than degrade, human dignity. While non-commercial surrogacy does not involve the offensive features of surrogacy for pay, and therefore should not be prohibited by law, it nonetheless should be discouraged. In order to deter commercial surrogacy and to punish those who, like broker/intermediaries, facilitate and profit from commercial arrangements, criminal penalties should be imposed.

At the same time, a comprehensive policy must anticipate that efforts to deter surrogacy will sometimes fail, and that custody disputes may arise. The same is true of non-commercial arrangements. The next chapter discusses how custody disputes in surrogacy cases ought to be addressed. The recommendations, including establishing a waiting period for the birth mother to decide whether she will relinquish custody and creating a legal presumption in favor of custody in the birth mother, bolster the major objective of deterrence, and are central to the goal of discouraging non-commercial arrangements.

NOTES

1. Barbara Katz Rothman gives a powerful presentation of this idea in "Recreating Motherhood: Ideology and Technology in American Society," in *Beyond Baby M: Ethical Issues in New Reproductive Techniques*, Dianne M. Bartels, Reinhard Priester, Dorothy E. Vawter, and Arthur L. Caplan, eds. (Humana Press 1990), pp. 9-27, and Barbara Katz Rothman, "Surrogacy: A Question of Values," in the same collection, pp. 235-41. For additional critical discussions of surrogacy that address this issue, *see generally* George J. Annas, "Fairy Tales Surrogate Mothers Tell," in *Surrogate Motherhood: Politics and Privacy*, Larry Gostin, ed. (Indiana Univ. Press 1990), pp. 43-55; New York State Task Force on Life and the Law, *Surrogate Parenting: Analysis and Recommendations for Public Policy* (May 1988); *In the Matter of Baby M*, 109 N.J. 396, 537 A.2d 1227 (1988).

2. "Baby M Contract," reprinted in *Beyond Baby M: Ethical Issues in New Reproductive Techniques*, Diane M. Bartels, Reinhard Priester, Dorothy E. Vawter, and Arthur Caplan eds. (Humana Press 1990), pp. 263-68.

3. For well-developed articulations of this position, *see* Elizabeth Anderson, "Is Women's Labor A Commodity?," *Philosophy and Public Affairs* 19 (1) (1990): 71-92 (hereinafter "Anderson"); Margaret Jane Radin, "Market-Inalienability," *Harvard Law Review* 100 (1987): 1849-937 (hereinafter "Radin").

4. Report of the Office of Technology Assessment, *Infertility: Medical and Social Choices* (United States Government Printing Office 1988), pp. 364-68 (hereinafter "OTA Report").

5. Congregation for the Doctrine of the Faith, *Instruction on Respect For Human Life in Its Origin and on the Dignity of Procreation: Replies to Certain Questions of the Day* (1987).

6. *Id.* at 9.

7. *Id.* at 11.

8. *Id.* at 12.

9. *Id.* at 25-26.

10. Baruch Brody, "Current Religious Perspectives on the New Reproductive Techniques," in *Beyond Baby M: Ethical Issues in New Reproductive Techniques*, Diane M. Bartels, Reinhard Priester, Dorothy E. Vawter and Arthur Caplan, eds. (Humana Press 1990), p. 54.

11. *Id.*, pp. 46-47.

12. Seymour Siegel, "The Ethics of Baby M's Custody," in *Sh'ma* (May 15, 1987): 107-08. In a 1982 statement by the Central Conference of American Rabbis, the Reform movement hesitantly approved surrogacy. This view, however, was not adopted by all reform rabbis. *See, e.g.*, Marc Gellman, "The Ethics of Surrogate Motherhood," in *Sh'ma* (May 15, 1987): 105-07 (hereinafter "Gellman").

13. Gellman, *supra* note 12, at 106.

14. *Id.*

15. *Id.*; Moshe D. Tendler, "Infertility Management: Cure or Ill?," in *Sh'ma* (May 15, 1987): 110 (hereinafter "Tendler").

16. Tendler, *supra* note 15, at 110; David M. Feldman, "Determining When We Have Gone Too Far," in *Sh'ma* (May 15, 1987): 109.

17. Tendler, *supra* note 15, at 110.

18. OTA Report, *supra* note 4, pp. 364, 367; Gellman, *supra* note 12.

19. For a fictional futuristic treatment of such possibilities, *see* Margaret Atwood, *The Handmaid's Tale* (Fawcett Crest 1987).

20. *See generally* Barbara Katz Rothman, *supra* note 1. For discussion strongly supporting gestational surrogacy, *see* Eugene C. Sandburg, "Only an Attitude Away: The Potential of Reproductive Surrogacy," *American Journal of Obstetrics and Gynecology* (1989): 1441-46.

21. *See* Lori B. Andrews, "Surrogate Motherhood: The Challenge For Feminists," in *Surrogate Motherhood: Politics and Privacy*, Larry Gostin, ed. (Indiana Univ. Press 1990), p. 170 (providing an extensive list of rhetorical labels used to describe surrogacy) (hereinafter "Andrews").

22. For an in-depth analysis of reproductive freedom and the new reproductive practices, *see* John A. Robertson, "Embryos, Families, and Procreative Liberty: The Legal Structure of the New Reproduction," *Southern California Law Review* (1986): 939-1041.

23. For a discussion of feminist perspectives on surrogacy, *see, e.g.*, Andrews, *supra* note 21, pp. 167-82.

24. *Id.*

25. Professor Martha A. Field presents an argument that any decision by a so-called "surrogate" to relinquish a child prior to birth may be unconstitutional as it may not be sufficiently informed or voluntary, in violation of the woman's constitutional right to know and raise her children. *Surrogate Motherhood: The Legal and Human Issues* (Harvard Univ. Press 1988), pp. 69-70 (hereinafter "Field"). In addition, Field cites to the research of professor and social worker Phyllis Silverman who has studied women who have suffered losses. Silverman reports: "It is one thing to agree in the abstract to give up a child, quite another to actually hand over a living human being after it is born and in the mother's arms." Silverman concluded that the women she surveyed did not understand in advance how they would feel subsequent to the infants' births. *Id.* at 73 (quoting Report of Phyllis R. Silverman for use in the *Baby M* Litigation, October 23, 1986, p. 4).

26. Psychological factors underlying the motivation of the so-called "surrogate" may include searching for love and acceptance, re-enactment of childhood abandonment, gratitude for her own adoption, or guilt over a prior abortion. *See* Field, *supra* note 25, pp. 20-21. However, as noted, some surveys indicate that women who agreed to relinquish custody prior to birth did not comprehend how they would feel after the infant was born. *See supra* note 25.

27. Deborah Solomon, reviewing books on surrogacy by Elizabeth Kane and Martha Field, asks whether surrogacy might not benefit society by changing the perception that parents possess and control children, and that a function of children is to enhance their parents. "My question is why this revolution, which Field says would change our fundamental concept of what it means to be human, is something necessarily to be feared? It's not as if our present standards for the proper parent-child connection ...couldn't be improved." *See* "Mothers In Law," *Women's Review of Books* 4 (4) (January 1989): 11. *See also* William Ruddick, Presentation to the Task Force on New Reproductive Practices of the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care, June 22, 1988; Nadine Taub, testimony presented to the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care and the Task Force on New Reproductive Practices, Joint Public Hearing, May 11, 1988, Newark, New Jersey.

28. *See* David M. Brodzinsky, "Looking at Adoption Through Rose-Colored Glasses: A Critique of Marquis and Detweiler's 'Does Adoption Mean Different? An Attributional Analysis,'" *Journal of Personality and Social Psychology* 52 (2) (1987): 394-98 (hereinafter "Brodzinsky"); Stephen E. Nickman, "Losses in Adoption: The Need for Dialogue," *Psychoanalytic Study of the Child* 40 (1985): 365-99 (hereinafter "Nickman"). For a forceful presentation of such evidence and of suggested changes in adoption practice, *see* Arthur D. Sorosky, Annette Baran and Reuben Pannor, *The Adoption Triangle* (Anchor Books 2nd edition 1984).

29. Brodzinsky, *supra* note 28, pp. 394-96; Sorosky, Baran and Pannor, *supra* note 28, pp. 105-19.

30. *See* Michael P. Sobol and Jeanette Cardiff, "A Socio-Psychological Investigation of Adult Adoptees' Search for Birthparents," *Family Relations* 32 (October 1983): 477-83 (hereinafter "Sobol and Cardiff"); Kathryn A. Kowal and Karen M. Schilling, "Adoption Through the Eyes of Adult Adoptees," *American Journal of Orthopsychiatry* 55 (3) (July 1985): 354-62 (hereinafter "Kowal and Schilling"); Sue A. Aumend and Marjorie Barrett, "Self-Concept and Attitudes Toward Adoption: A Comparison of Searching and Non-Searching Adult Adoptees," *Child Welfare* 63 (3) (May-June 1984): 251-59 (hereinafter "Aumend and Barrett").

31. Nickman, *supra* note 28; Sorosky, Baran and Pannor, *supra* note 28, pp. 87-105 and 121-43.

32. *See* Sobol and Cardiff, *supra* note 30; Kowal and Schilling, *supra* note 30; Aumend and Barrett, *supra* note 30.

33. *See generally* Sorosky, Baran, and Pannor, *supra* note 28; Aumend and Barrett, *supra* note 30.

34. Compare Aumend and Barrett, *supra* note 30, with Sobol and Cardiff, *supra* note 30. It is noteworthy that Aumend and Barrett, who find that searchers and non-searchers differ on some measures of well-being and self-esteem, nonetheless conclude their article by saying: "The results of this study do not support the belief, in general, that adoptees have low self-concepts and identity conflicts, or that adoptees need information about their biological families and reunions to resolve their identity conflicts. ... Although significant differences exist between the comparison groups, an important finding is that of all the adult adoptees, the majority scored above the 60th percentile on the Tennessee Self-Concept Scale and had positive scores on the Attitudes Toward Parents Scale." Aumend and Barrett at 258.

35. *Id.*

36. *See* Joseph Goldstein, Anna Freud and Albert J. Solnit, *Beyond the Best Interests of the Child* (Free Press 1979), pp. 21-22; *see also* Brodzinsky, *supra* note 28, p. 397.

37. Kamran S. Moghissi, "The Technology of AID and Surrogacy," in *New Approaches to Human Reproduction: Social and Ethical Dimensions*, Linda M. Whiteford and Marilyn L. Poland, eds, (Westview Press 1988), pp. 117-32 (hereinafter "Moghissi"); Judith N. Lasker and Susan Borg, "Secrecy and the New Reproductive Technologies," in *New Approaches To Human Reproduction*, Linda Whiteford and Marilyn Poland, eds. (Westview Press 1988), pp. 133-44 (hereinafter "Lasker and Borg").

38. *See* Moghissi, *supra* note 37; Lasker and Borg, *supra* note 37; *see also* Robert Snowden and G. Duncan Mitchell, *The Artificial Family* (Allen and Unwin 1981), p. 82 (hereinafter "Snowden and Mitchell").

39. *See* Snowden and Mitchell, *supra* note 38, p. 85.

40. Snowden and Mitchell, *supra* note 38, pp. 86-87.

41. An example of another factor is reported by an A.I.D. child who felt constantly haunted by a lack of information about her real father. *Id.*, pp. 88-90.

42. *Id.*, pp. 46-54.

43. *See* Bonnie Steinbock, "Surrogate Motherhood as Prenatal Adoption," in *Surrogate Motherhood: Politics and Privacy*, L. Gostin ed. (Indiana Univ. Press 1990), p. 133.

44. *Id.*

45. For excellent philosophical explorations of the concepts of "harm," "harming," and "wronging," and of the harming of future people, *see* Joel Feinberg, *Harm to Others: The Moral Limits of The Criminal Law* (Oxford Univ. Press 1984); Derek Parfit, *Reasons and Persons* (Oxford Univ. Press 1984); Matthew Hanser, "Harming Future People," *Philosophy and Public Affairs* 19 (1) (Winter 1990): 47-70; Bonnie Steinbock, "The Logical Case for Wrongful Life," *Hastings Center Report* 16 (2) (1986): 15-20. For a thoughtful analysis of the concept of harm in the context of genetics, *see* Jeffrey P. Kahn, "Genetic Harm: Bitten By The Body That Keeps You?," *Bioethics* 3 (4) (1991): 289-308; *see also* Noam J. Zohar, "Prospects For Genetic Therapy — Can A Person Benefit From Being Altered?," *Bioethics* 3 (4) (1991): 275-88.

46. 109 N.J. at 411, 537 A.2d at 1235.

47. For some of the literature relating to commercialization, *see generally* Radin, *supra* note 3; Anderson, *supra*, note 3; Thomas H. Murray, "On the Human Body as Property: The Meaning of Embodiment, Markets, and the Needs of Strangers," *University of Michigan Journal of Law Reform* 20 (4) (1987): 1055-88; Lori B. Andrews, "My Body, My Property," *Hastings Center Report* 16 (5) (Oct. 1986): 28-38; Patricia J. Williams, "On Being the Object of Property," *Signs: Journal of Women in Culture and Society* 14 (11) (1988): 5-24; Peter H. Schuck, "Some Reflections on the Baby M Case," *Georgetown*

Law Journal 76 (1988): 1793-810; Christine T. Sistare, "Reproductive Freedom and Women's Freedom: Surrogacy and Autonomy," *The Philosophical Forum* 19 (4) (1988): 227-40; Sharon Elizabeth Rush, "Touchdowns, Toddlers, and Taboos: On Paying College Athletes and Surrogate Mothers," *Arizona Law Review* 31 (1988): 549-614; Sara Ann Ketchum, "Selling Babies and Selling Bodies: Surrogate Motherhood and the Problem of Commodification," *Hypatia* 4 (3) (1989): 116-27.

48. 109 N.J. at 440, 537 A.2d at 1249.

49. Michael Walzer, professor at the Institute for Advanced Studies in Princeton, presentation to the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care and the Task Force on New Reproductive Practices, October 5, 1988.

50. Michael Walzer, *Spheres of Justice: A Defense of Pluralism and Equality* (Basic Books, Inc. 1983), pp. 100-03.

51. For an elaboration of the philosophical underpinnings of this view, *see* Radin, *supra* note 3.

52. Elizabeth M. Landes and Richard A. Posner, "The Economics of the Baby Shortage," *Journal of Legal Studies* 7 (1978): 323-48 (hereinafter "Landes and Posner"). An explication of this article was published almost ten years later by Richard A. Posner in "The Regulation of the Market in Adoptions," *Boston University Law Review* 67 (1987): 59-72.

For some reactions to the Posner-Landes proposal, *see* Ronald A. Cass, "Coping with Life, Law, and Markets: A Comment on Posner and the Law-and-Economics Debate," *Boston University Law Review* 67 (1987): 73-97; Tamar Frankel and Francis H. Miller, "The Inapplicability of Market Theory to Adoptions," *Boston University Law Review* 67 (1987): 99-103; and Jane Maslow Cohen, "Posnerism, Pluralism, Pessimism," *Boston University Law Review* 67 (1987): 105-75.

53. *See, e.g.*, Richard A. Posner, "The Ethics and Economics of Enforcing Contracts of Surrogate Motherhood," *Journal of Contemporary Health Law and Policy* 5 (1989): 21-31 (hereinafter "Posner").

54. Landes and Posner, *supra* note 52.

55. Posner, *supra* note 53, at 22.

56. Landes and Posner, *supra* note 52. Landes and Posner point out that the fact that prospective adoptive parents applying to an adoption agency for a child may wait years to obtain a child, or may never obtain one, indicates that the demand exceeds the supply; yet at the same time, the thousands of children in foster care reveals that there is in fact an "oversupply" of children. Both the glut of children in foster care and the shortage of children for adoption could be avoided, or at least minimized, if parents placing their children in foster care with little or no intention of re-establishing custody at some future date had a financial incentive to sever their parental rights at a time when the child was young enough to be adoptable.

Landes and Posner also suggest that many abortions occur because the women have little or no financial incentive to give up the child for adoption rather than choose to have an abortion, given that abortions are relatively inexpensive. Thus, he argues, allowing potential parents to compensate pregnant women for carrying to term and participating in a directed placement adoption would remedy this interference with the market and further relieve the market shortage. *Id.* at 337.

Under the current restrictively regulated regime, Landes and Posner find it entirely predictable for a black market to emerge, resulting in the middlemen being paid inflated fees and the buyers being deprived of the contractual protections that buyers in legal markets normally receive. *Id.* at 341.

57. For example, one might be favorably disposed to commercial surrogacy and yet disagree with Posner's view that the market in babies for adoption should be deregulated.

58. Ruth Macklin, "Is there Anything Wrong With Surrogate Motherhood: An Ethical Analysis," in *Surrogate Motherhood: Politics and Privacy*, L. Gostin, ed. (Indiana Univ. Press 1990), p. 146.

