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Surrogacy in the Context of Reproductive Rights

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Abstract: *The evolution of the medical technologies has also transformed the surrogate, from the traditional surrogate to the gestational surrogate, from the surrogate with the embryo of the infertile couple to the surrogate with embryos from donors or with embryos obtained from gametes taken from donors (surrogate mother or another person), from carrying a pregnancy by a woman of biological reproductive age and up to carrying a pregnancy by a woman past the reproductive age, all these stages or forms of surrogacy imply various debates in the medical, bioethical and, of course, human rights literature. As the forms of surrogacy diversified, the multitude of rights that had to be balanced (of the infertile couple, of the parents, of the surrogate mother, of the embryo in vitro or of the embryo transplanted into the uterus) were also increasingly difficult to quantify, to define as legal and to keep in a fair balance.*

Keywords: *surrogacy, reproductive rights, human rights.*

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Introduction

When discussing the legal nature of a possible right of infertile couples to benefit from access to surrogacy, from a human rights perspective, as shown above, it seems that there is no real controversy as to whether the right has an absolute relative character, since, as a derivative of the right to family, it is a relative right. What matters, from a practical perspective, is its positive or negative character.

On the one hand, if we were to consider it as a negative right, then the legal relations born of surrogacy could take place freely, in the absence of any interference by the state, which should only ensure that no arbitrary or illegal interference prevents the exercise of the right. The solution seems risky, because a quasi-total legislative vacuum, as observed in the practice of certain states, including Romania, can create the danger of the emergence of networks of exploitation and trafficking of surrogate mothers, camouflaged under the activity of apparently credible providers of reproductive services.

On the other hand, if we were to consider it a positive right, then it would imply an obligation on the part of the state to take measures, to undertake concrete actions to ensure the exercise of this right by all interested persons. The way in which the state could fulfill this role is mainly by providing financial support. At least at the present time, Romania does not seem to embrace the optics of a positive law, considering that no funds are released from the health insurance budget for IVF-ET programs with a surrogate mother or with gametes / embryos from donors.

In accordance with art. 45 para. 1 of Law no. 95/2006 on health reform, the national health programs are developed in order to prevent and fight the medical conditions with a major impact on the health of the population. By G.D. no. 1388/2010 on the approval of the national health programs for the years 2011 and 2012, chapter IV – "National programs regarding non-communicable diseases" -, point 5 – "National program for transplantation of organs, tissues and cells of human origin" -, the treatment of couple's infertility, as a national objective, took shape in subprogram 5.3. entitled "The sub-program of in vitro fertilization and embryo transfer".

Through this program, funding from the consolidated state budget is granted to infertile couples who wish to have children through medically assisted human reproduction techniques achieved through the in vitro fertilization, followed by embryo transfer. However, couples who wish to use surrogate mothers are excluded both by the government decision of 2010 and by all subsequent normative acts, up to the present time (similar provisions are found in G.D. no. 124/2013 regarding the approval of the

national health programs for the years 2013 and 2014, G.D. no. 206/2015 regarding the approval of the national health programs for the years 2015 and 2016, and G.D. no. 155/2017 regarding the approval of the national health programs for the years 2017 and 2018).

At international level, the same perspective is adopted, on the grounds that there is no obligation of the state to support infertile couples with financial resources, "the exercise of procreative rights can be significantly restricted by the economic and the social context" (Falasco, 2005). There is a big difference between invoking a right to reproduction in the context of a right to family by a person suffering from an illness that creates infertility and invoking a right to reproduction through technologies that make reproduction possible when it is biologically impossible, not because of a disease, but because of a lifestyle choice (postponing the time of conception until after the biological age of procreation, choosing a minority sexual orientation and so on).

Otherwise, the state would be required to take measures to restore the reproductive capacity of the individual who renounced this capacity by his own free choice and not imposed by external circumstances, which conflicts with other types of social rights, which in this context gain priority. Even the right of free access to medical services is not likely to change this conclusion, because the access to medical services must be guaranteed by the state, based on a positive obligation, for the treatment of diseases, not for the restoration of a biological capacity that has been voluntarily renounced to (Collins, 1994).

Rights in conflict – the surrogacy in terms of bioethics and bio law

In terms of bioethics, the debates on surrogacy are extensive and are organized around the ethical matrix for evaluating technologies in the medical field promoted by the authors Beauchamp and Childress (2019), according to which there are four great principles of bioethics, as we shall see.

