

REGULATING MARKETS FOR GESTATIONAL CARE: COMPARATIVE PERSPECTIVES ON SURROGACY IN THE UNITED STATES AND INDIA

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INTRODUCTION

Eighteen U.S. states and India, as well as at least forty other countries, have no legislation or case law that permits, prohibits, or regulates surrogacy.¹ This regulatory lacuna typically exists because of a failure to reach a consensus on legislation or sheer neglect of the issue. In jurisdictions where there is no regulation, a free market model prevails. Intended parents and surrogates negotiate contract terms based on their relative bargaining power and there are no statutes or common law that specifically address surrogacy in those jurisdictions.

In those eighteen U.S. states where state legislatures have not mandated certain protections for surrogates, the surrogacy industry has developed strong baseline protections for women who sell gestational care on its own accord. For example, industry norms require that intended par-

* I would like to thank everyone who participated in the Tel-Aviv University-Cornell colloquium in October 2017 in Ithaca, N.Y. for their comments. I am indebted to Bob Hillman, Eduardo Penalver, Bradley Wendel, Cynthia Bowman, and Bruce Hale for their close reading and insightful comments. I am grateful to Brad Lenox for his prompt and careful assistance with this Article.

¹ Sital Kalantry et al., *Should Compensated Surrogacy Be Permitted or Prohibited? Policy Report Evaluating the New York Child-Parent Security Act of 2017 that Would Permit Enforceable and Compensated Surrogacy*, available at: <https://cpb-us-e1.wpmucdn.com/blogs.cornell.edu/dist/2/7529/files/2017/05/Cornell-Report-273uhyk.pdf>.

ents pay for legal representation for surrogates, life insurance, and health insurance (unless the surrogate has her own health coverage). Like in the eighteen U.S. states, there is no regulation or protections imposed by legislation for surrogates in India. However, unlike in the United States, the Indian surrogacy industry has not provided similar basic protections for surrogates.

Both India and the United States are common law countries tracing their roots to British colonialism. Eighteen states in the United States and all of India lacks any legislation or common law specifically addressing surrogacy. Through a comparative study of gestational care markets in India and several of the eighteen U.S. states with unregulated surrogacy markets, I try to understand why the surrogacy industry in the United States has developed contract norms that are more protective of the surrogate than the surrogacy industry in India. This Article draws on interviews with lawyers, fertility specialists, surrogates, agents, and other actors involved in gestational care markets in India and the United States.² I argue that one of the main reasons that customary industry norms are more surrogate-protective in the United States than in India is because the shadow of the common law is darker and wider in the United States than in India.

In an important article, *Bargaining in the Shadow of the Law: The Case of Divorce*, Professors Robert H. Mnookin and Lewis Kornhausert pointed out that even when parties negotiate divorce settlements outside of court, the outcome that the common law impacts the negotiations of the parties.³ While Mnookin and Kornhausert's article focused on negotiations around dissolving contracts (namely, marriages), I extend their ideas to the contract formation stage. Their article was groundbreaking

² Eight Cornell Law students, Professor Bradley Wendel, and I travelled to New Delhi, India to (among other things) interview surrogates to understand their views on whether compensated surrogacy should be legal. We were working in collaboration with Professors Aparna Chandra and Mrinal Satish and eight students at the National Law University in Delhi. As part of the fieldwork, teams of four students visited medical clinics and interviewed doctors and surrogates, and also visited surrogacy homes. In total, we conducted nine semi-structured interviews of surrogates in New Delhi and Anand, Gujarat; each interview lasted approximately one hour. It should be noted that the surrogates we spoke to were referred to us by fertility and surrogacy medical professionals, and some interviews took place in surrogacy homes. Thus, there is likely sample bias. Nor are the interviews representative of all surrogates. In the United States, four students interviewed nine surrogacy lawyers in different American states. The interviews cited here were conducted by students supervised by an instructor, and other students took notes at the interview and all interviewees reviewed and revised the notes after the interview. Additionally, the questions for the interviews were developed in advance by the instructors and students. Cornell Law School, In "*Global Classroom, Students Study Surrogacy Law and Policy in India and the United States*," May 1, 2017, <http://www.law-school.cornell.edu/spotlights/In-Global-Classroom-Students-Study-Surrogacy-Law-and-Policy-in-India-and-the-United-States.cfm>.