59. OTA Report, *supra* note 4, pp. 269-75.

60. 109 N.J. at 439, 537 A.2d at 1249.

61. David H. Smith, "Wombs for Rent, Selves for Sale?," *Journal of Contemporary Health Law and Policy* 4 (1988): 33.

62. *Id.*

63. Samuel Gorovitz, Testimony before the House Subcommittee on Investigations and Oversight, in "Buying and Selling of Human Organs," James Humber and Robert Almeder eds., *Biomedical Ethics Review* (1985), pp. 8-9.

64. *Id.*, p. 11.

65. 109 N.J. at 440, 537 A.2d at 1249.

66. *See, e.g.*, Field, *supra* note 25, p. 28.

67. Marx W. Wartofsky, "On Doing it for Money," National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *Appendix: Research Involving Prisoners* (Department of Health Education and Welfare Publication No. (OS) 76-132 1976), p. 193.

68. *See* Field, *supra* note 25, p. 28.

69. *See* Anderson, *supra* note 3.

70. *See* Andrews, *supra* note 21.

71. Anderson, *supra* note 3, at 76.

72. In noting in the *Baby M* case that although Mrs. Whitehead was psychologically evaluated by the Infertility Center, the evaluation report was never shown either to the Sterns or to Mrs. Whitehead, the New Jersey Supreme Court commented that "[i]t is apparent that the profit motive got the better of the Infertility Center." 109 N.J. at 437, 537 A.2d at 1247.

73. For an insightful discussion of the roles of medical and legal professionals in commercial surrogacy, *see* Karen H. Rothenberg, "Baby

M, the Surrogacy Contract, and the Health Care Professional: Unanswered Questions," *Law, Medicine & Health Care* 16 (1-2) (Spring 1988): 113-20.

74. Field, supra note 25, p. 21.

75. "All In The Family: How does that gutsy South Dakota grandma feel about being pregnant with her daughter's twins?," *Time* (August 19, 1991), p. 58.

76. *See* Judith C. Areen, "Baby M Reconsidered," *Georgetown Law Journal* 76 (1988): 1747.

CHAPTER SIX

WHEN DETERRENCE FAILS: RESOLUTION OF PARENTAL RIGHTS DISPUTES

The recommended legal regime prohibiting financial payments (other than for medical and related expenses) for so-called "surrogates," banning commercial brokers and intermediaries, and rendering unenforceable contractual promises by a birth mother to relinquish custody or voluntarily terminate parental rights, would do much to discourage the practice of surrogacy, particularly in its commercial form. However, the possibility remains that some will enter into surrogacy arrangements, either formally or informally, and that children will be born through surrogacy. In such cases, if the birth mother refuses to relinquish the child, and if the biological father and his wife (and, in gestational surrogacy, possibly the genetic mother as well) also seek custody of the child, the Solomonic question cannot be avoided: the competing claims, rights and responsibilities of the various parties must be addressed.* Among the most important of these rights and responsibilities are custody, visitation rights and support obligations.

A Waiting Period

When a surrogacy arrangement leads to a successful pregnancy and birth, an initial question arises concerning whether the birth mother should be entitled to a specified period of time in which to decide whether or not to relinquish custody and parental rights (a "waiting period"). The provision of a waiting period for the birth mother after childbirth serves the important function of allowing the natural mother some time to decide whether she wishes to retain, transfer, or reclaim custody of the infant. At the same time, the crafting of a waiting period must weigh the interests of all the parties -- the birth mother, the infant, and the contracting couple. The Commission and Task Force believe that a waiting period of 90 days, commencing from birth, properly balances and protects these interests.

* Although this discussion focuses on the allocation of rights and responsibilities where multiple parties claim a parental interest, the converse situation, namely, cases in which all adult participants disclaim responsibility for the child and the child is threatened with abandonment, also presents a serious issue, and is discussed below.

At the time of childbirth, many women experience a range of feelings resulting from a combination of physical and hormonal changes and emotional reactions to the birth. A woman who has previously agreed to relinquish custody of the infant may find a waiting period helpful insofar as it affords her body an opportunity to return to its pre-pregnancy state before she makes a decision regarding custody.

While the readiness of the birth mother to make an informed decision about the transfer of custody and relinquishment of parental rights is highly individualistic and will depend on a number of factors,[1] medical research indicates that in general the body of a postpartum woman who is not nursing and who is sleeping normally will return to its pre-pregnancy state in most relevant respects within approximately 4-6 weeks.[2] By that time, the postpartum woman is likely to be physically and emotionally in a position to make a firm decision regarding custody. Thus, the objective of informed decisionmaking would be furthered by a waiting period of at least this length. A longer period provides greater assurance of considered reflection.

The point at which an infant becomes so attached to his or her mother that permanent separation could produce adverse effects has not been determined with precision. A number of studies conducted in the past three decades suggest that as a general pattern, within the first three months of life there seems to be little or no effect upon infants when separated from the birth mother and placed with another parent. However, after the first three months an infant's reaction to an alteration in family becomes progressively more negative. Between the third and fourth months, the infant's reactions may range from moderate to severe; by six months, some (but not all) infants show signs of disturbance, which become heightened by nine months.[3] (The psychological impact of mother-infant attachment for both the infant and the birth mother are discussed more fully below.)

As far as the prospective parents are concerned, it is clearly in their interest to have the custody decision made as expeditiously as possible. The sooner the decision is made, the sooner they can prepare emotionally and practically for the arrival of the infant. Thus, there should be a limited period of time within which a decision must be made to allow the contracting couple to plan accordingly.

In arriving at the conclusion that a 90 day waiting period protects the interests of all the parties, the Commission and Task Force reviewed the New Jersey adoption statutes concerning the termination of a birth mother's parental rights after she has surrendered her child for adoption. The statutory scheme for private placement adoptions requires that not less than two nor more than three months elapse subsequent to the filing of a complaint by the adoptive parents before a preliminary hearing determining custody can be held. The rationale underlying this provision is that a period of two to three months is necessary in order to conduct an investigation and submit a report detailing the facts and circumstances surrounding the surrender of custody and placement, as well as an evaluation of the child and adoptive parents. At the conclusion of the preliminary hearing, if the court awards custody to the adoptive parents, the parental rights of the natural parents are terminated.[4] Although not the primary purpose of the statute, an incidental benefit flowing from the two to three month fact-finding period is that it allows the natural parents a period in which to reconsider their decision and reclaim the child -- in effect, a waiting period. Thus, to the extent New Jersey adoption law effects in practice a waiting period, it serves as a helpful analogy and lends support to the recommended waiting period for surrogacy arrangements.

A further question to be considered is the point in time from which the waiting period should be calculated: whether from the birth of the child or from the birth mother's transfer of physical custody. While the former approach fosters certainty and resolution of the custody question, the latter approach presents the possibility of manipulation by the birth mother and/or undue hardship on the contracting couple, as the birth mother could (provisionally) transfer custody at a time of her choosing while retaining the right to change her mind and assert her parental rights within the following three months. (For example, the birth mother might decide to retain custody for six months or a year or more before ultimately transferring custody to the adoptive parents.) In such a case, the determination of custody might be indefinitely extended, thereby seriously undermining the child's needs for attachment and stability, as well as the interests of the adoptive parents. Therefore, the 90 day waiting period should begin from the fixed date of the infant's birth, rather than from the (unpredictable) date that the birth mother

actually transfers physical custody.* In the event the birth mother transfers custody to the adoptive parents and then changes her mind within the 90 day period, she should be entitled to regain physical custody for the balance of the waiting period. For example, if the birth mother decides to transfer custody to the adoptive parents on day 15 following birth, and on day 50 she changes her decision, she should be entitled to physical custody for the remaining 40 days. As discussed below, under the recommended approach to custody disputes she would also be entitled to the benefit of a custody presumption favoring the birth mother, because she has made her intention known within the 90 day waiting period.

Custody

The legal approach that is ultimately adopted in resolving parental rights disputes in surrogacy should aim to achieve and reconcile several goals. These goals include assuring that the basic needs of the child are met; avoiding the kind of social and economic biases that were evident in the *Baby M* case at the trial level; reflecting the broader interests of society in discouraging surrogacy; and avoiding the introduction of incentives for covert surrogacy arrangements or surreptitious financial bargaining. There is real concern that even if surrogacy contracts are ruled illegal and unenforceable, some individuals desperate enough to acquire a child through this means will be emboldened to do so if there are grounds to believe that in the event of a dispute over custody they are likely to prevail. Given the differences in income level, education, and social class thought to exist between so-called "surrogates" and adoptive couples (and likely to be exacerbated, and perhaps further complicated by racial disparities in cases of gestational surrogacy), and the weight given to such factors in conventional custody disputes, couples may reasonably

* This conclusion differs from the statutory scheme addressing private placement adoptions. A preliminary hearing in an action for such an adoption is held not less than two nor more than three months after the natural parents surrender the child and the adoptive parents file a complaint. *N.J.S.A.* 9: 3-48 (West 1977). Although in the majority of cases these events occur at childbirth or immediately thereafter, a natural parent could decide to retain custody for an indefinite time. The rationale underlying this section of the adoption scheme differs from that of a waiting period in surrogacy cases, as its purpose is not to provide a waiting period (although this is an incidental benefit), but rather to ensure adequate time to investigate and submit a report on the circumstances surrounding the surrender of custody and relinquishment of parental rights. Clearly, a court cannot order such an investigation until a complaint for adoption has been filed, and a complaint for adoption presupposes the surrender of custody by the natural parent.

conclude that the risk of losing a custody battle is sufficiently low as to be a risk worth taking. In that event, surrogacy may flourish as a partially underground phenomenon, with the parties being able to call upon the assistance of the courts in contested cases. Thus, if society desires to avoid the re-introduction of surrogacy through the "back door", it must assure that the risk of losing a custody battle is sufficient to deter the undesired behavior. The challenge is to achieve this result without detriment to the legitimate interests of the child.

Custody Determinations in the Baby M Opinions°

The trial court in the *Baby M* case held that the surrogacy contract between Mrs. Whitehead and Mr. Stern was a valid contract. With respect to remedy, the trial court conflated its analysis of the availability of specific performance with a determination of best interests, concluding that specific performance of the contract would be granted if consistent with the child's best interests. Upon determining that it was in the best interests of the child to be placed with the Sterns, the trial court ordered specific performance of the contract.[5]

On appeal, the New Jersey Supreme Court reversed the ruling below, holding that the surrogacy contract was illegal, unenforceable, and irrelevant to the custody determination. Instead, in the view of the New Jersey Supreme Court, the operative legal framework was not an issue of contract, but that of "a dispute between two couples over the custody of a child produced by the artificial insemination of one couple's wife by the other's husband."[6] Thus, the Court applied the best interests standard. Although analyzing the facts rather differently than the trial court, on this basis the Court ultimately affirmed the lower court's finding that the Sterns should be awarded custody.

The Court also made some observations regarding the initial order granting temporary custody to the Sterns. Although acknowledging that many of Mrs. Whitehead's alleged "character failings" were demonstrated in actions that may have resulted from the crisis brought about by the initial *ex parte* order, and that this order may have been a legal error, the Court held that the initial order had "lost relevance."[7] The Court stated that the child's best interests must be determined as the

° The *Baby M* decisions are discussed at length in chapter four of the report. This section focuses upon those portions of the decisions which address the issue of custody.

circumstances existed at the present time, not as they might have existed on some hypothetical set of facts. Basing its conclusion on "strongly persuasive testimony contrasting both the family life of the Whiteheads and Sterns and the personalities and characters of the individuals",[8] the Court held that, as the circumstances then existed, Baby M's interests would be best served by awarding custody to the Sterns.[9]

The path taken by the New Jersey Supreme Court on the issue of custody in the *Baby M* case requires careful analysis. In the interests of clarity, the following section treats separately two aspects of the Court's opinion: First, the relevant standard for determining custody disputes in surrogacy, and second, the initial order granting temporary custody.

The Relevant Standard in Custody Disputes in Surrogacy

In *Baby M*, counsel for the Whiteheads argued that "even if the child's best interests would be served by our awarding custody to the Sterns, we should not do so, since that will encourage surrogacy contracts."[10] The Whiteheads' position was "in order that surrogacy contracts be deterred, custody should remain in the surrogate mother unless she is unfit, regardless of the best interests of the child."[11] The Court rejected this position, finding that declaring the surrogacy contract unenforceable and illegal operated as a sufficient deterrent. Significant is the Court's statement in this context, that "[w]e need not sacrifice the child's interests to make that point sharper."[12] The Court also found that it would be inappropriate to establish a presumption in favor of one or the other parent in a custody determination, as any such presumption "might serve as a disincentive for the meticulous fact-finding required in custody cases."[13]

In arriving at its conclusion that the best interests of the child is the determinative standard, the Court pointed to the Parentage Act and the equivalent statutory provision under New Jersey law, *N.J.S.A.* 9:2-4.[14] This section provides, in part, that in a custody dispute "...the rights of both parents, in the absence of misconduct, shall be held to be equal, and they shall be equally charged with their care, nurture, education and welfare, and the happiness and welfare of the children shall determine the custody or possession." In declaring that the rights of both parents are equal, the Parentage Act (and its historical antecedent[15]) ostensibly abolished the "tender years" doctrine. This doctrine, which persisted throughout much of the nineteenth century, created a strong presumption

of custody in the mother for children of "tender years", as it provided that in a custody dispute children under the age of seven years should be placed with the mother, absent a showing of unfitness. As one court has stated, "[t]he 'tender years presumption' is actually a blanket judicial finding of fact that, until proven otherwise by the weight of substantial evidence, mothers are always better suited to care for young children than fathers."[16]

Despite the statutory abolition of the tender years doctrine, however, it is clear that not all vestiges of the rule have been eliminated. In describing the statutory provision proclaiming equality in custody claims, the New Jersey Supreme Court in *Baby M* made the following important observation:

> This does not mean that a mother who has had custody of her child for three, four, or five months does not have a particularly strong claim arising out of the unquestionable bond that exists at that point between the child and its mother; in other words, equality does not mean that all of the considerations underlying the "tender years" doctrine have been abolished.[17]

It is clear from this passage that the Court placed considerable weight on the mother-infant tie, and would be reluctant to sever a bond that had formed over a period of time between mother and child. This point takes on potential significance in the context of the Court's statements regarding the initial, theoretically temporary, order of custody granted by the trial court in *Baby M*.

The Initial Custody Order

Although the Court concluded that the initial order in *Baby M* was not relevant to the final disposition of custody in that case (though it may have been issued without legal basis and could have affected subsequent events), the Court sent out a strong message to trial judges aimed at discouraging them from following the trial court's lead in future cases. The Court stated that "[w]hen father and mother are separated and disagree, at birth, on custody, only in an extreme, truly rare, case should the child be taken from its mother *pendente lite*..."[18] This conclusion was based on the probable degree of bonding between mother and child which was, in the Court's view, likely to be significantly

greater in most cases than the bond with the father. (The Court did not, however, cite any social science evidence in support of this conclusion.) A deviation from this principle would require "[a] substantial showing that the mother's continued custody would threaten the child's health or welfare..."[19] The Court concluded that "[a]ny application by the natural father in a surrogacy dispute for custody pending the outcome of the litigation will henceforth require proof of unfitness, of danger to the child, or the like, of so high a quality and persuasiveness as to make it unlikely that such application will succeed."[20]

Impact of the Court's Reasoning on Future Cases

The Court's directive regarding the initial order means that in future cases the trial judge will, in all but the rarest situations, grant the initial order in favor of the birth mother. This initial award to the birth mother may have a substantial impact on the final disposition of custody.

The practical effect of granting the initial order in favor of the birth mother is that in some cases (arguably most cases) the initial order will in fact prove dispositive of the final outcome. Given the emphasis placed by the New Jersey Supreme Court on continuity of care, it may be predicted that in many cases the initial order and the consequent opportunity for the birth mother to establish a strong psychological and emotional relationship with the child will largely determine the final award of custody, virtually by default. Therefore, despite the fact that the Court concluded on the particular facts before it that Baby M's best interests would be served by awarding custody to the biological father, the result of the Court's analysis is one which in many cases could amount to a presumption favoring the birth mother. The Court thus achieved a gender sensitive result, through means proclaimed to be gender neutral, by switching the key determination from the ultimate award of custody to an initial determination that in practice will almost always favor the birth mother. The rule in future cases is likely most often to grant initial custody to the birth mother, and this initial order will likely control the ultimate custodial award.