1. The beneficence – which requires that any innovative medical technology be used for the purpose of doing good, i.e. to bring a benefit, an added good or to solve a medical issue of the technology recipient (Beauchamps & Childress, 2019). From the perspective of the beneficence, it is natural that the surrogacy allows infertile couples to have children, but the debate begins when the issue of dysfertility is raised, who are usually healthy people and who could conceive if their sex lifestyle or orientation would be different (more precisely, according to the biological imperatives of the

species, which require that the act of reproduction occurs between two individuals of the opposite sex).

In other words, where the right to medical treatment ends (so where there is no actual medical condition) the right to reproduction through the surrogate also ends. On one side it is believed that (Amato & Jacob, 2004) there is no obligation for states to recognize the right to reproduce through innovative medical technologies to people who, due to the choices they make, put themselves in the position of not conceiving.

On the other side, the supporters (Robertsonon, 2005) the position of the LGBTIQ community believe that there is a right to one's own sexual identity, to the choice of a partner, that the freedom of private life also includes these rights and, as long as they are recognized as such, there is no reason to limit the right to have a family by limiting the access to reproductive technologies to the members of this community. Practically, the right to private and family life cannot be fully exercised if the right to have genetically related children is not also recognized. To do otherwise would cause them great emotional harm. The access to surrogacy, viewed from this viewpoint, would therefore respect the rigors of the principle of beneficence.

2. The non-maleficence – this principle involves not harming, or more precisely, the fact that a technology must be used in such a way as not to cause harm to any human being (Beauchamps & Childress, 2019). It is believed that (Macklin & Delaney, 1991) the surrogacy produces the very evil that should be avoided by applying the non-maleficence to precisely the human beings who are conceived through this procedure. A number of statistical studies have shown that the children who were conceived by this method exhibited in a high enough percentage to be considered worrisome, as they suffered emotional and psychological trauma after learning about how they were brought into the world.

From another perspective, the contract of surrogacy is not just any contract, but it concerns the human body itself and the pregnancy is an invasive process for the woman's body. Being subjected to contractual obligations in the context of a pregnancy, when the object of the contract is the pregnancy itself, presupposes, in addition to the inconveniences inherent in a pregnancy, that the surrogate mother be subjected to a lifestyle led under a double monitoring: that of the medical team and that of the infertile couple (which can be extremely emotionally invasive and demanding).

The medical investigations to which the surrogate mother is subjected are more complex and invasive than in the case of a regular pregnancy; her lifestyle may be imposed by the demands of the infertile

couple or by their vision of how the surrogate mother should lead her life in the months of pregnancy, all of this under the umbrella of the desire to have a healthy child, and at the extreme opposite pole, there were even cases of contracts whereby the surrogate mother obliged to terminate the pregnancy at the request of the infertile couple (Patterson, 1996).

However, the most extensive discussion regarding the negative effects of the surrogacy is related to the fate of the surplus embryos left after the in vitro fertilization procedure and not transferred into the uterus. The debate brings into discussion aspects of vital importance regarding a possible right to life of the human being conceived in vitro, which will be the subject of the second part of this paper.

3. The autonomy - implies the right of the individuals with decision-making capacity to make these informed decisions, freely, based on informed consent (Olaru, 2005), in the case of RMA, to decide which technology to use to have a child and the risks they are willing to take against the benefits they can get from using the technology.

We will not enter into the debate concerning the risk-benefit balance in bioethics, as it exceeds the scope of this paper, but we will mention the fact that some authors see (Markens, 2007) the surrogacy as a way of manifesting the right to freely dispose of one's own body (so a manifestation of autonomy), while others (Raymond, 1990) believe that what is happening is exactly the opposite, more precisely that the surrogate implies an act of renouncing this right, in favor of the infertile couple, who, moreover, has interests contrary to those of the surrogate mother, not being interested in her well-being except within the limits that the child to be born will be healthy. From a feminist perspective, the surrogacy has been considered (Hewitson, 1997) to be a way of promoting the inequality between the genders, thus of the female exploitation, more precisely of the female reproductive capacity, and thereby it violates the principle of autonomy, because the surrogate attacks the very human dignity of the women who are used for this purpose.

4. The equity – involves the access to resources, meaning that the access to a technology must be provided equally to all the members of a society, without financially disadvantaging one social category or another. When the principle of equity is discussed, the discussion turns again towards the LGBTIQ community, those who oppose (Markens, 2007) ethically to recognizing the right of the members of this community to have children through surrogacy, opposing even more fervently when the discussion is translated into the health insurance plan and the financing of this practice from the state budget.

The argument is that their sexual choice makes it impossible for them to have children, and not some disease that medically induces infertility, therefore the society should not invest resources to facilitate their exercise of a right that they would very easily benefit from in a natural way, if they changed their lifestyle option. Another argument is that the society must prioritize the allocation of resources to truly ill people, not to healthy people who, thanks to the autonomous manifestation of a choice, have put themselves in the position of denying their access to certain aspects of life (practically, denying through the choice they made the right to a family that also includes genetic descendants).