³ Robert H. Mnookin & Lewis Kornhausert, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L.J. 950, 968 (1979).

because it observed the ways in which common law rules created by family courts influenced the negotiation positions and the substantive terms agreed to by the divorcing parties.

The comparative study of the legal regimes in India and the United States further contributes to the shadow of the law theory by suggesting that a prerequisite condition is necessary for the common law to create a shadow under which private parties bargain fairly. For common law rules to create a legal shadow or to inform private bargaining, courts must be both accessible to injured parties and the timeframe for adjudication of cases must be reasonably fast.

Industry actors in the United States negotiate surrogacy contracts within the “shadow of the law” while industry actors in India do not do so to the same extent. This occurs because American courts are more accessible to American surrogates than Indian courts are to Indian surrogates. Judgments are also generally rendered faster by courts in the United States than in India. On the other hand, in India, due to laws prohibiting contingent fees (among other things), there is limited access to courts for the poor women who become surrogates and the lengthy timeframe for adjudication makes court decisions less meaningful. It is for this and other reasons that the common law does not cast as dark or wide of a shadow over industry actors in India as it does in the United States.

There are also other factors that one might think also influences the development of more surrogate-protective norms in the United States and not in India. The substance of the law, particularly tort law, may be less favorable to plaintiffs in India as compared to similarly-situated plaintiffs in the United States. In the United States there are well-publicized cases where high tort awards have been granted to plaintiffs. Typically, Indian courts do not award high punitive damages. However, even if Indian courts awarded higher tort damages, that would still not constrain Indian surrogacy industry actors since they are aware that surrogates generally lack access to courts.

Another explanation for why the Indian surrogacy industry may not offer the same level of surrogate-protective norms than the surrogacy industry in the United States is the greater relative economic inequality, between surrogates in India and intended parents in India, on the one hand, and between surrogates and intended parents in the U.S., on the other hand. Interestingly, poor women in the United States are excluded from the gestational care markets by industry actors—many matching agencies refuse to consider applications from women below the Federal poverty line. This policy may itself be in response to the shadow of the common law. Industry actors might worry that surrogacy contracts with poor women are more likely to be invalidated by courts on grounds of

duress or unconcionability. Thus, the fact that poor women are not allowed to be surrogates in the United States is itself a consequence of the strong shadow of the law created by common law rules in the United States.

The findings of this Article have implications for surrogacy law and policy in India as well as other emerging gestational care markets around the world. Over the last decade transnational demand from same-sex couples and infertile people fueled robust gestational care markets in India. Reports of unfair treatment of surrogates soon emerged. Witnessing the abusive conditions faced by surrogates, Indian policymakers responded by banning transnational gestational care completely. In 2015, the executive denied visas to foreigners seeking gestational care. One year later, it proposed to prohibit women from receiving any compensation for providing gestational care. Similarly, Nepal, Thailand, Cambodia, and Mexico⁴ once had flourishing unregulated transnational gestational care markets, but have moved to ban compensated surrogacy rather than to legalize and regulate it.

Instead of prohibiting surrogacy completely, this Article suggests another policy response to protect surrogates. In countries where the common law does not cast a dark shadow (either because of its substance or because of the lack of access to courts), the government should permit but heavily regulate surrogacy by providing baseline levels of protections to surrogates. I outline a menu of regulatory options that countries can consider as they develop a regulatory framework based on their specific circumstances.

Within the spectrum of contract law, jurisdictions can allow for full freedom of contract or heavily regulate surrogacy contracts. In India, surrogacy contracts seem most similar to consumer contracts. In consumer contracts there is a problem with genuine consent, non-reading, and there is a vulnerable party on one side of the transaction. The legislative framework of many countries and some states in the United States already draw upon solutions proposed in consumer contract context with India to address concerns about surrogacy contracts. I suggest that