It should be noted, however, that this outcome, although perhaps very likely, is not an automatic one, and will depend on at least two variables. One important factor is the length of the litigation process. Where the process is relatively speedy, so that little time has elapsed between the temporary order and the final disposition, the importance of

maintaining continuity of care with the birth mother will carry lesser weight. A second significant factor is that in some cases there may be a perceived and very substantial disparity between the parenting capacities of the birth mother and those of the contracting couple, in favor of the contracting couple. In such cases, although continuity of care would still be a relevant consideration, it may be outweighed by other considerations indicating that the best interests of the child are better served by awarding custody to the contracting couple.

The following section examines some of the implications of employing a comparative standard such as the best interests test, and sets forth the alternative legal approach recommended for the resolution of disputed surrogacy arrangements.

Formulating Public Policy: A Comparative Standard or a Presumptive Rule?

In custody determinations following dissolution of marriage the best interests of the child is the traditional and determinative standard applied in New Jersey and elsewhere.[21] However, the best interests test presents serious problems in the context of surrogacy, suggesting the plausibility of an alternate approach.

The Best Interests Standard

The best interests standard is essentially a comparative test which seeks to determine who among a group of candidates (usually the biological parents) would best promote the interests of the child. In the context of a marital dissolution in which the children are typically beyond infancy and well-established ties may exist between one or both parents and the children, much can be said in favor of the best interests test. In such circumstances, there is at least some basis for judging the parenting capacities and attachment between the parents and children." In the context of surrogacy, however, where the child is a newborn at the time of litigation and records of parenting capabilities (particularly with this

[21] However, even in this context, the best interests test has been subject to some criticism. For a thoughtful analysis and review of the literature on this subject, *see* Robert H. Mnookin, "Child Custody Adjudication: Judicial Functions in the Face of Indeterminacy," *Law and Contemporary Problems* 39 (1975): 226-69.

child) are absent, the use of the best interests test presents a number of serious problems.

First, being a comparative standard, the best interests test invites lengthy and often bitter litigation, often involving negative, destructive attacks on parental capacity, thereby creating a record of rancor which could have an enduring negative effect on the child and leaving the child's permanent status unsettled for a potentially lengthy period. This destructive result, while not limited to the surrogacy context, may be especially likely in such cases. Second, the best interests standard invites an inquiry as to the relative social and economic status of the parties, presenting a risk that some judges (as well as some expert witnesses) may associate a constellation of features, including wealth, education and social class, with better parenting capabilities, and may therefore equate "favorable" patterns with the best interests of the child.[22] Such judgments may say more about social biases and stereotypes than about the welfare of children. While present in traditional custody disputes, this risk is further heightened in surrogacy, where the litigation arises between biological parents from predictably disparate backgrounds. Unlike the situation in custody cases following dissolution of a marriage or long-term relationship, where there will generally be an established relationship between the child and her or his parents and a "track record" for assessing relative parenting capacities, in surrogacy the judge has virtually no such information. This increases the likelihood of speculation and with it the possibility of inappropriate class and economic bias.

Moreover, comparison of class and economic status is likely to favor the wealthier party (most often the contracting couple) who has greater resources to spend on attorneys, psychological experts, and other means to wage a successful court battle (as well as, in some cases, greater sophistication and contacts among fellow professionals).* As the

* The wealthier party may be in a position to negotiate a settlement whereby the child support payments are set at an extremely low level – a result that clearly is not to the child's benefit. As observed in *Garska v. McCoy*, 278 S.E. 2d 357, 360 (1981), a West Virginia case dealing with custody upon dissolution of marriage, "[o]ur experience instructs us that uncertainty about the outcome of custody disputes leads to the irresistible temptation to trade the custody of the child in return for lower alimony and child support payments."

Baby M case illustrated," the wealthier party may be at a considerable advantage in working with experts prior to and during the litigation.[23]

A further problem with employing the best interests standard in surrogacy, related to the problem of bias, is that a court may be inclined to assess negatively the actions of the so-called "surrogate" in participating in a surrogacy arrangement, or her efforts to retain custody of the child."" The very fact that a woman agreed to be a so-called "surrogate" may cast her in an unfavorable light in the minds of some, even though she later changes her mind. The fact that she later changes her mind may in itself provide further ammunition for criticism, since inconsistency and lack of commitment may now be added to her list of "faults." The *Baby M* decision at the trial level bears eloquent testimony to these possibilities.

Finally, there is an unsatisfying circularity about the best interests standard, as it might be applied in the surrogacy context. In surrogacy, following the child's birth, there will typically be a need for an initial order of custody pending litigation (*pendente lite*). No full examination of the factors involved in a best interests determination will be possible at this early stage in the process, virtually by definition. Nonetheless, a decision about temporary custody must be made, and, as noted above, a major factor in the ultimate custody determination may be the emotional and psychological bond established between the child and the parent who has been granted temporary custody during the period of litigation. This means that enormous weight will have been placed on the initial order, which was granted on the basis of less than a full hearing of the full scope of relevant evidence. Such a result may well undermine the purported integrity of the best interests standard.

If, for all of these reasons, the contracting couple perceives that in the event of a custody dispute, their chances of succeeding in the

" For example, the experts criticized Mrs. Whitehead for failing to avail herself of professional mental health counselling; yet such criticism ignores the fact that less affluent people have less access to professional help, and may not place the same value on such "assistance" (or, as Mrs. Whitehead saw it, intrusion).

"" To counter this possibility, New York's recently enacted law, S.1906, 214th Leg., 1991-92 Sess., section 124(1), provides that "the court shall not consider the birth mother's participation in a surrogate parenting contract as adverse to her parental rights, status or obligations."

ensuing litigation are very high, as they might be under a conventional best interests test, then much of the deterrent effect of the underlying law and policy seeking to discourage the practice of surrogacy would be undermined."

In addition, there are some important concerns of a more general nature. The reliability (or lack thereof) of psychological expert testimony regarding the child's best interests has been the subject of vigorous debate in the literature. (*See, e.g.*, the discussion of psychological issues in disputed custody arrangements, below.) The questions raised in this controversy may be especially pointed in the surrogacy context -- as illustrated in the finding in the *Baby M* case that Mrs. Whitehead was a good mother to her other two children, but might not be a good mother to Baby M. The difficulty of making accurate predictions is further compounded by society's lack of consensus as to what values should inform the determination. As one commentator writes:

> Deciding what is best for a child poses a question no less ultimate than the purposes and values of life itself. Should the judge be primarily concerned with the child's happiness? Or with the child's spiritual and religious training? Should the judge be concerned with the economic "productivity" of the child when he grows up? Are the primary values of life in warm, interpersonal relationships, or in discipline and self-sacrifice? Is stability and security for a child more desirable than intellectual stimulation? These questions could be elaborated endlessly. And yet, where is the judge to look for the set of values that should inform the choice of what is best for the child? ...[I]f the judge looks to society at large, he finds neither a clear consensus as to the best child rearing strategies nor an appropriate hierarchy of ultimate values.[24]

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[24] In fact, one might wonder whether a contracting couple might even seek to maximize their chances in a potential custody battle by selecting as their so-called "surrogate" a woman with characteristics that would be looked upon less favorably by a court. Such a choice might pose some risk to the well-being of the child during the gestational period; the potential parents would have to weigh this risk against the positive incremental impact on their prospects for gaining custody.

The problem described in the above passage was amply illustrated in the *Baby M* decisions. At the trial level, Judge Sorkow clearly placed a premium on wealth and opportunity for educational advancement.* The New Jersey Supreme Court responded to the trial court's emphasis with some concern, stating that "...it should not be overlooked that a best-interests test is designed to create not a new member of the intelligentsia but rather a well-integrated person who might reasonably be expected to be happy with life", and that "[s]tability, love, family happiness, tolerance, and, ultimately, support of independence -- all rank much higher in predicting future happiness than the likelihood of a college education."[25]

Thus, the general problem of value bias in applying a best interests standard, and the specific problems that such a test presents in the surrogacy context -- namely, its potential for inviting lengthy, bitter litigation, for highlighting in a particularly blatant way class and economic biases, and its capacity for undermining the deterrent objective of a legal structure designed to discourage surrogacy arrangements -- suggest strongly that an alternative approach is called for in disputed surrogacy arrangements.

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* *See* Judge Sorkow's statements, for example, contrasting the attitudes of the Whiteheads and the Sterns regarding Baby M's future education. Of the Whiteheads, he stated:

> Mrs. Whitehead said that if she was given custody the infant would be taught kindness and understanding. She would be supportive of the child's educational wishes. The court questions the measure of this mother's emphasis about the importance of education in light of her actions and attitude with her son's school and her own limited high school experience.

Of the Sterns, he stated:

> [The Sterns] plan to enroll "Baby M" in a nursery school at about age three not for learning purposes, but for socialization. As she grows up, opportunity for music lessons and athletics will be made available. With the strong emphasis on education already exhibited by the Sterns, it is understood and expected when they say that "Baby M" would attend college.

In the Matter of Baby M, 217 N.J. Super. 313, 354-55, 525 A.2d 1128, 1147-48 (1987), *aff'd in part, rev'd in part*, 109 N.J. 396, 537 A.2d 1227 (1988). For an analysis of the class and economic biases contained in the trial court's opinion, *see also* George J. Annas, "Baby M: Babies (and Justice) for Sale," *Hastings Center Report* 17(3) (June 1987): 13-15.

A Presumption Favoring the Birth Mother

In formulating an alternative approach, the Commission and Task Force concluded that a presumption favoring a grant of custody to one parent is preferable to a comparative standard, assuming that the parent is able and willing to provide for the needs and welfare of the child.

In reaching this conclusion, a number of important objectives were considered. First, the basic interests of the child should be assured. The parent being considered for presumptive custody should meet basic social standards for raising a healthy, secure child. He or she would therefore have to meet at least the "fitness" criteria traditionally employed in termination of parental rights cases (discussed below), and possibly a more demanding criterion. Second, the rule should be one that does not invite litigation, particularly when that litigation is likely to be prolonged, expensive, and bitter, with attendant destructive attacks on parenting capacities and the likelihood of class and economic bias. A rule that is clear, predictable, and which can be uniformly applied, thus enabling people to plan their actions with some degree of certainty of the probable outcome, is most likely to meet this objective. Finally, the rule should be consistent with a social policy of discouraging surrogacy and should minimize the potential for surreptitious evasion of such a policy.

While a presumption could in theory favor either biological parent, a presumption favoring the birth mother would further a number of important public policy objectives. First, a birth mother presumption recognizes that the experience of pregnancy constitutes a substantial physiological (and potentially psycho-social) involvement of the birth mother with the child. In this respect it is consistent with a broadly shared view of the birth mother as the "natural" mother and the parent closest to the child at the time of birth. Second, a birth mother presumption significantly lessens the potential for highly visible and destructive class and economic bias that is present in a litigation process, and substantially redresses the imbalance in bargaining power that is generally present between the so-called "surrogate" and the natural father. Third, a birth mother preference rule encourages parties to resolve their disputes without resorting to litigation, a result that benefits society, the custodial parent(s), and the child. Finally, such a rule furthers a major purpose of the Commission and Task Force recommendations -- to discourage the practice of surrogacy. It is

unlikely that many couples will enter a surrogacy arrangement if they are aware not only that any promise by the so-called "surrogate" to relinquish custody or to voluntarily terminate parental rights is legally unenforceable, but also that in the event the so-called "surrogate" changes her mind and seeks custody of the child, she is highly likely to be awarded custody."

Conflicts Between Three or More "Reproductive Collaborators"

It should be noted that the presumption favoring the birth mother would apply not only to conflicts between a birth mother and a biological father, but also to conflicts between three or more parties in cases of gestational surrogacy. In gestational surrogacy, a number of possible scenarios may arise: The two genetic parents may be a couple who are seeking to raise the child together, or the two genetic parents may be unrelated to one another and may originally have had no intention of rearing the child. In cases of a custody dispute between a gestational mother and one or more individuals who have contributed genetic material, the gestational mother's claim should have presumptive priority. This policy reflects the view that the contribution of the gestational mother over a nine month period is substantially greater in degree, and more significant in kind, than an individual who contributes an egg or deposits sperm.** This position would apply even where the genetic

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* It is interesting to compare the approach of the New York State Task Force on Life and the Law on this issue. The New York State Task Force proposes that "in custody disputes arising out of surrogate parenting arrangements the birth mother should be awarded custody unless the court finds, based on clear and convincing evidence, that the child's best interests would be served by an award of custody to the father and/or genetic mother." New York State Task Force on Life and the Law, *Surrogate Parenting: Analysis and Recommendations for Public Policy* (May 1988), p. 136. The New York approach thus employs a comparative standard, but one which favors the birth mother by means of increasing the burden of proof to a "clear and convincing evidence" standard. This report declines to adopt this approach, chiefly on the view that a comparative test, even with a clear and convincing evidence standard, would not be a sufficient deterrent to an economically and socially advantaged contracting couple, who might feel justifiably confident that in the event of litigation, their chances of prevailing over the so-called "surrogate" would be quite high.

** As one commentator has noted in contrasting the experience of pregnancy with that of sperm or egg donation:

> While a gamete donor may "find genetic transfer a vital source of feelings connecting him or her with nature or future generations", the gestator/childbearer is the parent whose entire being is dynamically and dramatically revamped by the procreative process. The gestator must cope with intra-psychic reorganization in accepting the fetus into her womb, with

mother and the biological father intend to raise the child together. In other words, the felt importance of the gestational contribution is such that it will be given priority even over the combined claim of two individuals who have made (only) genetic contributions.

Overcoming the Custodial Presumption

The presumption in favor of the birth mother would operate as an initial presumption, which may be overcome under certain circumstances. An appropriate standard should achieve the important objectives of measuring the capacity of the birth mother to meet the child's basic needs and ensuring that the child's interests are adequately protected, and avoiding the introduction of "expert" testimony that might indulge biases and prejudices concerning the respective socioeconomic positions of the parties. The standard arrived at attempts to meet these objectives by requiring a demonstration "based on clear and convincing evidence, that the individual giving birth fails to meet minimal parenting standards necessary to satisfy the basic needs and welfare of the child", and by explicitly stating that "such determinations shall not be based on considerations of economics or social class."

This approach declines to adopt the traditional "unfitness" standard, applied most frequently in New Jersey case law in the context

integrating herself with its presence, and ultimately with adjusting to its physical severance from her body.

S. O'Brien, "The Itinerant Embryo and the Neo-Nativity Scene: Bifurcating Biological Maternity," *Utah Law Review* 1 (1987): 25 (citing John A. Robertson, "Procreative Liberty and the Control of Conception, Pregnancy and Childbirth," *Virginia Law Review* 69 (1983): 409).

This approach differs from the conclusion reached recently by the California Court of Appeal in the gestational surrogacy case of *Anna J. v. Mark V.*, 234 Cal. App. 3d 1557, 286 Cal. Rptr. 369 (Ct. App. 1991), *review granted*, 4 Cal. Rptr. 2d 170, 822 P.2d 1317 (Sup. Ct. 1992). Relying on its interpretation of the California Uniform Parentage Act (enacted in 1975), the Court found that blood tests presumptively reveal the identity of the natural and legal mother. Since blood tests demonstrated a connection between the child and the donor of the egg and since the gestational mother stipulated that the donor of the egg was the genetic mother, the donor of the egg was presumptively ascertained to be the natural and legal mother of the child. *Id.* at 1569, 286 Cal. Rptr. at 376. The entire discussion of the Court took place in the context of traditional determinations of paternity and maternity and did not address relevant differences in cases of gestational surrogacy. Further, the Court did not address the problem as an issue of custody. An appeal to the California Supreme Court is currently pending.

of involuntary termination of parental rights." It is clear, both from the formulations offered by the courts as standards justifying termination and from a review of the facts of termination cases, that the behavior required to be exhibited by the parent toward the child must be extremely destructive before the courts will sever the parent-child relationship. In the *Baby M* case, the New Jersey Supreme Court stated that there must be "...a most substantial showing of harm to the child if the parental relationship were to continue, far exceeding anything that a "best interests" test connotes."[26] A formulation frequently cited is that there must be evidence of "very substantial neglect of both parental duties and claims, with no reasonable expectation of any reversal of that conduct in the near future."[27]

Several considerations explain, and perhaps justify, the very high standard of "unfitness" insisted upon by the courts in termination proceedings. Termination cases highlight the profound tension that exists between two very fundamental values -- on the one hand, the autonomy and privacy of the family, which requires as minimal as possible

The statutory basis for the involuntary termination of parental rights is found at *N.J.S.A.* 30:4C-15. This section provides:

> Whenever (a) it appears that a court wherein a complaint has been proffered as provided in chapter 6 of Title 9 of the Revised Statutes, has entered a conviction against the parent or parents, guardian, or person having custody and control of any child because of abuse, abandonment, neglect of or cruelty to such child; or (b) it appears that any child has been adjudged delinquent by a court of proper jurisdiction in this State; or (c) it appears that the best interests of any child under the care and custody of the Division of Youth and Family Services require that he be placed under guardianship; or (d) it appears that a parent or guardian of a child, following the acceptance of such child by the Division of Youth and Family Services pursuant to sections 11 or 12 of this act, or following the placement or commitment of such child in the care of an authorized agency, whether in an institution or in a foster home, and notwithstanding the diligent efforts of such agency to encourage and strengthen the parental relationship, has failed substantially and continuously or repeatedly for a period of more than 1 year to maintain contact with and plan for the future of the child, although physically and financially able to do so; a petition, setting forth the facts in the case, may be filed with the juvenile and domestic relations court of the county where such child may be at the time of the filing of such petition. A petition as provided in this section may be filed by any person or any association or agency, interested in such child, or by the Division of Youth and Family Services in the circumstances set forth in items (c) and (d) hereof.

intrusion by the State; and, on the other hand, the desire and need to protect the child's interests when intervention becomes necessary."