An evolutionary perspective of surrogacy in the international jurisprudence

The first step towards the gestational surrogacy was made by the artificial production of the hormone estrogen, starting in 1936, in the USA (American Surrogacy, n.d.) a hormone without which the implantation of the embryo in the uterus (after its creation in vitro) would not be possible if the woman did not become pregnant naturally (since her body would not produce enough endogenous estrogen and then the pregnancy would end in a spontaneous abortion). The first successful in vitro fertilization took place in 1944 and it was carried out by a team of doctors from the Harvard University, under the leadership of Professor John Rock (American Surrogacy, n.d.). In 1953, the first successful cycle of cryopreservation and thawing of sperm was carried out (as a result of thawing, the sperm preserved its properties and the spermatozoa remained viable for egg fertilization) (American Surrogacy, n.d.)

These three moments had a paramount impact on the possibility of achieving gestational surrogacy, in the form known and practiced today. Although the first successful artificial insemination was reported by Dr. John Hunter as early as 1770 (he used a rudimentary process, given the lack of technology at the time, namely a syringe, to transfer the husband's sperm and achieve a viable pregnancy) (Worldwide Surrogacy, 2021), the artificial insemination became truly possible on a large scale and out of the experimental zone only after the appearance of the first sperm banks, around the 1970s, approximately 15 years after the time when sperm cryopreservation technology became available.

Later on, the practice of surrogacy experienced a much faster evolution; in 1976 the first surrogacy contract was drafted by lawyer Noel Keane (Worldwide Surrogacy, 2021), a contract under which the surrogate mother was remunerated for the costs of the medical procedures and those

inherent to the pregnancy, but she did not receive any financial bonus from the infertile couple. Also during the same period, the first successful cycle of IVF-TE (in vitro fertilization followed by embryo transfer) was recorded, by a team of doctors led by Professors Patrick Steptoe and Robert Edwards, for the couple Lesley and John Brown, who became famous in the annals of medicine because the pregnancy led to the birth, in 1978, of the world's first child conceived by in vitro fertilization (Worldwide Surrogacy, 2021), Luise Joy Brown (*nota bene*, in this case it was not about surrogacy, as the pregnancy was carried by the genetic mother of the child, the wife of the genetic father).

Two years later, in 1980, Elizabeth Kane becomes the first surrogate mother to receive a financial bonus (excluding the medical and pregnancy costs under a surrogacy contract) (Worldwide Surrogacy, 2021). The first birth as a result of gestational surrogacy was registered in 1985 (Patel et al., 2018). In a short while, only a year away, in 1986, the need to regulate relationships resulting from surrogacy was felt for the first time, with the registration of the first litigation between an infertile couple and the surrogate mother in the courts of New Jersey, USA, which became famous throughout the world known as the "Baby M case." (Supreme Court of New Jersey, 1988).

In brief, the surrogate mother (Mary Beth Whitehead) entered into a surrogacy contract with an infertile couple (William and Elizabeth Stern) whereby she agreed to be artificially inseminated with William Stern's sperm, with the surrogate providing the egg. According to the contract, on the date of the child's birth, she was to relinquish her maternal rights over the child in favor of the foster mother (Elizabeth Stern), and the biological father was to be listed on the child's birth certificate as the father.

However, after the birth, the surrogate mother listed her husband (as the father) and herself (as the mother) on the birth certificate. Her husband's paternity right was not contested at the time of the issuance of the birth certificate due to a presumption operating in American law (also provided for in Romanian law), according to which the mother's husband is considered to be the child's biological father . The surrogate mother's maternity rights were not challenged as she had provided the egg, so she was the child's genetic mother and also the biological mother, as she had carried the pregnancy and given birth to her own genetic child.

At first instance, it was decided the surrogacy contract be given effect and the custody was awarded to the Sterns. On the occasion of the trial of the appeal brought by the surrogate mother, the Supreme Court of the State of New Jersey considered the surrogacy contract absolutely null

and void, as it contravened the adoption legislation of that state, so the decision was not made on the basis of the contract, but in the basis of the existing principles regarding the granting of custody in case of divorce to one or the other of the biological parents. The biological father, William Stern, was awarded custody of the child, but his wife was denied any parental rights to that child.

The Baby M. case demonstrated the fragility of the relationship between the infertile couple and the surrogate mothers in the case of the traditional surrogacy. In its current sense, the traditional surrogacy is the practice whereby a woman carries the pregnancy for the infertile couple and she also provides the egg which is inseminated with the sperm of the man of the infertile couple or with the sperm of a donor. In other words, the modern traditional surrogate no longer considers the method of insemination of the surrogate mother (sexual intercourse or artificial insemination), but the genetic link she has with the child.