⁴ See, e.g., Rachel Abrams, *Nepal Bans Surrogacy, Leaving Couples With Few Low-Cost Options*, N.Y. TIMES May 2, 2016, <https://www.nytimes.com/2016/05/03/world/asia/nepal-bans-surrogacy-leaving-couples-with-few-low-cost-options.html>; National Health Policy 2071, pt. 12 cl. 14, 2014 (Nepal); Supreme Court of Nepal, Case 072-WO-0119 (2016); *New Thai Surrogacy Law Bans Foreigners*, SBS, Jul. 31, 2015, <http://www.sbs.com.au/news/article/2015/07/31/new-thai-surrogacy-law-bans-foreigners>; Child Born Out of Assisted Reproductive Technology Protection Act B.E. 2558 (Thai. 2015); Kuch Naren, *Prime Minister Warns Mothers Against Surrogacy in Midst of Ban*, CAMBODIA DAILY, Feb. 22, 2017, <https://www.cambodiadaily.com/morenews/prime-minister-warns-mothers-against-surrogacy-in-midst-of-ban-125583/>; Eleonara Lamm, *Mexico, in* INTERNATIONAL SURROGACY AGREEMENTS: LEGAL REGULATION AT THE INTERNATIONAL LEVEL 255, 255–56 (Katarina Trimmings & Paul Beaumont eds. 2013).

policymakers should more explicitly consider reforms proposed in the consumer contract context to address inequalities in the surrogacy contract.

I use the term “gestational care” to describe the services provided by surrogates. On the other hand, anti-commodification opponents of surrogacy use vocabulary that emphasizes a woman’s body parts and suggests that she lacks choice or agency. For example, commentators refer to the services surrogates provide as renting their wombs, particularly when speaking of women in the Global South.⁵

American surrogacy industry actors have also failed to develop a more positive label for the services a woman provides. Some American surrogacy contracts describe the payment received by the surrogate as compensation for “pain and suffering.”⁶ While clearly there is pain and suffering for many women during pregnancy and childbirth, the tort law terminology does not adequately capture the role surrogates play. Intended parents are not paying to cause a surrogate “pain and suffering”—rather they are paying for the nurturing she provides to the embryo and fetus. The reason the tort term is used relates to taxes. In the United States, damages for physical injuries are not taxed.⁷ Industry actors might use this tort terminology to perpetuate the idea that the surrogate should not have to pay taxes on the services she provides. Ultimately, tax-free surrogacy benefits both intended parents and matching entities since it allows them to pay surrogates less money. Thus, albeit for different reasons, both actors that are opposed to surrogacy and those that favor it, use terminology that devalues the surrogate and the work that she does.

I propose a term, “gestational care,” that imbues the surrogate with more agency and recognizes the role she plays. I use the word “care” to reflect the nurturing a surrogate provides to the embryo and fetus she carries. I use the word “gestational” because in ninety-five percent of surrogacy contracts in the United States (and probably more in India), women engage in gestational surrogacy. They have no genetic connec-

⁵ See Sonia Allan, *The Surrogate in Commercial Surrogacy: Legal and Ethical Considerations*, in *SURROGACY, LAW AND HUMAN RIGHTS* 113, 122 (Paula Gerber & Katie O’Byrne eds., 2015) (stating that women are seen as “empty vessels,” “walking wombs,” or “breeders”); Interview with Hemu Sahu, in India (Apr. 7, 2017) (explaining that some doctors analogize surrogacy to domestic work and question why we would describe surrogacy as “renting a womb” when we do not describe domestic work as “renting a hand”).

⁶ E.g. *SAMPLE GS CONTRACT*, http://www.allaboutsurrugacy.com/sample_contracts/GScontract1.htm (last visited Sep. 16, 2017).

⁷ 26 U.S.C. § 104(a) (2015) (“[G]ross income does not include . . . the amount of any damages (other than punitive damages) received (whether by suit or agreement and whether as lump sums or as periodic payments) on account of personal physical injuries or physical sickness”).

tion to the embryo.⁸ Using in vitro fertilization, the eggs of the intended mother are fertilized by the sperm of the intended father. In cases where the intended parents are a same-sex couple and/or where one or both of the intended parents is infertile, either the sperm or egg or both comes from a third party, but usually not from the surrogate. Some U.S. states permit only gestational surrogacy and explicitly prohibit genetic surrogacy.⁹

In Part I, I describe surrogacy law and policy as it currently stands in India and the United States. I demonstrate that surrogates in unregulated markets in the United States receive greater protections than surrogates in India where the market is also unregulated. In Part II, I ask what accounts for the disparate industry norms in two legal environments that both lack any legislation on surrogacy. I argue this occurs because industry actors in the United States operate in the shadow of common law, particularly contract and tort law, while industry actors in India do not change their behavior in light of the common law rules. Where common law casts a weak shadow or no shadow at all, policymakers should enact regulations to protect surrogates rather than ban surrogacy. In Part III, I examine the spectrum of contract law regulation and propose the consumer contract regulatory framework as another option for countries like India to consider when formulating legislation to regulate gestational care markets.