A fundamental privacy interest is involved in termination proceedings. As the United States Supreme Court stated in *Stanley v. Illinois*, "[t]he Court has frequently emphasized the importance of the family. The rights to conceive and to raise one's children have been deemed 'essential',...'basic civil rights of man,' and rights far more precious...than property rights'..."[28] A related factor is the desire to respect the family as a functioning, integral unit wherever possible.[29] Further, termination is an extreme remedy which results in the severance of all legal bonds between parent and child. When parental rights are terminated a variety of important rights and responsibilities aside from custody are also lost, including for example, visitation rights, support obligations, and inheritance rights. Also of note, state-initiated termination proceedings involve the individual being pitted against the state, with the two parties having vastly different resources at their disposal.[**] And finally, a child may suffer detriment when he or she becomes a ward of the state following a termination order and multiple placements occur before a permanent placement is found.[30] In view of all these factors, and the drastic and irrevocable nature of a termination of

* As the New Jersey Supreme Court noted in *N.J. Division of Youth and Family Services v. A.W.* 103 N.J. 591, 599, 512 A.2d 438, 442 (1986):

> Termination of parental rights presents the legal system with an almost insoluble dilemma. On the one hand, we emphasize the inviolability of the family unit, noting that "[t]he rights to conceive and to raise one's children have been deemed 'essential'...'basic civil rights of man'...(citation omitted). The interests of parents in this relationship have thus been deemed fundamental and are constitutionally protected. On the other hand, it has been recognized "that a state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized." (Citations omitted.) These two concepts run so deeply in our culture that we find their reconciliation to be very difficult.

** The inequality between the parties in such a proceeding, and the consequent need for procedural safeguards, was emphasized by the U.S. Supreme Court in *Santosky v. Kramer*, 455 U.S. 745 (1982), a case involving a constitutional challenge to a New York termination of parental rights law. In holding that due process required that the State support its allegations by at least "clear and convincing evidence", rather than the lesser standard of "preponderance of the evidence", the Supreme Court observed that "[t]he State's ability to assemble its case almost inevitably dwarfs the parents' ability to mount a defense. No predetermined limits restrict the sums an agency may spend in prosecuting a given termination proceeding." *Id.* at 763.

parental rights order, it is not surprising that the standard required to establish "unfitness" in this context has been set at a very high level, with the rights of the parents being weighted heavily against the interests of the child,* nor that this remedy has been invoked with great caution by courts and only in the most extreme circumstances.

While "unfitness" may be an acceptable standard in termination cases, it is not an acceptable standard in determining custody in surrogacy cases. At least two critical differences exist between the termination context and the surrogacy context which justify the use of a different standard in disputed surrogacy arrangements -- a standard more protective of the child's interests. First, the nature of the custody award in the surrogacy case carries with it none of the drastic and final implications involved in a termination of parental rights order. A strong argument can be made that the non-custodial parent in a surrogacy case should ordinarily continue to be the child's parent in the eyes of the law, and should thus still enjoy a variety of parental rights and responsibilities. Second, whereas a termination of parental rights order generally results in the child becoming a ward of the state until such time as a permanent placement can be found, in a surrogacy custody dispute the child will be cared for by its other biological parent (assuming the parent is able and willing to undertake parental responsibilities).

Therefore, the unfitness standard is inappropriate in the surrogacy context as a standard for overcoming the presumption in favor of the birth mother. The alternative recommended standard recognizes the claim of the birth mother while at the same time seeking to protect the child's interests and to avoid undesirable comparative judgments which may be unduly influenced by social and economic bias.

In sum, the Commmission and Task Force recommend that the issue of custody in surrogacy cases be governed by the following:

> **In the event the birth mother makes known, within 90 days from the date of birth, her intention to retain**

* *See Alsager v. District Court*, 406 F.Supp. 10, 22 (S.D.Iowa 1975), *aff'd*, 545 F.2d 1137 (8th Cir. 1976), where a federal district court stated: "The state's interest in protecting the child is not absolute, however. It must be balanced against the parents' countervailing interest in being able to raise their children in an environment free from governmental interference."

custody of the child, any dispute over custody and parental rights should be governed by the following:

A legal presumption should be established, favoring custody by the birth mother, consistent with assuring satisfaction of the needs and welfare of the child. This presumption may be overcome by a demonstration, based on clear and convincing evidence, that the individual giving birth fails to meet minimal parenting standards necessary to satisfy the basic needs and welfare of the child. Such determinations should not be based on considerations of economics or social class.

Psychological Issues in Disputed Custody Arrangements

Psychological Evidence in Policy and Law

As noted above, the Commission and Task Force deliberations considered psychological, social, ethical, and legal implications of several alternatives for the handling of disputed surrogacy arrangements. Although it was considered important to create a scheme consistent with the goal of deterring such arrangements, deterrence was not the sole basis for reaching these conclusions. Considerable attention was paid to possible psychological and social ramifications of the various alternatives as they affected the birth mother, the biological father, and the child. This section briefly discusses these psychosocial issues and their role in the conclusions and recommendations presented in this report.

Before examining the psychological data, a few caveats are in order. First, as noted by much current literature discussing the place of social science in moral and policy analysis,[31] the social sciences are not value free or value neutral. Assessments of potential harms or benefits to mothers, fathers, and children of a possible custody arrangement contain implicit (and sometimes explicit) values. Such characteristics as interest in higher education, willingness to consult professional experts, or eagerness to offer a child many opportunities for exploring the world (all of which proved of some consequence in the *Baby M* case),[32] actually may be values masquerading as traits deemed essential for mental health or good adjustment. Second, psychology and psychoanalysis have limitations as predictors of human behavior.[33] Clinical evaluations of

individuals may provide some useful hypotheses about a person's current and future capacities to handle the vicissitudes of life and interpersonal relationships, but data gathered on one topic from a particular sample may be inadequate or inappropriate when applied to a specific fact situation or when generalized to a topic other than that for which they were collected.[34] Nonetheless, development of an approach to custody disputes should be informed by the relevant available empirical evidence bearing on the psychological effects of surrogacy arrangements on the parties involved.

Because the parties to surrogacy arrangements may not be evenly matched in a dispute, it is essential that great care be taken to protect those most vulnerable in the surrogacy situation: namely, the birth mother and the child. As an unconsenting party to the arrangement, whose creation is the purpose of the arrangement, the child surely needs protection if the adults involved in his or her creation cannot agree among themselves about what should happen after birth. The birth mother, as the person who has made a commitment to do something she may now deeply regret, and as one who may have entered into the arrangement with fewer resources of wealth, education, or professional expertise than the child's biological father, may find herself in a contest for which she is ill-equipped. Framing a fair and compassionate policy requires ensuring that the practice of surrogacy will not cause psychological and social harm to those who could be most victimized by it. A review of diverse information on child custody determinations, responses of birth mothers who relinquish children to adoption, literature on parent-infant bonding and infant-caregiver attachment, and reactions of so-called "surrogates" who participate in surrogacy programs, suggests that the weight of the psychosocial evidence does not firmly support any one approach to protecting the well-being of the child, the birth mother, or the intended rearing parents. This conclusion, therefore, lends further support to the recommended presumption favoring custody in the birth mother.

Effects on the Child

Four sources of evidence were examined for their possible guidance in the resolution of custody disputes in a way that would best promote the growth, development, and stability of the child: the literature on the effects upon children who experienced immediate post-birth contact with birth mothers (referred to as "maternal-infant bonding"); on infant-caregiver attachment; on children of adoption; and on the effects

of joint, as opposed to single-parent, custody upon the children of divorce.

Psychologists concerned with promoting the welfare of infants and children have studied the moments of contact between mother and child immediately after birth to learn about the impact of such contact on both the child and its birth mother. These moments of skin-to-skin contact of mother and child are called "bonding" and have been thought to influence both maternal behavior and, as a result, child welfare and development.[35] The influence of this contact was thought to be positive not merely immediately after birth but also months and years later. Because the phenomenon of "bonding" has been considered relevant for both the infant and the birth mother, it is discussed here as it concerns the infant, and next, as it concerns the birth mother.

Hypotheses about "bonding" were first discussed in the early 1970's by researchers who claimed that it was beneficial for maternal behavior toward the infant and consequently for infant development. "Bonding" is described as a rapidly occurring process taking place shortly after birth, in which the birth mother forms an affectionate connection to the infant. This emotional connection is usually facilitated by early contact between mother and newborn that includes skin-to-skin touching, mutual looking, and breastfeeding.[36] Claims about the benefits of "bonding" for infants and mothers were based on findings about differences between mother-infant pairs who had this post-birth interaction and pairs who did not. Mothers who had the immediate post-birth contact with their infants were more involved with and affectionate toward them two and five years later than mothers who did not have such experiences. The researchers reported that infants of these mothers, at ages two and five, were more mature developmentally than infants born to similar mothers who did not have this immediate post-birth interaction. All the salutary consequences for the children who had had the early physical contact with their mothers were attributed to their mothers' increased emotional responsiveness, and the heightened responsiveness was, in turn, attributed to the moments of contact after birth.[37]

Claims about the value of bonding have become tenets of both professional and popular childbirth and parenting literature. Several discussions of the topic of surrogacy have cited the importance to

children of the "bonding" experience as reason to argue for permitting the birth mother to retain custody of the child. These discussions have suggested that because bonding is purported to be beneficial to children who experience it, children may be harmed if they are raised by parents with whom they do not have this early interaction.[38]

However, those who have suggested that the maternal-infant bond is sufficiently powerful and special for the child as to justify maternal custody in a disputed surrogacy arrangement have sometimes relied on the concept of "bonding", or used the terms "bonding" and "attachment" interchangeably. Yet, whereas "bonding" refers to the mother's response to the infant, "attachment" refers to the slowly developing emotional connection between the infant and a caretaker who is sensitive to the child's needs. An infant's attachment is in no way automatic, nor is it dependent upon early skin-to-skin contact and other interactions with the mother described as the "bonding" experience; rather, it grows slowly as a response to the activities and empathy of the caring person toward the infant.[39] Infants and young children need to be securely attached to at least one person who will respond reliably to their needs -- needs not merely for physical care but for comfort, affection, and stimulation as well.

Psychoanalytic literature on infancy prior to the 1970's (and the custody law in response to it) presumed that in nearly all circumstances maternal care was preferable to care by a father for infants and very young children.[40] Literature that inclined courts to award custody of young children to their mothers in instances of divorce or contests between unwed parents was buttressed in the 1970's by the pioneering work of Goldstein, Freud, and Solnit, who strove to define the phrase "the best interest of the child."[41] These authors contended that the child's need for stability and certainty was such that only one of two contending parents should be awarded custody; moreover, they argued that such awards should be based upon the needs of the child and not those of the disputing adults. "Continuity of relationship, surroundings, and environmental influence are essential for a child's normal development. Since they do not play the same role in later life, their importance is often underrated by the adult world."[42] Since mothers were thought to be better than fathers at caring for children (especially when the children were young), and since a child's need for stability and security was believed to be synonymous with direction from and loyalty to only one

parent if the parents were living separately and not presenting themselves to the child as a unit, orders of custody were likely to be those of sole custody to the child's mother.

The trend toward granting custody to the mother was challenged by the increased interest of men in childrearing and in taking on joint or primary custody of their children after divorce. This social phenomenon of the mid-1970's and 1980's, the increasing willingness of courts to grant fathers primary or joint custody (sometimes even when opposed by mothers), and the empirical studies of the effects of such custody arrangements upon the children and their families all cast some doubt on the need for the sole custody prescription.[43] Although several empirical studies on joint custody [44] suggest that the arrangement works best when both parents agree to it, they conclude that the children can benefit from it even when parents are not initially predisposed toward shared child care. The findings regarding the impact of joint custody on children and families of divorce may be of limited value when applied to the situation of a child born of a surrogacy arrangement. The parents battling over the custody of a child born of surrogacy have no history of a relationship with the child, nor may they have any history of relationship or cooperation with one another, save for the surrogacy arrangement itself. Their life goals, values, and hopes for any children may differ markedly from one another, perhaps much more than the differences that could arise when a marriage dissolves.

Thus, while it appears well-documented that infants may display clear preferences for a particular person by the age of three months, and they may be affected adversely by a change in primary caregivers any time between three and six months of age,[45] what is important is the stability and responsiveness of the caregiver and not the person's gender.[46] Such data suggest that custody disputes should be settled quickly,[47] so that the infant may have an early and stable experience with the person or people with whom he or she will live; but these data do not indicate that the infant inevitably needs to be cared for by a woman, whether that woman be the biological mother or the wife of the biological father (the adoptive mother). In short, as men increasingly became involved in caring for their infants and young children, studies ceased focusing exclusively on the "mother" and instead referred to "the mothering figure" or "the primary caregiver." The concept that infants needed to feel secure with at least one caregiver remained central to

thinking about child development. What changed was the conviction that such attachment inevitably had to be to the infant's mother, as opposed to the father.[48]

The belief that an infant's birth mother will be the best caretaker, as compared to the father or adoptive mother, also found support in some psychological work that focused on how the experience of pregnancy "prepared" the woman physiologically and psychologically for her new role as mother.[49] However, to the extent that pregnancy assists a woman in becoming attuned to her newborn, such attunement is not found to result in differences between infants' attachment to biological, as compared with adoptive, mothers by the time infants were thirteen to eighteen months of age.[50] When biological mother-infant pairs were compared with adoptive mother-infant pairs, no significant differences in the infant's level and security of attachment were shown. Such findings suggest that the infant develops an attachment based upon the relationship with the caretaker after birth. These data do not lead to a presumption that the woman who gives birth to the child is by nature better at eliciting or stimulating feelings of connection and security from her infant than is one who takes on a commitment to care for the infant early in its life. Again, data suggest that custody disputes should be settled quickly to provide the infant with the best opportunity to form a good relationship with a reliable caretaker, but they do not favor biological connectedness as a basis for a custody determination.

Effects on the Birth Mother

Literature on maternal-infant bonding, on the effects on birth mothers who relinquish children to adoption, and on womens' responses to being so-called "surrogates" were examined to learn about the consequences for birth mothers of surrender of a child in surrogacy. Although the literature on the phenomenon of "bonding" and the studies of women who relinquish children to adoption have been cited as supporting the awarding of the child of surrogacy to the birth mother in case of dispute,[51] their use for this purpose is open to question.

Proponents of a custody determination in favor of the birth mother maintain that as a result of the experience of carrying and bearing the child, the birth mother's physical involvement with and psychological connection to the child, and thus her moral claim to custody of the child, should be considered greater than anyone else's, including the biological

father. Such a view recognizes the profound dependence of the developing fetus upon its mother during pregnancy, as well as the myriad of ways that the pregnant woman handles her life and cares for herself to promote the growth and well-being of the fetus.

The significance attached by psychologists and by the public to the experience of pregnancy as a preparation for empathic and loving childrearing has not itself undergone question or empirical scrutiny. However, since the attention to "bonding" began in the early 1970's, pediatric and popular literature have suggested that "bonding" is beneficial to the people who will care for the infant by making them more interested in and responsive to the infant than caregivers who do not have this experience. Mothers who had such immediate and extended contact with their infants after birth were reported as uniformly appreciative and delighted with the opportunity to spend this time with their newborns.[52] Birth mothers who had this early skin-to-skin contact with their infants were found to be more emotionally responsive to them than mothers similar in age, education, living conditions, and socioeconomic status who had not had such early post-birth contact. The difference in the responses of mothers with and without this experience was found to exist when the children were two years and five years of age.[53] As discussed above, however, the concept of bonding has been severely criticized as being imprecise in meaning. Studies of its value for infants or mothers have been questioned on methodological grounds, and several alternate interpretations of its purported benefits have been offered.[54] Even if mothers who have early post-birth contact with their infants enjoy this experience, it has not been shown to reap the long-term benefits for them or their children that were originally claimed. It is possible, however, that so-called "surrogates" who spend time with the infants after birth may have more difficulty in relinquishing them than those without such post-birth contact.