The gestational surrogacy is that form of surrogacy in which the surrogate mother has no genetic connection with the child, the embryo that is transferred to her uterus being created with gametes from the infertile couple or some donors. The Baby M. case created a general reluctance towards traditional surrogacy, due to the legal complications involved in the genetic link between the surrogate mother and the child, currently being preferred to gestational surrogacy and only rarely to traditional surrogacy.

However, even the gestational surrogate was not slow to raise its own legal issues, on the occasion of the trial, also in the USA, of the Johnson v. Calvert case (California Court of Appeal, 1990) , which started just four years after the Baby M. case, in 1990, and which is important regardless of the legal system we refer to, not only because it was the first such case in history, but also because it raised issues of principle common to any national legislative system. This time, the California state courts were approached. At that time, there was a legal principle operating in California and in the Romanian legislation - *mater semper certa est* taken over from the period of the Roman law, according to which the mother of a child is always certain and known, since it is invariably the woman who gives birth.

This principle comes from an era when the artificial insemination was technologically impossible, and the creation of an embryo outside the human body was inconceivable, much less the woman who would give birth to the child was not also the genetic mother of it (as approximately 2,000 years ago, the genetics was completely unknown to humanity). What Johnson v. Calvert did was to highlight the inadequacy of already existing legal principles governing the matter of parenthood which have been forced,

due to technological advances in the medical field, to be modified or, in other words, to be adapted to encompass the new realities.

The California Court of Appeals produced a major shift in legal principles when it awarded custody to the infertile couple, holding that to be considered the "natural" (or "biological") mother of a child, therefore the genetic element and the gestational element must not be identical. Since that time the terminology in the field of surrogacy has changed to encompass three different concepts for naming the mother (Velte, 2013):

1. the genetic mother – the person who provides the egg;

2. the biological mother – the person carrying the pregnancy (who may or may not be the genetic mother, if the egg with which the embryo was created comes from an egg donor);

3. the social mother – the woman who is part of the infertile couple and who will raise and educate the child (who may or may not be the child's genetic mother, as she herself or a donor provided the egg with which the embryo was created was implanted in the womb of the biological mother).

Likewise, in terms of paternity, the father of the child can be the genetic father or the social father. This leads to the separation of roles in the field of parenthood (traditionally, the parents are both genetic and social, as well as – in the case of women – biological). This has led some authors (Huidu, 2019) to state that the traditional principles of law are no longer applicable in the contemporary family law, and under the empire of genetic engineering, which makes the self-fertilization (the "self-reproduction") or the cloning possible and the traditional *mater semper certa est, pater incertus*, today becomes *mater incerta est, pater non est necessarium*.

Conclusions

The gestational surrogacy has become particularly widespread worldwide, with more than 18,000 children born this way in the US alone between 1999-2013, another 5,000 between 2004-2008, and currently the US reports approximately 750 children born annually by surrogate mothers. In 2008, Jacilyn Dalenberg became not only the oldest surrogate mother in history, giving birth to a healthy baby at the age of 56 (Patel et al., 2018), but this case brings with it new legal challenges because this surrogate mother carried the pregnancy for her own child, essentially giving birth to her grandchildren. In 2009, Ukraine adopts a law (Reznik & Yakushchenko, 2020), which was very permissive regarding the surrogacy, essentially allowing all forms of surrogacy, so that it becomes the pole of interest for international surrogacy, not only at the European level, but worldwide. The case of Ukraine opens other topics of debate, regarding the medical tourism

(Deech, 2003), a practice whereby couples who cannot conceive with the help of a surrogate in their own country, due to legislative prohibitions in that country, decide to move to a legally permissive country, where their child will be born, and to return later with that child in their own country where their parental rights, acquired in the state where the child was born, will be recognized, based on the laws of private international law.

Not only Ukraine opens up such possibilities, but also other states, such as the case of the US state of Nevada, which in 2019 passed a law (Nevada Surrogacy Insurance Bill AB 472, 2019) by which it compels insurance companies to grant postnatal leave benefits to surrogate mothers, even if they relinquish parental rights over the children. *Nota bene*, we are talking about the postnatal leave, which takes place during the time the biological mother recovers after giving birth, and it is not about the maternity leave, which is granted to social mothers, although they did not give birth to the child.

The medical tourism makes it imperative to establish a set of common principles, at an international level, according to which to assess the rights involved in surrogacy, their identification, their recognition, the establishment (clear and reasoned) of their limitations, as well as the positive and negative obligations of states in the field of surrogacy from a human rights perspective.

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