I. INDIAN AND AMERICAN GESTATIONAL CARE MARKETS AND REGULATION

In this section, I describe the regulatory environment and the industry standards in regard to surrogates in the U.S. and India. Both India and eighteen U.S. states have not enacted legislation or administrative rules that protect surrogates or that provide any regulations on actors in the industry. I demonstrate that in practice the industry norms and customary

⁸ Diane S. Hinson & Maureen McBrien, *Surrogacy Across America*, FAMILY ADVOCATE, Fall 2011, at 32, 33.

⁹ Kentucky prohibits traditional surrogacy but allows gestational surrogacy. See KY. REV. STAT. ANN. § 199.590(4); Louisiana prohibits traditional surrogacy and compensated gestational surrogacy, but does not explicitly prohibit uncompensated gestational surrogacy. See LA. STAT. ANN. 9:2719 (2016) (explicitly prohibiting traditional surrogacy); LA. STAT. ANN. 9:2720(c) (2016) (explicitly prohibiting compensated surrogacy); Maine prohibits a woman from entering into a gestational carrier agreement if she contributes gametes, unless she is a family member of the intended parents but otherwise prohibits gestational surrogacy contracts. See ME. STAT. tit. 19-A, § 1931(E) (2016); New Jersey allows for uncompensated gestational surrogacy. *A.H.W. v. G.H.B.*, 772 A.2d 948, 954 (N.J. Super. Ct. Ch. Div. 2000); *In re T.J.S.*, 54 A.3d 263, 280 (N.J. 2012); Traditional surrogacy is still prohibited because *Baby M* has never been overturned by case law or statute. *In re Baby M*, 537 A.2d 1227, 1264 (N.J. 1988); North Dakota allows gestational surrogacy. See N.D. CENT. CODE § 14-18-08 (2005); However, it prohibits traditional surrogacy, N.D. CENT. CODE § 14-18-05 (2005).

contractual provisions that have developed in the United States are much more protective of surrogates than those that have evolved in India.

A. *Gestational Care Markets and Regulation India*

The surrogacy market in India has flourished over the last few decades.¹⁰ Some estimates place the value of the Indian surrogacy market at over two billion dollars.¹¹ Gay male couples and infertile heterosexual couples flocked to India because their own countries prohibited surrogacy or because it was more cost-effective in India. India is an ideal host country for surrogacy—it has state-of-the-art medical tourism facilities, English-speaking medical professionals, and a relatively large supply of poor women willing to provide gestational care.¹² Surrogates are often women who do not speak English, live in slums, or are squatters.¹³ In a typical arrangement, both intended parents, if they are a fertile heterosexual couple, are biologically related to the child.¹⁴

Surrogacy activity in India occurs without any serious government monitoring or regulation. In 2005, the Indian Council of Medical Research (ICMR) issued guidelines on surrogacy.¹⁵ The ICMR is a body, funded by the Indian government, responsible for the formulation, coordination, and promotion of biomedical research.¹⁶ Many fertility clinics today follow the ICMR guidelines, but they are neither binding nor robust.¹⁷ Moreover, Witzleb and Chawla point out that the guidelines “lean too much towards protecting the interests of ART providers and prospective parents, leaving surrogate mothers vulnerable and open to exploitation.”¹⁸

¹⁰ The first Indian child to be born as a result of IVF treatments was born in 1978; by 2005, there were about 250 IVF clinics in India. INDIAN COUNCIL OF MEDICAL RESEARCH & NATIONAL ACADEMY OF MEDICAL SCIENCES, NATIONAL GUIDELINES FOR ACCREDITATION, SUPERVISION AND REGULATION OF ART CLINICS IN INDIA (2005), 4–5, http://icmr.nic.in/art/art_clinics.htm [hereinafter ICMR GUIDELINES]; Commercial surrogacy was legalized in India in 2002. Priya Shetty, *India's Unregulated Surrogacy Industry*, 380 LANCET 1633, 1633 (2012); There were approximately 3,000 IVF clinics by 2012. Nita Bhalla & Mansi Thapliyal, *Foreigners are Flocking to India to Rent Wombs and Grow Surrogate Babies*, BUSINESS INSIDER, Sept. 30, 2013, <http://www.businessinsider.com/india-surrogate-mother-industry-2013-9>.