A second source of data linking surrender of the child in surrogacy to harmful consequences for the birth mother is that of women who relinquish their children to adoption. Because some studies of relinquishment link the surrender experience to ongoing psychological difficulties and unsatisfactory life adjustment for birth mothers in traditional adoption,[55] it has been suggested that relinquishment in surrogacy will lead to similar results for the so-called "surrogate."[56] Review of the relinquishment literature attests to the fact that for many

women who surrendered children to adoption in the past three decades, the surrender has not been the unmixed blessing for them that a number of professionals in adoption believed it could be. Many women report continuing sadness about the surrender experience. They have been found to be anxious about the child's welfare and to be angry with parents or child welfare professionals who insisted that their child would be better off once adopted. Although the studies describe the women's feelings of loss, grief, anguish, and sadness lasting months or years after the adoption, they do not differentiate between the emotions resulting from loss of a child and those resulting from the loss of control over their own lives that the pregnancy and surrender experiences may represent.

Unwavering acceptance of the relinquishment literature as analogous to surrogacy must be questioned because of two features of the experience that differentiate traditional adoption from surrogacy as it is currently practiced in at least some centers (*see* chapter 3): Namely, the lack of knowledge of the adopted child's whereabouts and welfare as compared to the potential for contact and knowledge in surrogacy arrangements; and second, the fact that an unplanned pregnancy gives rise to traditional adoption while surrogacy involves extensive planning. To an unknown but considerable extent, much of the sadness, grief, and anxiety of birth mothers in traditional adoption can be attributed to concerns about the child's well-being and to lack of knowledge of the child's safety, happiness, or even whereabouts. Studies of reunions between birth mothers and their adopted children reveal that knowledge and contact healed many of the wounds of the surrender experience.[57] The birth mothers, assured of their children's contentment and well-being, found that many of their long-standing symptoms of distress were considerably alleviated. Current practice in at least some surrogacy centers may avoid many of these problems posed in traditional adoption. First, children are assured information about the birth mother if they want it. Second, the birth mother has information about and often contact with the rearing parents for at least the early years of the child's life, and in some cases beyond. Thus, children and birth mothers need not wait many years for the emotional reunion that has typified the searches of birth parents and adoptees. These features of surrogacy are analogous to the reforms urged in adoption over the past fifteen years[58] and differ markedly from the traditional adoption stories that gave rise to the existing relinquishment literature.

Thus, the findings about women who relinquished children to adoption are not necessarily indicative of the responses of so-called "surrogates", although they may resemble the reactions of those women who regret the arrangements and seek to retain custody after childbirth. Further, in traditional adoption, the birth mother is typically unmarried, does not have other children, and does not have the financial and social resources to support a child. In general, the pregnancy is unplanned and undesired, and the adoption is seen as the best of several unfortunate alternatives. For the woman who believes that she enters into a surrogacy arrangement voluntarily and who feels that there is no undue inducement because of financial difficulties or strong emotional needs in her life, the adoption analogy may be entirely inapt. On the other hand, the experience of a woman who engages in commercial surrogacy for the purposes of creating emotional ties and obtaining financial security may be more akin to the unmarried mother of the traditional adoption, and her surrender of the child may be accompanied by the regret and the sense of lack of control captured in the accounts of the adoption experience.

Finally, some data on the after-effects of surrogacy on the birth mother comes from the women themselves, including published accounts of several women's experiences,[59] reports in the press,[60] testimony before legislatures,[61] briefs submitted in the *Baby M* case,[62] staff interviews with so-called "surrogates",[63] and one study undertaken by two researchers unconnected with any surrogacy program.[64] The weight of this evidence supports the conclusion that the experience of participation in surrogacy can be stressful for the birth mother under a range of circumstances: poor relationships with the intended rearing parents; feelings of betrayal or deception in terms of the arrangements; loss of the relationship with the people who intend to raise the child, especially the relationship with the woman who will rear the child (the infertile wife of the biological father); lack of social support from the close family and friends of the so-called "surrogate"; and the stigma surrounding the decision to become a so-called "surrogate." Thus, these data point to reasons to protect against the pitfalls that can accompany surrogacy arrangements. However, they do not suggest that relinquishing the child is the sole or primary cause of the grief reactions of women who are so-called "surrogates."

Support Obligations

The Commission and Task Force are of the view that the non-custodial parent in a surrogacy arrangement should be obligated to pay child support. It is well-established as a general matter that those who are responsible for bringing a child into the world should also bear responsibility for its welfare, even if they do not have custody of the child. Under traditional family law principles an unwed father is liable for the support of his child, and there seems little reason to distinguish surrogacy cases in this regard.* Further, the possibility of a legal obligation of support serves as an additional deterrent measure in a legal regime designed to discourage the practice of surrogacy. It is therefore recommended that:

> **The non-custodial parent in a surrogacy arrangement should have an obligation of child support. Contractual disclaimers of support obligations should not be effective in such cases.**

The question whether a support obligation should be imposed upon the spouse of the non-custodial biological parent was also considered. This issue is particularly relevant in case of death of the non-custodial parent, especially where that parent's assets might pass directly to the spouse. Given concern about the potential unfairness of burdening a spouse, who may have participated reluctantly in the original surrogacy agreement, with continuing financial responsibility for a child raised by another in the event of the non-custodial parent's death, the Commission and Task Force conclude that support obligations should be consistent with existing law regarding support by a non-custodial parent, and that no new support obligation should be imposed on the spouse.

In the case of gestational surrogacy, there may be two biological parents who have support obligations. If, for example, the gestational

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* Theoretically, the obligation to pay support could fall either on the biological mother or the biological father, depending on which parent has been awarded custody and on the respective financial resources of each parent. While it is possible that a birth mother in a surrogacy arrangement will be in a superior economic position to a biological father, this probably will not be so in most cases. As the New Jersey Supreme Court in *Baby M* noted, "...it is unlikely that surrogate mothers will be as proportionately numerous among those women in the top twenty percent bracket as among those in the bottom twenty percent." 109 N.J. at 440, 537 A. 2d at 1249.

mother is the custodial parent, then both the genetic mother and the biological father, who were also the intended social parents, may be potentially liable for support. However, a person who merely donates gametes with no expectation or intention of becoming a social parent should not have any financial responsibility toward the child. (The reference to a "non-custodial parent" in this policy recommendation is not intended to apply to a person whose sole role in the arrangement is to provide sperm or eggs without any intent or expectation of serving as a rearing parent.)*

Visitation Rights

A further issue considered was that of visitation by the non-custodial parent.

There are competing psychological theories as to the value (or otherwise) for the child of shared parenting in cases of marital dissolution or out-of-wedlock birth. Some experts in child psychology argue that the child's interests are best served by allowing him or her the opportunity to maintain contact with all biological parents;[45] others maintain that it may be disruptive and confusing to the child to have that contact, especially if it is contrary to the wishes of the custodial parent.[46] While noting that analogies to visitation rights of a non-custodial parent upon dissolution of marriage or out-of-wedlock birth may be of limited usefulness in surrogacy,** the Commission and Task Force conclude that

* This situation is analogous to that currently existing with regard to A.I.D. Under the A.I.D. model a "safe harbor" is created for a sperm donor who fits within the narrow set of circumstances described in *N.J.S.A.* 9:17-44. This section assures a sperm donor that if the procedures specified in the statute are complied with, no rights or responsibilities will flow from the act of sperm donation.

** This is so for at least two reasons. First, in most surrogacy situations, and particularly in commercial surrogacy, the persons collaborating in the creation of the child never intended or desired to form one family. In the usual surrogacy case, the adults are strangers to each other, generally come from disparate social and economic backgrounds, and consequently are likely to have less in common than biological parents who have procreated in a non-surrogacy (or A.I.D.) context. The absence of shared backgrounds and values may make it more difficult in surrogacy for the parties to cooperate with each other to make the arrangement workable and harmonious for the child. Second, in contrast to the typical marital dissolution in which a parent-child relationship has developed, it is generally the case in surrogacy that the non-custodial parent will not have developed a relationship with the child. In a marital dissolution with an established parent-child relationship, a court may well be reluctant to deny the non-custodial parent visitation. In surrogacy,

the law should recognize that a child may have competing interests in psychological stability and in maintaining contact with his or her biological parent(s), and that both interests should be considered in individual case determinations. It is therefore recommended that:

> **A presumption should be established in favor of visitation rights for the non-custodial parent, unless it is demonstrated that such visitation would be contrary to the best interests of the child. The extent and conditions of visitation should be considered on a case-by-case basis, with due regard for the child's interests both in psychological stability and in the maintenance of contact with the child's biological parents.***

In the case of gestational surrogacy, there may be two biological non-custodial parents seeking visitation rights. For example, if custody is awarded to the birth mother, it is possible that both the genetic mother and the biological father may seek visitation, if they were also the intended rearing parents. Whether it is in the child's interests to maintain contact with both biological parents in such a situation should be determined on an individual case basis.** However, in situations in which the genetic parent or parents merely contributed their gametes with no intention or expectation of rearing the child, they should have no visitation rights.

however, this consideration would not apply, at least when the child is a newborn at the time of litigation.

* Again, the reference here to "non-custodial parent" is not intended to apply to a person whose sole role in the arrangement is to provide sperm or eggs, without any intent or expectation of serving as a rearing parent.

** There seems little reason in principle for distinguishing in such a case between the genetic parents on the basis of sex. If a court decides that it is in the best interests of the child to maintain contact with his or her genetic parents, then this should apply, arguably, to both the genetic mother and the genetic father. A contrary argument that could be made is that while it is in the interests of a child to have a parental role model of each sex, it may be confusing and potentially harmful to the child to present him or her with two "mothers." At the present time, however, psychological data supporting such a conclusion does not exist.

Abandonment

There may be some rare cases in which none of the adults involved in a surrogacy arrangement will wish to take custody of, or assume responsibility for, the resulting child. This may occur, for example, when the child is born with a severe disability,* more than one child is born, a child of an undesired sex is born, or circumstances in the adults' lives (such as divorce or the death of a partner) make surrogacy and the resulting child no longer desirable.

At least two instances of "abandoned" children born of surrogacy arrangements have come to public attention to date. As noted earlier, one case involved a child who was born HIV positive. This case involved a non-commercial surrogacy arrangement, in which the so-called "surrogate" was the sister of the infertile woman. The so-called "surrogate" was not screened for HIV antibody prior to insemination; unknown to her family she had a history of drug abuse, the likely means by which she contracted HIV.[67] Another case, currently in litigation, concerns a boy who was one of a set of twins, and the biological father and his wife decided they wanted to accept only the girl.[68]

The Commission and Task Force conclude that existing New Jersey law should govern situations in surrogacy in which none of the parties to the arrangement assume responsibility for the child. The New Jersey statutory and agency schemes provide a detailed process for the termination of parental rights in the adoption context. A child's biological parent(s) may arrange for the adoption of a child in one of three ways, each with its own procedure: to a private child care agency licensed to practice in New Jersey; to the Division of Youth and Family Services (DYFS); or directly to a family, as a private placement adoption. In private placement adoptions, relinquishing biological parents retain parental rights until the conclusion of a preliminary hearing that takes place not less than two nor more than three months after the adoptive family files a complaint for adoption.[69] In both licensed private

* An infant's disability constitutes the reason most commonly cited by commentators for potential refusal of custody of the surrogate-born child. *See* Judith C. Areen, "Baby M Reconsidered," *Georgetown Law Journal* (1988): 1741-58; Martha A. Field, "Surrogate Motherhood: The Legal Issues," *Human Rights Annual* IV (1987): 481-553; Angela R. Holder, "Surrogate Motherhood and the Best Interests of Children," *Law, Medicine and Health Care* 16 (1-2) (1988): 51-56.

agency adoptions and DYFS proceedings, the procedure is different. Prior to accepting a signed surrender of custody, DYFS and any private agency must offer birth parents counseling that fully explores alternatives designed to keep the child in the natural family, including mental health services for the parent(s), foster care, day care, care by relatives, and community resources (such as services for children with disabilities). The signing of a valid surrender of custody cannot be executed until 72 hours after childbirth, and is final and irrevocable.[70] To relinquish custody and all parental rights, the parent(s) must sign a witnessed and notarized affidavit reciting that the surrender is voluntary; that the parents demonstrate an understanding of the implications of severing the parent-child relationship; that there is no promise of reward or benefit from any source; that there is no mental or physical coercion; and that the agency or DYFS is permitted to place the child for adoption.[71]

Biological parents may surrender custody without terminating their parental rights by placing the child with DYFS for foster care for either a temporary or a long-term period.[72] This route is often chosen when the parents and DYFS believe that at a future time and after appropriate services are offered, the natural parents will be able to resume responsibility for the child. Foster care also becomes the setting for children for whom an adoptive home cannot be found, even if the parents have made the child available for adoption.

Although children born with disabilities (or, as they are sometimes described, "children with special needs") have historically been difficult to place in adoptive homes and in foster care, a number of factors now make it considerably easier to find suitable and caring families for these children. Programs of adoption subsidies to assist with disability-related medical and educational expenses, increasing support services provided to adoptive families by child welfare agencies, changes in societal attitudes toward people with disabilities, and the desire of many people to raise a child, all have contributed to an eased situation of adoption for children with disabling conditions. Indeed, children with disabilities are sometimes less difficult to place in adoptive homes than older children with histories of previous disrupted placements or children with histories of physical or sexual abuse.[73]

Financial Responsibility in Case of Abandonment

The Commission and Task Force further conclude that both biological parents in a surrogacy arrangement should bear financial responsibility for the child, in accordance with their respective financial abilities, until the adoption becomes final. In arriving at this recommendation, the focus was again on the main objectives of protecting the interests of children and deterring the practice of surrogacy.

A child born of a surrogacy arrangement is as entitled to an opportunity for a stable and caring home as is any other child, and should not be penalized because his or her parents engaged in an illegal or disfavored arrangement. Thus, in circumstances in which both biological parents are in a position to contribute financially to the child's support, both should be financially responsible in accordance with their respective financial means. Arguments for and against imposing the entire financial burden on one or the other party were considered,* but it was ultimately concluded that both parties should contribute financially.** Such a division of responsibility conforms to the reality that both parties participated in the arrangement and in the creation of the child. Moreover, a policy which allocates responsibility in this manner should serve as a further disincentive for all parties contemplating surrogacy

* One argument in favor of imposing full financial responsibility on the intended rearing parents is that they frequently (and particularly in commercial surrogacy cases) have the greatest financial resources. Further, it can be argued that their intent and desire to bring the child into the world was the force instigating the surrogacy arrangement, and that therefore they should bear the full financial burden. However, to grant intent such weight in the context of "abandoned" children contrasts sharply with the manner in which intent has been handled in custody disputes, where the recommendations favor (through an initial presumption) the birth mother, based largely upon her biological, psychological and social connection to the child. Thus, requiring the intended rearing parents to be solely responsible for the financial support of an unwanted child seems somewhat inconsistent and inappropriate.

An argument in favor of requiring the birth mother to be fully financially responsible is based on her close connection -- biological, psychological and social -- to the child. It may be argued that just as she has the right to choose whether or not to retain custody, so does she incur the greatest obligation to the child financially if she chooses to relinquish custody and the intended rearing parents do not wish to take custody. However, if, as is likely, she is less affluent than the intended rearing parents, she may be being asked to bear a disproportionate burden.

** It should be noted, however, that consistent with the recommendations on support obligations in surrogacy cases in which the child is not abandoned, gamete donors who never had any expectation or intention of becoming the rearing parents should not be asked to bear any financial responsibilities.

arrangements. If the combined financial abilities of the biological parents are insufficient to support the child, the State should supplement the financial need.

The recommendation regarding support obligations for abandoned children born of surrogacy arrangements is consistent with the State's method of handling financial obligations for relinquishing parents outside the surrogacy context. When parents relinquish a child to DYFS and the child is placed in a foster home, the parents are not relieved of financial obligations until such time as the child is placed with an adoptive family.[74] DYFS establishes an amount to be expended for each child based on the services needed for the child, with a maximum set by regulation. Amounts paid by relinquishing parents reduce the total State expense required for the child. Financial obligations for any relinquishing parent and any child exist on a sliding scale, based on family earnings and the cost of placement for the child. If the income of the relinquishing parent falls below the guidelines established for maintenance of the child's support, the State assumes part or all of the costs.

It is therefore further recommended that:

In the event neither the intended rearing parents nor the birth mother are willing or able to assume custody of the child, the child should be placed for adoption in accordance with existing law. Until such time as adoption is final, both the intended rearing parents and the birth mother should be obligated to provide appropriate financial support for the child, in accordance with their respective financial abilities.

Repudiation of the Surrogacy Agreement

A further issue regarding financial responsibilities that arises in the event one of the parties repudiates the agreement is who will pay for the birth mother's medical and hospital expenses. That the surrogacy agreement is unenforceable (under the recommendations made here and under existing law) should not relieve the intended rearing parents of responsibility for the birth mother's medical and hospital expenses incurred in the course of conception and pregnancy. This should hold

when either party repudiates the agreement, and regardless of whether rejection of the agreement occurs prior to or after birth. However, payment of costs other than medical and hospital expenses allowable under current adoption law, such as ordinary living expenses or disguised compensation, should not be imposed on the contracting couple.

When a surrogacy arrangement is repudiated by either party, the birth mother should be entitled to medical and hospital expenses to be paid by the intended rearing parents, as currently allowable under adoption law, even though the surrogacy arrangement is unenforceable. Any expenses other than medical and hospital expenses currently allowable under adoption law should not be the responsibility of the intended rearing parents.

Multi-State Arrangements*

As discussed in chapter four, to date only fifteen states have addressed the practice of surrogacy in their statutory law. In the absence of any uniform legislation on surrogacy, the range of possible responses by states is potentially varied. Currently, only a few states are hospitable to the practice, although those states whose laws are silent might be viewed as permissive by those interested in a surrogacy arrangement. Disparities among state laws may invite "forum shopping", *i.e.*, attempts to evade the strictures of New Jersey law and to take advantage of the law elsewhere. For example, a New Jersey couple might seek a so-called "surrogate" from another more hospitable state, and might seek to build additional connections to the more permissive forum by entering into the agreement, performing the insemination procedure, or effecting the transfer of custody there. Or, a couple and a so-called "surrogate", both residents of New Jersey, might travel to another more hospitable state, engaging in some or all aspects of the transaction in that state.

* For an excellent in-depth analysis of choice of law approaches in surrogacy, including discussion of the application of the Uniform Child Custody Jurisdiction Act and the Parental Kidnapping Prevention Act, *see* Susan Frelich Appleton, "Surrogacy Arrangements And The Conflict Of Laws," *Wisconsin Law Review* (1990): 399-482. The Commission and Task Force are indebted to Professor Appleton, Washington University School of Law, for her earlier paper of the same title, prepared for the Commission.

Attempts to evade restrictive state laws may occur either in cases in which all parties wish to abide by the terms of their agreement or where one party wishes to breach the agreement.

New Jersey has a strong interest in having its law and public policy applied to the resolution of disputed surrogacy arrangements involving its own citizens. In order to promote this public policy disfavoring surrogacy arrangements, New Jersey law should apply to disputed multi-state surrogacy arrangements within the jurisdiction of the New Jersey courts. This rule would assure that surrogacy contracts involving New Jersey residents will be unenforceable; that custody, visitation and support will be determined in accordance with New Jersey law (consistent with constitutional notions of fairness and due process); and that the motive for forum shopping will be minimized; thereby bolstering the goal of deterring the practice of surrogacy. Therefore, the Commission and Task Force recommend that:

When a disputed surrogacy arrangement is within the jurisdiction of the New Jersey courts and involves citizens of or contacts with the state of New Jersey and one or more other states, New Jersey law should apply.

Conclusion

Despite a legal regime which is intended to discourage the practice of surrogacy, particularly in its commercial form, some people may nevertheless decide to enter into surrogacy arrangements. It is foreseeable that in some of these cases disputes relating to parental rights and responsibilities may arise between the participants. The Commission and Task Force have therefore addressed a number of important issues in this context: a waiting period for the birth mother prior to transferring custody; resolution of custody disputes in cases in which two or more parties compete for custody; support obligations of the non-custodial parent(s); visitation rights of the non-custodial parent(s); and the situation of the "abandoned" child for whom none of the adults wish to take custody. The conclusions and recommendations on these issues should apply with equal force to resolution of questions of custody, support, and visitation in both commercial and non-commercial arrangements, and in multi-state surrogacy arrangements. Ultimately, positions taken on these

issues aim to protect the interests of the child and at the same time seek to advance the broader interests of society in discouraging surrogacy.

NOTES

1. Relevant factors include whether the birth mother is breastfeeding the child; whether she has had children previously; and whether she has a supportive family.

2. By that time, the uterus returns to its pre-pregnancy weight and position in the pelvis; the placental site returns to its pre-pregnancy condition; postpartum bleeding ceases; the endometrium is restored; the cervix closes; the normal structure of the vagina and Fallopian tubes are regained; cardiovascular output returns to normal; the sex drive gradually returns; and the hormonal balance of the body is resumed. In addition, postpartum exhaustion and fatigue can be alleviated within the first couple of weeks with proper rest, and non-strenuous activities can begin within two weeks, though it is recommended that women who have had cesarian deliveries delay this period to four to six weeks following childbirth. Ovulation may take a longer period; for non-lactating mothers, it occurs after approximately eight to twelve weeks, while for mothers who breastfeed, the onset of menstruation may range from two months after birth to six to eight months after the baby is weaned. *See* Harry Oxorn, *Oxorn-Foote Human Labor & Birth* (Appleton-Century-Crofts 5th ed. 1986), pp. 865-69; The Columbia University College of Physicians and Surgeons, *Complete Guide to Pregnancy* (Crown Publishers 1988), pp. 286-99; Mike Samuels and Nancy Samuels, *The Well Pregnancy Book* (Summit Books 1986), pp. 405-43.

3. The psychological impact of mother-infant attachment for both the infant and the birth mother are discussed more fully below.

4. *N.J.S.A.* 9:3-48 (West 1977).

5. 217 N.J. Super. 313, 525 A.2d 1128 (1987), *aff'd in part, rev'd in part*, 109 N.J. 396, 537 A.2d 1227 (1988).

6. 109 N.J. 396, 453, 537 A.2d 1227, 1256 (1988).

7. *Id.* at 456, 537 A.2d at 1258.

8. *Id.* at 457, 537 A.2d at 1258.

9. *Id.* at 459, 537 A.2d at 1258.

10. *Id.* at 454, 537 A.2d at 1257.

11. *Id.*

12. *Id.*

13. Id. at 453 n.17, 537 A.2d at 1256 n.17 (quoting the Court's statement in *Beck v. Beck*, 86 N.J. 480, 488, 432 A.2d 63, 66 (1981)).

14. 109 N.J. at 453 n.17, 537 A.2d at 1256 n.17.

15. The genesis of this statutory provision is found in an 1871 statute L. 1871, c. 48, s. 6.

16. *State ex. Rel. Watts v. Watts*, 77 Misc. 2d 178, 350 N.Y.S.2d 285 (1973).

17. 109 N.J. at 453 n.17, 537 A.2d 1256 n.17.

18. *Id.* at 462, 537 A.2d at 1261.

19. *Id.*

20. *Id.* at 462-63, 537 A.2d at 1261.

21. *See, e.g., In re Guardianship of C.*, 98 N.J. Super. 474, 237 A.2d 652 (1967); *Fiore v. Fiore*, 49 N.J. Super. 219, 139 A.2d 414 (1958).

22. George J. Annas, "Baby M: Babies (and Justice) for Sale," *Hastings Center Report* 17 (3) (June 1987): 13-15.

23. For an account of the bias pervading the expert testimony in *Baby M* at the trial level, *see* Michelle Harrison, "The Social Construction of Mary Beth Whitehead," *Gender and Society* 1 (3) (1987): 300-11.

24. Robert H. Mnookin, "Child Custody Adjudication: Judicial Functions in the Face of Indeterminacy," *Law and Contemporary Problems* 39 (3) (1975): 260-61.

25. 109 N.J. at 460, 537 A.2d at 1260.

26. 109 N.J. at 396, 537 A.2d at 1242.

27. *J. and E. v. M. and F.*, 157 N.J. Super. 478, 385 A.2d 240 (1978). In that case, the parental rights of two natural parents of a child born to the mother during her incarceration were terminated. The evidence showed a past and continuing course of neglect to their two other children, including a criminal record based on an unequivocal admission by both parents of the unlawful killing of their 3 year old son and the gross abuse of their 18 month old daughter.

See also the following statement in *N.J. Div. of Youth and Family Services v. A.W.*, 103 N.J. 591, 607, 512 A.2d 438, 447 (1986):

> A court analyzing the ability of the parents to give their children care should not look at the parents to determine whether they are themselves unfit or whether they are the victims of social circumstances beyond their control; it should only determine whether it is reasonably foreseeable that the parents can cease to inflict harm upon the children entrusted to their care. No more and no less is required of them than that they will not place their children in substantial jeopardy to physical or mental health.

28. 405 U.S. 645, 651 (1972).

29. *See, e.g., In re Adoption of Children by D.*, 61 N.J. 89, 93, 293 A.2d 171, 173 (1972), in which the court stated that the "child's relationship with the parent is of such significance that all doubts are to be resolved against its destruction" (quoting *In re Adoption of Children by N.*, 96 N.J. Super. 415, 425, 233 A.2d 188, 193 (App. Div. 1967)).

30. As observed in *In re Angela P.*, 28 Cal. 3d 908, 930, 623 P. 2d 198, 210 (1981) (Bird, C.J., concurring and dissenting):

> It is an unfortunate truth that not all children, who are "freed" from their legal relationship with their parents, find the stable and permanent situation that is desired even though this is the implicit promise made by the state when it seeks to terminate the parent-child relationship. Multiple placements and impermanent situations sometimes mark the state's guardianship of a child. This unstable situation is frequently detrimental to a child.

Indeed, the detriment may be greater than keeping the parent-child relationship intact since the child's psychological and emotional bond to the parent may have been broken with nothing substituted in its place. (Citations omitted.)

31. Two useful collections discussing the relationship between values and the social sciences are Norma Haan, Robert N. Bellah, Paul Rabinow, William Sullivan eds., *Social Science As Moral Inquiry* (Columbia Univ. Press 1983) and Daniel Callahan and Bruce Jennings eds., *Ethics, The Social Sciences, and Policy Analysis* (Plenum Press 1983).

32. Michelle Harrison, "The Social Construction of Mary Beth Whitehead," *Gender and Society* (September 1987): 300-11.

33. Robert H. Mnookin, "Child-Custody Adjudication: Judicial Functions in the Face of Indeterminacy," *Law and Contemporary Problems* 39 (3) (1975): 226-93. Mnookin captures these concerns when he states: "The indeterminacy flows from our inability to predict accurately human behavior and from our lack of social consensus about the values that should inform the decision." *Id.* at 264.

34. John Monahan and Laurens Walker, "Social Science Research in Law: A New Paradigm," *American Psychologist* 43 (6) (June 1988): 465-72.

35. The first major statement of these ideas in book form appeared in Marshall Klaus and John Kennell, *Maternal-Infant Bonding* (C.V. Mosby 1976). The updated and reissued title of this work is called *Parent-Infant Bonding* (C.V. Mosby 1982) (hereinafter "Klaus and Kennell"). Much of the evidence in support of the importance of "bonding" stems from the research of Klaus & Kennell and is reviewed in these sources; the books also include the work of others who employed the concept of bonding in their study of birth mothers and infants.

36. *Id.* at 35-86.

37. *Id.* at 35-53.

38. *See In the Matter of Baby M*, 109 N.J. 396, 537 A.2d 1227 (1988); New York State Task Force on Life and the Law, *Surrogate Parenting: Analysis and Recommendations for Public Policy* (New York May 1988).

39. Jay Belsky and Teresa Nezworski, eds., *Clinical Implications of Attachment* (L. Erlbaum Associates 1988), pp. 3-17 (hereinafter "Belsky and Nezworski").

40. *Id.*; John Bowlby, *Attachment and Loss* 1 (Basic Books 1969), pp. 177-79 (hereinafter "Bowlby").

41. *See generally* Joseph Goldstein, Anna Freud, and Albert Solnit, *Beyond the Best Interests of the Child* (Free Press 1973) (hereinafter "Goldstein, Freud and Solnit").

42. *Id.* at 31-32.

43. David R. Coller, "Joint Custody: Research, Theory, and Policy," *Family Process* (December 1986): 459-69 (hereinafter "Coller"); John Monahan and Laurens Walker, *Social Science in Law: Cases and Materials* (Foundation Press 1985), pp. 382-92 (hereinafter "Monahan and Walker").

44. *See* Coller, *supra* note 43, at 459-69; Monahan and Walker, *supra* note 43, pp. 382-92.

45. *See* Bowlby, *supra* note 40, pp. 265-330.

46. For discussions that emphasize the greater developed ability of women as caregivers for infants and young children, *see* Alice S. Rossi, "A Bio-Social Perspective on Parenting," *Daedelus* 106 (2) (Spring 1977): 1-31; Alice S. Rossi, "Gender and Parenthood," in *Gender and the Life Course*, Alice S. Rossi, ed. (Aldine 1985), pp. 161-90; Teresa Benedek, "The Psychobiology of Pregnancy," in *Parenthood: Its Psychology and Psychotherapy*, E. James Anthony and Teresa Benedek, eds. (Little Brown 1970), pp. 136-52 (hereinafter "Anthony and Benedek").

47. Benjamin M. Schutz, Ellen B. Dixon, Joanne C. Lindenberger, and Neil J. Ruther, *Solomon's Sword: A Practical Guide to Conducting Child Custody Evaluations* (Jossey-Bass 1989), pp. 1-41.

48. *See* Belsky and Nezworski, *supra* note 39. The title change in the second edition of Klaus and Kennell's book (*see supra* note 35) clearly reflected the authors' intent to respond to the increasing public interst in male, as well as female, involvement with children. While not repudiating the value of the skin-to-skin contact between birth mother and infant for establishing the mother's emotional response to the child, this later discussion suggests in the text as well as the title that this "bonding" may take place between the father and the child by early physical involvement with the infant. Moreover, the book broadens the concept to include responses to infants on the part of nonrelated caregivers. Thus, in their 1982 publication, the proponents of "bonding" were less committed to a view that such a response was either exclusive to the birth mother or intrinsic to biological parenthood.

49. D. W. Winnicott, "Primary Maternal Preoccupation," in *Collected Papers: Through Pediatrics To Psychoanalysis* (Basic Books 1958); Anthony and Benedek, *supra* note 46.

50. Leslie M. Singer, David Brodzinsky, Douglas Ramsay, Mary Steier, and Everett Waters, "Mother-Infant Attachment in Adoptive Families," *Child Development* 56 (1985): 1543-51.

51. *See, e.g., In the Matter of Baby M*, 109 N.J. 396, 537 A.2d 1227 (1988); New York State Task Force on Life and the Law, *Surrogate Parenting: Analysis and Recommendations for Public Policy* (New York May 1988).

52. For a detailed examination of the effect of the concept of "bonding" on childbirth practice, the medical and mental health profession's work with parents and children, and its translation into popular thinking, *see* Dianne E. Eyer, *Maternal-Infant Bonding: Portrait of a Paradigm* (Unpublished Doctoral Dissertation, Department of Sociology, Graduate School of Education, University of Pennsylvania, 1988).

53. *See* Klaus & Kennell, *supra* note 35, pp. 35-53.

54. The concept of "bonding" generated scores of studies in the pediatric, psychological, and nursing literature, as well as much discussion in the popular press. By the early 1980's, however, many researchers became critical of the clarity of the concept, the methodology of the scientific work used to define it, the validity of the data reported about it, or the interpretations made of the data reported in the original Klaus and Kennell work.

Illustrative of the scholarly dialogue are the following articles: Michael Lamb, "The Bonding Phenomenon: Misinterpretations and Their Implications," *Journal of Pediatrics* 101(4) (1982): 555-57; Barbara J. Myers, "Mother-Infant Bonding: The Status of This Critical Period Hypothesis," *Developmental Review* 4 (1984): 240-74; John H. Kennell and Marshall H. Klaus, "Mother-Infant Bonding: Weighing the Evidence," *Developmental Review* 4 (1984): 275-82; Barbara J. Myers, "Mother-Infant Bonding: Rejoinder to Kennell and Klaus," *Developmental Review* 4 (1984): 282-88; "Maternal-Infant Bonding: A Joint Rebuttal," *Pediatrics* 72(4) (October 1983): 569-72; "Joint Reply to Maternal-Infant Bonding: A Joint Rebuttal," *Pediatrics* 72(4) (October 1983): 574-76.

55. Edward Rynearson, "Relinquishment and Its Maternal Complications," *American Journal of Psychiatry* 139(3) (March 1982): 338-40; Annette Baran, Reuben Pannor, and Arthur Sorosky, "The Lingering Pain of Surrendering a Child," *Psychology Today* (June 1977): 58-60, 88; Eva Deykin, Lee Campbell, and Patricia Patti, "The Post-Adoption Experience of Surrendering Parents," *American Journal of Orthopsychiatry* 54(2) (1984): 271-80 (hereinafter "Deykin, Campbell and Patti"); *see generally* Kate Inglis, *Living Mistakes: Mothers Who Consented To Adoption* (George Allen and Unwin 1984).

56. *See* Brief Submitted to the New Jersey Supreme Court by the Committee for United Birth Parents in the *Baby M* case, 109 N.J.396, 537 A.2d 1227 (1988); Deykin, Campbell & Patti, *supra* note 55, pp. 271-80.

57. Phyllis R. Silverman, Lee Campbell, Patricia Patti, and Carolyn Style, "Reunions Between Adoptees and Birthparents: The Birthparents' Experience," *Social Work* 33 (6) (November/December 1988): 523-28.

58. *See generally* Arthur D. Sorosky, Annette Baran, and Reuben Pannor, *The Adoption Triangle* (Anchor Books 2nd ed. 1984).

59. *See* Lori B. Andrews, *Between Strangers: Surrogate Mothers, Expectant Fathers, and Brave New Babies* (Harper and Row 1989).

60. Rebecca Powers and Sheila Gruber Belloli, "The Baby Business: A Five Part Series," *Detroit News* (September 17 - September 21 1989).

61. *See, e.g.*, Testimony submitted to the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care and the Task Force on New Reproductive Practices (May 11, 1988); Testimony submitted to the Joint Public Hearing, New York Assembly Standing Committee on the Judiciary, New York Assembly Task Force on Women's Issues on A-10851-A and S-9134, Governor's Program Bills with Respect to Surrogate Parenting Contracts (December 8, 1988).

62. *See, e.g.*, Amicus Brief submitted to the New Jersey Supreme Court by the National Association of Surrogate Mothers in the *Baby M* case, 109 N.J. 396, 537 A.2d 1227 (1988).

63. Interviews conducted by New Jersey Bioethics Commission staff members, Adrienne Asch and Anne Reichman, during site visits to surrogacy centers (September 1, 1988; November 29-30, 1988; December 5, 1988).

64. *See* Kathy Forest and David MacPhee, "Surrogate Mothers' Grief Experiences and Social Support Networks," Department of Human Development and Family Studies, Colorado State University (Fort Collins, Colorado 1989).

65. *See* Coller, *supra* note 43, at 459-69.

66. Goldstein, Freud, and Solnit, *supra* note 41, pp. 43-45, 52-57, 136, 183-85.

67. Judith C. Areen, "Baby M Reconsidered," *Georgetown Law Journal* 76 (1988): 1747.

68. New York State Assembly Judiciary Committee, Testimony of Patty Nowakowski (December 8, 1988). A third case to come to public attention involved a child born with microcephaly. In this case, however, it was subsequently discovered in a dispute over paternity that the contracting father was not the child's biological father, but that the child was in fact fathered by the so-called surrogate's husband. Consequently, the contracting father had no responsibility for the child. Thus, it is unclear whether the child would have been abandoned because of the disability. This case is discussed in Judith Areen, Patricia S. King, Susan Goldberg and Alexander M. Capron, *Law, Science & Medicine* (Foundation Press 1989), pp. 1313-14.

69. *N.J.S.A.* 9:3-48 (West 1977).

70. *See N.J.S.A.* 9:3-41 (West 1977).

71. *See N.J.S.A.* 9:2-16, 9:2-17 (West 1955); N.J.S.A. 30:4C-23 (West 1962); DYFS *Manual Field Operations Casework Policy and Procedures: Adoption Services* (1985): Section IV. *See generally* American Bar Association National Legal Resource Center for Child Advocacy and Protection, Ellen C. Segal ed., *Adoption of Children with Special Needs: Issues in Law and Policy* (1985), pp. 127-69 (hereinafter "ABA Resource Center"); Cecilia Zalkind, "Adoption Law, Policy and Practice in New Jersey," presentation to the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care Task Force on New Reproductive Practices, April 27, 1988.

72. *N.J.S.A.* 30:4C-26 (West 1980).

73. *See* ABA Resource Center, *supra* note 71, pp. 127-69.

74. *N.J.S.A.* 30:4C-29.1.

Table 1
Commissioners

Paul W. Armstrong, M.A., J.D., LL.M., Chairman, served as counsel to the families of Karen Ann Quinlan and Nancy Ellen Jobes before the Supreme Court of New Jersey, and to the American Hospital Association, as Amicus Curiae, before the United States Supreme Court in the case of Nancy Beth Cruzan. He is Chairman of the Governor's Advisory Council on AIDS and serves as President of the Samaritan Homeless Interim Program (SHIP). He is a widely published author holding an M.A. in history from the University of Dayton, a J.D. from the University of Notre Dame, and an LL.M. from New York University School of Law. An Adjunct Professor at Rutgers Law School and Robert Wood Johnson Medical School, Mr. Armstrong was the recipient of the 1989 Citizen's Award of the Academy of Medicine of New Jersey, the 1990 Victoria Fellowship in Contemporary Issues at Rutgers University, the 1990 President's Award of the New Jersey State Nurses Association and the 1991 John Elbridge Hines Lectureship of the Episcopal Diocese of Newark.

Sr. Jane Frances Brady, M.S., M.B.A., Vice-Chairman, representing the New Jersey Hospital Association, is President and Chief Executive Officer of St. Joseph's Hospital and Medical Center. A Board of Directors member and Trustee of many leading health care organizations, and past President of the New Jersey Conference of Catholic Health Care Facilities, she received her M.B.A. from Seton Hall University and her M.S. in Hospital Administration from Columbia University.

Thomas P. Brown, M.A., is the Acting Ombudsman for the Institutionalized Elderly. Mr. Brown previously served as Director of Investigations for the Office. Before coming to the Ombudsman's Office, he served as a psychologist for the School of Medicine of the University of Maryland, and for the Division of Developmental Disabilities of the State of Maryland. Mr. Brown holds an M.A. in psychology from the University of the District of Columbia and is a graduate of Glassboro State College.

Senator Gerald Cardinale, D.D.S. (R), has served in the New Jersey Legislature since 1980 and is Chair of the Senate Commerce Committee. He is a Board of Trustee member for Dumont Mental Health Center, and has established several community programs for the elderly. Following receipt of his D.D.S. at New York University College of Dentistry, he served as Assistant Professor at Columbia University.

Diana Czerepuszko, R. N., L.N.H.A., representing the New Jersey Association of Health Care Facilities, is Executive Director of the Cheshire Home in Florham Park. A graduate in nursing of Trenton State College, she has 20 years experience in acute and long term health care and has held positions from staff nurse to Nursing Director. She has participated in numerous committees and has made numerous presentations regarding the care of the elderly.

Robert Deaton, is Director of Long Term Care for the Diocese of Camden, and represents the New Jersey Association of Non-Profit Homes for the Aging, Inc. Currently responsible for the administration of the Diocese's four skilled nursing facilities, he previously served as Director of Finance for the Diocese of Camden. Mr. Deaton is a graduate of Rutgers University with a major in accounting.

Joseph Fennelly, M.D., practices in the field of internal medicine, and is Vice-Chairman of both the New Jersey Medical Society's Committee on Biomedical Ethics and the Citizens' Committee on Biomedical Ethics. He is the original chair of the Ethics Committees at Morristown Memorial Hospital and King James Nursing Home, and has participated in numerous panels and programs in bioethics. Associate Professor of Medicine of the College of Physicians and Surgeons, Columbia University, he received his M.D. from the New York Medical College.

J. Richard Goldstein, M.D., is President of Stopwatch, Inc., a health care firm dealing primarily with AIDS patients. From 1983 to 1986, Dr. Goldstein was New Jersey's Commissioner of Health and Chairman of the Health Care Facilities Financing Authority. Prior to his service as Commissioner, Dr. Goldstein was president of a health planning consulting firm. He received his M.D. from the Ohio State University College of Medicine and an M.A. from Harvard University.

Noreen Haveron, R.N., B.S.N., is Assistant Nursing Supervisor of the Nutley Nursing Service. She was formerly a Public Health Staff Nurse and Hospice Coordinator at Nutley, in addition to holding staff nurse positions at various hospitals. Ms. Haveron received her B.S.N. from Thomas A. Edison State College.

Lois Hull, Director of the New Jersey State Division on Aging, represents the Commissioner of Community Affairs. Ms. Hull was the Executive Director of the Community Mental Health Center in South Orange. Former Director of the Essex County Division on Aging, she has taught courses in gerontology for Seton Hall University. Ms. Hull received her B.A. from Rutgers University.

Assemblyman C. Richard Kamin (R), Vice-Chair of the Assembly Appropriations Committee, is Vice President of a financial publishing firm. He has served as President of Mt. Olive Township Council and as Chairman of the Township Board of Health. He is a graduate of Temple University where he majored in business and economics.

Assemblyman David C. Kronick, M.B.A. (D), has been a member of the New Jersey General Assembly since November of 1987 where he sits on the Assembly's Environmental Quality and Transportation and Communications Committees. He is a member of the Hudson River Waterfront Trust and sits on the Board of Directors of St. John's Lutheran Shelter for the homeless in Union City. He is a member of the Jewish War Veterans, the American Legion and the Veterans of Foreign Wars. The founder and president of an advertising

specialty company, Mr. Kronick received his B.S. and M.B.A. from New York University.

Rabbi Charles Kroloff, is a graduate of Yale University and Hebrew Union College and has been the Rabbi of Temple Emanu-El since 1966. He is an adjunct lecturer in Pastoral Counseling and Jewish Theology at Hebrew Union College and is a clinical member of the American Association of Marriage and Family Therapists.

Paul R. Langevin, M.A., Assistant Commissioner for Health Facilities Evaluation, represents the Commissioner of Health. He directs the licensure and inspection process for nearly 1,000 health care facilities regulated by the Department of Health. Mr. Langevin received his B.S. from Rutgers University and his M.A. from Rider College.

Mary K. Lindner, R.N., M.A., is Senior Vice President, Patient Services and Executive Director of Nursing at Overlook Hospital. She is a member of the Council on Professional Practices of the New Jersey Hospital Association and is on the advisory board of the Citizens' Committee on Biomedical Ethics. She holds a B.S. in nursing from Skidmore College and an M.A. in human development from Fairleigh Dickinson University.

Rita Martin, is Legislative Director for Citizens Concerned for Life - NJ and a past President of the NJ Right to Life Committee. Ms. Martin is also a member of the NJ Hospice Organization. She attended St. Joseph's College and Temple University.

Russell L. McIntyre, Th.D., is an Associate Professor of Medical Ethics at the University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School. Dr. McIntyre is also the Director of Programs in Medical Humanities for the medical school. A graduate of Wagner College, he received a divinity degree from the Lutheran Theological Seminary at Philadelphia and two Masters Degrees from Wittenberg University. He received a Doctorate in Ethics from the University of Toronto and was a Fellow in Medical Ethics at Harvard Medical School. Dr. McIntyre is the Editor of *Trends In Health Care, Law & Ethics.*

Patricia Ann Murphy, R.N., Ph.D., FAAN, represents the New Jersey State Nurses Association. President-Elect of the New Jersey State Nurses Association, she is a Clinical Specialist in Bereavement at Newark Beth Israel Medical Center. She has chaired the American Nurses Association's Task Force on the Nurse's Role in End of Life Decisions, is a member of the Board of Trustees of the Citizens' Committee on Biomedical Ethics and lectures widely on both bereavement and health care ethics.

Michael Nevins, M.D., an internist practicing in Westwood, is former Governor for New Jersey of the American College of Physicians. He is Chairman of the Bioethics Committee at Pascack Valley Hospital. Dr. Nevins is a member of the Citizens' Committee on Biomedical Ethics, a Clinical Associate Professor of

Medicine at the University of Medicine and Dentistry of New Jersey, and the author of numerous articles on bioethics. Dr. Nevins is a graduate of Dartmouth College and Tufts University School of Medicine.

Sally J. Nunn, R.N., is a Nursing Specialist in bioethics and assessments at Shore Memorial Hospital, Somers Point, New Jersey. She is a co-founder of Shore Memorial's Bioethics Committee and currently serves as its Chair. She is also Chair and founder of the Cape-Atlantic Regional Ethics Committee and a board member of the Delaware Valley Ethics Committee Network. Originator and coordinator of the annual Tri-State Area Bioethics Conference, Ms. Nunn is a frequent speaker to professional and civic groups. She is a graduate of the Chestnut Hill Hospital School of Nursing in Philadelphia.

Robert L. Pickens, M.D., is a board certified urologist who practices in Princeton. He is currently Chairman of the Committee on Biomedical Ethics of the Medical Society of New Jersey. Dr. Pickens also serves as Chairman of the Biomedical Ethics Committee of the Medical Center at Princeton, and is a member of the Biomedical Ethics Committee of the New Jersey Hospital Association. Dr. Pickens received his A.B. degree from Princeton University and his M.D. degree from Yale University. He is a past president of the medical and dental staff of the Medical Center at Princeton, and is a member of its Board of Trustees.

David Rogoff, M.S., is Director of the Haven, a hospice program at the John F. Kennedy Medical Center in Edison. He is a member of the hospital's Bioethics Committee and of the Ethics Committee of the National Hospice Organization. Trained as a psychologist and psychotherapist, Mr. Rogoff is a Phi Beta Kappa graduate of Rutgers University, where he also received his M.S. degree.

RitaMarie G. Rondum, of Lawrenceville, is a member of the American Association of Retired Persons (AARP) State Legislative Committee. She is a retired career New Jersey State employee who developed and administered a variety of state-wide service programs for the elderly and the disadvantaged. Ms. Rondum is the author of *Aging in Action*, the first independent report of the New Jersey State Division on Aging. She is a Trustee of Senator Garrett W. Hagedorn Geropsychiatric Hospital. Ms. Rondum is a member of the Older Women's League and WAVES National, an organization of U.S. Navy Women Veterans. She is a graduate of Temple University.

Mary S. Strong, is one of the founders of the Citizens' Committee on Biomedical Ethics and currently serves as its Chair. She also serves as Chair of American Health Decisions. Mrs. Strong was formerly Executive Director of the Schultz Foundation, and has served on the State Health Coordinating Council, and as Chair of the New Jersey Task Force on Transplant Organ Retrieval. Mrs. Strong was the recipient of the 1987 Citizen's Award of the Academy of Medicine of New Jersey.

Joseph F. Suozzo, Esq., representing the New Jersey Office of the Public Advocate, is Assistant Director of Litigation involved in areas of health policy, mental health and disabilities, and children's issues. He also serves on the Governor's Advisory Council on AIDS. Mr. Suozzo holds an A.B. from Harvard College and a J.D. from Rutgers Law School.

Edward H. Tetelman, Esq., representing the Commissioner of Human Services, is Assistant Commissioner for Intergovernmental Affairs. A former employee of the N. J. Department of the Public Advocate, where he specialized in health care issues, particularly access to health care for low and middle income persons, Mr. Tetelman received his J.D. from Case Western Reserve School of Law.

Table 1 (a)
Former Commissioners

William R. Abrams, Esq.
Acting Ombudsman for the Institutionalized Elderly

The Hon. Gabriel M. Ambrosio, Esq.
Senator - District 36

Rabbi Shmuel Blech
Rabbi, Lakewood, New Jersey

The Hon. Stephanie Bush, Esq.
Assemblywoman - District 27

Harold Cassidy, Esq.
Attorney

The Hon. Richard J. Codey
Senator - District 27

Jack R. D'Ambrosio, Esq.
Ombudsman for the Institutionalized Elderly

Theresa Dietrich
(representing the Director, Division on Aging)

The Hon. Thomas Deverin
Assemblyman - District 20

David Eckstein, M.D. (deceased)
Chairman, Committee on Biomedical Ethics of the Medical Society of N.J.

Martin Epstein, M.D.
Chief Medical Consultant, Dept. of Human Services (representing the Commissioner of Human Services)

Robert Fischer, D.D.S.
Acting Chief Medical Consultant, Department of Human Services (representing the Commissioner of Human Services)

Harold George, Esq.
(Ombudsman for the Institutionalized Elderly)

Franklyn Gerard, M.D.
Vice-Chairman, Board of Trustees, University of Medicine and Dentistry of New Jersey

Donald L. Gilmore
Administrator, Wiley Christian Retirement Community (representing the N. J. Association of Non-Profit Homes for the Aging)

Rev. Robert E. Harahan
Chairman, Pastoral Theology Department, Seton Hall University

Rev. Ernest S. Lyght
Pastor, St. Mark's United Methodist Church

Elmer Matthews, Esq.
Counsel to the New Jersey Catholic Conference of Bishops

Rev. Marvin McMickle
Pastor, St. Paul's Baptist Church

Sarah Mitchell, Esq.
Director, Division of Advocacy for the Developmentally Disabled (representing the Public Advocate)

Lois Mulcahy, R.N.
Administrator, Mercerville Nursing and Convalescent Center (representing the N. J. Association of Health Care Facilities)

Daniel F. O'Connell, Esq.
Shanley & Fisher
Past Chairman of the New Jersey Bioethics Commission

Anne Perone, Esq.
Attorney

Hector Rodriguez, Esq.
Ombudsman for the Institutionalized Elderly

The Hon. Linda Rosenzweig, J.S.C.
Formerly Director, Division of Mental Health Advocacy (representing the Public Advocate)

John H. Rutledge, M.D., J.D.
(deceased)
Deputy Commissioner of Health (representing the Commissioner of Health)

Joan Scerbo
Legislative Aide

The Hon. David Schwartz
Assemblyman - District 17

William I. Strasser, Esq.
Donohue, Donohue, Costenbader & Strasser

The Hon. Gary Stultragher
Assemblyman - District 3

Harris S. Vernick, M.D.
Internist

E. John Walzer, Esq.
Regulatory Officer, Dept. of Human Services (representing the Commissioner of Human Services)

The Hon. Karl Weidel
Assemblyman - District 23

Raymond Wolfinger, Esq.
Office of Legal and Regulatory Liaison (representing the Commissioner of Human Services)

Table 2
Staff

Robert S. Olick, M.A., J.D., served as **Executive Director** of the Bioethics Commission from Fall of 1989 to Fall of 1992. He also serves as a consultant to the Governor's Advisory Council on AIDS, and is a member of several institutional and professional ethics committees in New Jersey. Mr. Olick received his B.A. from Colgate University, his J.D. from the Duke University School of Law, and his M.A. in philosophy and bioethics from Georgetown University and the Kennedy Institute of Ethics. He joined the staff in August of 1987, and previously served as the Commission's Assistant Director. Mr. Olick has authored a number of publications in bioethics and is a frequent speaker on legal and ethical issues in health care. In the Fall of 1992, Mr. Olick will be joining the health care group of the Roseland law firm of Lowenstein, Sandler, Kohl, Fisher & Boylan.

Adrienne Asch, M.S., Ph.D., served as **Associate in Social Science and Policy** of the Bioethics Commission from Fall of 1987 to Summer of 1990. Her principal work was as Co-Project Director of the Task Force on New Reproductive Practices. Her work in bioethics is informed by her training and background in social work, social psychology, civil rights, and psychotherapy. She publishes frequently on issues in bioethics, including genetic screening, reproduction, and the meaning of disability for treatment decisionmaking. After receiving her doctorate in social psychology from Columbia University in 1992, she takes up her new position as Associate Professor at the Boston University School of Social Work.

Ellen B. Friedland, Esq., Consultant, an attorney in private practice in Montclair, New Jersey, has been a member of the staff since October 1988. Her primary responsibilities have been in the areas of new reproductive practices and decisionmaking for incompetent patients, including those who have not clearly expressed their preferences, and "Baby Doe" and *Grady* issues. Ms. Friedland serves as a consultant to the Governor's Advisory Council on AIDS, and she speaks frequently and has written several articles on bioethical topics. Prior to joining the Commission, Ms. Friedland was a partner at Berkowitz and Friedland. She received her B.A. from Brandeis University and her J.D. from Cardozo School of Law, Yeshiva University.

Anne Reichman Schiff, LL.B., LL.M., Associate in Law, joined the staff in February of 1988 and served as Co-Project Director of the Task Force on New Reproductive Practices until Summer of 1990. Ms. Reichman received her Masters degree in Law from Yale University, and her LL.B. and B.A. from Monash University in Australia. She is currently a doctoral candidate at Yale

Law School, writing in the area of reproductive technologies. She was a Bigelow Fellow and Lecturer in Law at the University of Chicago Law School. In the Fall of 1990 she assumed an appointment as Assistant Professor at the University of Pittsburgh Law School.

Eve Sundelson, Esq., Consultant, has served with the Bioethics Commission since September of 1988 in connection with its work on death and dying, principally with respect to institutional ethics committees. Ms. Sundelson serves as Co-Project Director of the Task Force on Institutional Ethics Committees. Formerly an attorney at Davis Polk & Wardwell in New York City, she is a graduate of Yale College (*summa cum laude*, Phi Beta Kappa) and Harvard Law School.

Sally M. Sutphen, Administrative Assistant, has served with the Commission since July of 1991. Ms. Sutphen is a graduate of The American University with a degree in Communications, Law, Economics and Government.

Michael Vollen, M.A., Associate Director (Administration and Public Affairs), was formerly associated with The New School in New York City as a member of the faculty and Associate Dean of both Undergraduate and Adult Education. Mr. Vollen, who joined the staff in November of 1987, was responsible for the general administration of the Commission, including budget preparation and oversight. Mr. Vollen served as the Commission's Public Information Officer and as Co-Project Director of the Task Force on Public and Professional Education. Mr. Vollen assumed an appointment as Assistant Dean of Academic Affairs at Hudson County Community College in June of 1992.

Table 2 (a)

Former Staff

EXECUTIVE DIRECTOR

The Commission's first Executive Director, **Constance A. Myers**, served from April of 1986 to October of 1986. Ms. Myers was formerly an aide to Assemblyman Weidel, an early member of the Commission.

Herbert Hinkle, Esq., a former official in the New Jersey Public Advocate's Office, and a practicing attorney in Lawrenceville, served as Interim Acting Director of the Commission from November of 1986 until February of 1987.

Alan J. Weisbard, Esq., is a professor at the Law and Medical Schools of the University of Wisconsin, Madison. Formerly Associate Professor of Law at Benjamin N. Cardozo School of Law, Yeshiva University, he served as Executive Director of the Commission from July 1, 1987 through February 1, 1990.

STAFF

Janice M. Chiantese, legislative aide to Assemblyman Paul Kramer, served as the Commission's Executive Administrative Assistant (1986-1989), and as Director of Government Relations (1990).

Donna Horak Mitsock, a doctoral candidate at Georgetown University's Kennedy Institute of Ethics, served as Associate in Ethics from September of 1986 through October of 1987.

Elizabeth Manousos, served as the Commission's secretary from September of 1988 through August of 1990.

Jessica Raymond, served as the Commission's secretary from September of 1987 through July of 1989.

Theresa San Juan, served as the Commission's part-time secretary from September of 1989 through March of 1990.

Sarah Jo Sarchett, served as the Commission's part-time administrative assistant from March of 1992 through May of 1992.

Tracy Daub, served as the Commission's part-time administrative assistant from June of 1992 through July of 1992.

Table 2 (b)

Student Interns

Moshe Levy Yale University	June - July, 1989
Brenda Mears Rutgers Law School, Camden	September, 1989 - May, 1990
Daniel Newman Brown University	January, 1990 - February, 1990
Krista Robbins George Washington University	June - September, 1988 and 1989
Scott Styles Princeton University	September - December, 1989
Allison Gotsch Drew University	July - August, 1990
Andrew Dennis Clark University	June - August, 1991

Table 3

Members of the Task Force on New Reproductive Practices

Commissioners

Paul W. Armstrong, M.A., J.D., LL.M.
(Chair: September, 1989 to Present)
(Member: March, 1988 to Present)

Sr. Jane Frances Brady
(March, 1988 to Present)

The Hon. Stephanie R. Bush, Esq.
(March, 1988 to December, 1991)

Rev. Robert E. Harahan, M.A., S.T.D., S.T.L.
(March, 1988 to December, 1988)

Mary K. Lindner, R.N., M.A.
(March, 1988 to Present)

Non-Commissioners

Emily Arnow Alman, J.D., Ph.D.
(March, 1988 to Present)

David Brodzinsky, Ph.D.
(March, 1988 to February, 1989)

Mary Gibson, Ph.D.
(March, 1988 to Present)

Michael Grossman, D.O.
(March, 1988 to Present)

Mary Sue Henifin, J.D., M.P.H.
(March, 1988 to Present)

Marcia Potter Katz
(March, 1988 to February, 1989)

Ruth Macklin, Ph.D.
(March, 1988 to Present)

Artist Lesley Parker, Ph.D.
(March, 1988 to August, 1989)

Steven E. Perkel, Ph.D.
(March, 1988 to January, 1989)

The Hon. Linda Rosenzweig, J.S.C.
(March, 1988 to September, 1989)
(former Commissioner and Task Force Chair, March, 1988 to September, 1989)

Lee Silver, Ph.D.
(March, 1988 to Present)

Nelson S. T. Thayer, Th.D.
(March, 1988 to May, 1989)

Gerson Weiss, M.D.
(March, 1988 to Present)

Cecilia Zalkind, M.A., J.D.
(March, 1988 to Present)

Advisor
Jay Katz, M.D.
(March, 1988 to Present)

Table 3 (a)

Task Force On New Reproductive Practices
Non-Commissioner Members

Emily Arnow Alman, J.D., Ph.D., is both an attorney, specializing in family law, and a sociologist. She is a member of the New Jersey Task Force on Gender Bias in the Courts, the Middlesex County Bar Association's Matrimonial and Women's Committees, and the Board of Middlesex County Legal Services. She is also Professor Emeritus of Sociology at Rutgers University. Dr. Alman received her J.D. from Rutgers Law School, her Ph.D. and M.A. from the New School for Social Research, and a B.A. from Hunter College. She has also produced several films, one of which won First Prize at the American Film Festival in 1984.

Mary Gibson, Ph.D., is Associate Professor of Philosophy at Rutgers University. A member of the American Philosophical Association, the Society for Philosophy and Public Affairs, and the Institute for Research on Women, Dr. Gibson's areas of special interest include social and political philosophy, philosophy and public policy, and philosophical issues in feminism. She has published articles on such contemporary issues as workers' rights, the link between morality and rationality, autonomy, informed consent, and risk. She received her B.A. from Hunter College and her Ph.D. from Princeton University.

Michael B. Grossman, D.O., is President of the New Jersey State Board of Medical Examiners and Associate Professor of Clinical Obstetrics and Gynecology at the UMDNJ School of Osteopathic Medicine in Camden. He also serves as Medical Director of the Ambulatory Care Center at Kennedy Memorial Hospital-UMC in Stratford, New Jersey. Dr. Grossman received his B.A. from Rutgers University and his D.O. from the Philadelphia College of Osteopathic Medicine.

Mary Sue Henifin, J.D., M.P.H., is an attorney with special interests in public health and women's rights. She received her B.A. in Biology from Harvard, M.P.H. in Environmental Science from Columbia University's School of Public Health, and J.D. from Rutgers University School of Law (where she is now an Adjunct Professor). Currently Deputy Attorney General, Environmental Prosecutions Task Force, New Jersey Division of Criminal Justice, Ms. Henifin is a member of the Project on Reproductive Laws for the 1990s of the Rutgers University Institute for Research on Women, and has published widely on reproductive and environmental health issues.

Ruth Macklin, Ph.D., is Professor of Bioethics in the Department of Epidemiology and Social Medicine at Albert Einstein College of Medicine in New York. Previously associate for behavioral studies at the Hastings Center, Dr. Macklin lectures widely on biomedical ethics, has served as a consultant to local and federal government agencies, and has authored numerous leading books and articles in the field of bioethics. She received her B.A. from Cornell University and was awarded a Masters and Ph.D. from Case Western Reserve University.

The Hon. Linda Rosenzweig, J.S.C., is a judge of the Superior Court, Camden County. She previously served as Camden County Counsel. Formerly the Public Advocate's representative on the Bioethics Commission, she served as the first Chair of the Task Force on New Reproductive Practices. Ms. Rozenzweig was the Director of the Divison of Mental Health Advocacy and a member of both the Supreme Court Task Force on Mental Commitments and the Insanity Defense Study Commission. A graduate of Rutgers Law School, she has served as panelist for numerous programs on the rights of mentally ill persons.

Lee Silver, Ph.D., is Associate Professor of Molecular Biology at Princeton University. He is co-organizer of a Policy Task Force on "Reproductive Technologies and Human Embryo Manipulation" being conducted at the Woodrow Wilson School of Public and International Affairs. He is also Associate Editor of the *Journal of Heredity*. Dr. Silver received his B.A. and M.S. in Physics from the University of Pennsylvania, and his doctorate in biophysics from Harvard University.

Gerson Weiss, M.D., is Professor and Chairman of the Department of Obstetrics and Gynecology at UMDNJ-New Jersey Medical School, Newark. He is also Chief of Service of the Department of Obstetrics and Gynecology at UMDNJ-University Hospital in Newark. He received his B.A. from New York University and his M.D. from New York University School of Medicine. His field of special expertise is reproductive endocrinology.

Cecilia Zalkind, M.A., J.D., is the Assistant Director of the Association for Children of New Jersey, Newark. She specializes in advocacy and legislation for child welfare, emphasizing foster care and adoption issues. She received her B.A. and M.A. from New York University and her J.D. from Rutgers University Law School. She has published articles on child welfare, including a training manual for pro bono attorneys.

Jay Katz, M.D. (Advisor), is the John A. Garver Professor of Law and Psychoanalysis at Yale Law School and one of the nation's leading scholars on informed consent, human experimentation, and law and psychiatry. The author of many leading works on law and medicine, Dr. Katz is a member of the

National Academy of Science's Institute of Medicine, and has served as a consultant to numerous national commissions. A graduate of Harvard Medical School, he is a training and supervising psychoanalyst at the Western New England Institute for Psychoanalysis. Dr. Katz has been developing teaching materials for his law school course on Reproductive Technologies.

Table 4

Meetings of the Task Force on New Reproductive Practices

1988

March 16, 1988
April 27, 1988
May 11, 1988 (Public Hearing)
June 1, 1988
June 22, 1988
September 7, 1988
October 5, 1988
October 19, 1988
November 2, 1988
December 7, 1988

1989

January 25, 1989
March 1, 1989
April 5, 1989
May 3, 1989
June 7, 1989
June 28, 1989

1990

April 4, 1990
May 3, 1990

Joint Meetings of the Task Force on New Reproductive Practices and the New Jersey Bioethics Commission

July 20, 1988
July 11, 1989
July 18, 1990
August 14, 1990
November 7, 1990

Table 5

Consultants and Invited Speakers

The Bioethics Commission has employed several outside experts as consultants for specific projects. In addition, the Commission has frequently invited guest speakers from around the country to address the Commission on particular issues relevant to its work. The Commission has been fortunate to have had several distinguished consultants and speakers who assisted the Commission and Task Force in their work on New Reproductive Practices.

Consultants

Susan Frelich Appleton, Esq.
Washington University
St. Louis, Missouri

Walter P. Loughlin, Esq.
Rutgers School of Law
Newark, New Jersey

Morton Winston, Ph.D.
Trenton State College
Trenton, N.J.

Invited Speakers

Jay Katz, M.D.
Yale Law School

David H. Smith, Ph.D.
Indiana University

Michael Walzer, Ph.D.
Princeton University

Table 6

Public Hearing Witnesses
May 11, 1988
Newark Museum

Gary Skoloff, Esq., member of the law firm of Skoloff and Wolfe

Lorraine Abraham, Esq.

Harold Cassidy, Esq., member of the law firm of Cassidy, Despo, Foss and San Filippo

Professor Nadine Taub, Professor of Law, Rutgers Law School, Newark

Dr. Elizabeth Aigen, founder and director of the Surrogate Mother Program, New York

Jerrold Kaminsky, Esq.

Kathryn Quick, Resolve, Central New Jersey

Candace Mueller, New Jersey Committee for Adoption

Phyllis Chesler, Associate Professor of Psychology, College of Staten Island, City University of New York

R. Alta Charo, Esq., Office of Technology Assessment, Washington, D.C.

Bernice Davis, Director of One Church, One Child of New Jersey

Rabbi Edward Feld, Chaplain, Princeton University Hillel Society

Reverend Elizabeth Maxwell, St. Matthew's Church, Paramus, New Jersey

Allison Ward, Concerned United Birth Parents

Patricia Coyle, New Jersey Right to Life Committee

New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care

Publications

- *After Baby M: The Legal, Ethical and Social Dimensions of Surrogacy.* September 1992.
- *Death and the Brain-Damaged Patient.* June 1992. (Pamphlet).
- *The New Jersey Advance Directives for Health Care Act (and the Patient Self-Determination Act): A Guidebook for Health Care Professionals.* May 1992.
- *The New Jersey Advance Directives for Health Care and Declaration of Death Acts: Statutes, Commentaries and Analyses.* November 1991.
- *Advance Directives for Health Care: Planning Ahead for Important Health Care Decisions.* March 1991. Available in English and Spanish.
- *Problems and Approaches in Health Care Decisionmaking: The New Jersey Experience.* May 1990.

The New Jersey Bioethics Commission
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on Legal and Ethical Problems
in the Delivery of Health Care

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