¹¹ Shetty, *supra* note 10, at 1633.

¹² See Normann Witzleb & Anurag Chawla, *Surrogacy in India: Strong Demand, Weak Laws*, in SURROGACY, LAW AND HUMAN RIGHTS 167, 168 (Paula Gerber & Katie O’Byrne eds., 2015).

¹³ See Centre for Social Research, *Report of the National Conference on “A Police Dialogue on Issues around Surrogacy in India,”* 1, 14.

¹⁴ In some cases, there may be a sperm donor and/or egg donor.

¹⁵ Witzleb, *supra* note 12.

¹⁶ INDIAN COUNCIL OF MEDICAL RESEARCH, http://www.icmr.nic.in/About_Us/About_ICMR.html (last visited on December 1, 2017).

¹⁷ See ICMR GUIDELINES, *supra* note 10.

¹⁸ Witzleb, *supra* note 12, at 175.

The Indian government proposed legalizing and regulating surrogacy under three separate bills in 2008, 2010, and 2014, but none of them passed.¹⁹ In 2015, the Ministry of Home Affairs, in response to the Indian Supreme Court's order, started to deny foreigners visas for surrogacy purposes in November 2015.²⁰ The ban on transnational surrogacy significantly reduced demand, but intended parents in India continued to hire surrogates.²¹

The Surrogacy (Regulation) Bill of 2016 (the "2016 Bill")²² was the first legislation proposed to prohibit compensated surrogacy completely.²³ On the other hand, uncompensated surrogacy (commonly referred to as "altruistic surrogacy"), in which the intended parents pay only for costs such as medical expenses and insurance coverage would be allowed under the 2016 Bill.²⁴ Similarly, in Louisiana and Nebraska,²⁵ a surrogate who carries a child to term without compensation is bound to relinquish custody of the child. But if that same surrogate were

¹⁹ The Assisted Reproductive Technology (Regulation) Bill (India 2008), http://www.prsindia.org/uploads/media/vikas_doc/docs/1241500084~~DraftARTBill.pdf; The Assisted Reproductive Technology (Regulation) Bill (India 2010), <http://www.icmr.nic.in/guide/ART%20REGULATION%20Draft%20Bill1.pdf>; The Assisted Reproductive Technology (Regulation) Bill (India 2014), [www.prsindia.org/uploads/media/draft/Draft%20Assisted%20Reproductive%20Technology%20\(Regulation\)%20Bill,%202014.pdf](http://www.prsindia.org/uploads/media/draft/Draft%20Assisted%20Reproductive%20Technology%20(Regulation)%20Bill,%202014.pdf).

²⁰ Circular No. 462, Ministry of Home Affairs, Government of India (Nov. 3, 2015), available at <http://mha1.nic.in/pdfs/surrogacy03112015.pdf>; Hari G. Ramasubramanian, *Indian Government Hurriedly Notifies Stopping of Surrogacy for Foreign Nationals*, INDIAN SURROGACY L. CENTRE (Oct. 28, 2015), <http://blog.indiansurrogacylaw.com/indian-government-hurriedly-notifies-stopping-of-surrogacy-for-foreign-national/>; Previously, in January 2013, the Ministry of Home Affairs had prohibited foreign gay people and single people from availing of medical and gestational care. However, Indian single individuals and gay couples continue to be able to hire a surrogate. Madhavi Rajadhyakshal, *No Surrogacy Visa for Gay Foreigners*, TIMES OF INDIA, Jan. 18, 2013, <http://timesofindia.indiatimes.com/india/No-surrogacy-visa-for-gay-foreigners/articleshow/18066771.cms>; Gay Bollywood film producer, Karan Johar, recently made headlines for having twins from a surrogate. *Parenthood Through Surrogacy: Karan Johar Confirms Birth of Twins – Roohi and Yash*, INDIAN EXPRESS, Mar. 6, 2017, <http://indianexpress.com/article/india/parenthood-through-surrogacy-karan-johar-confirms-birth-of-twins-roohi-and-yash-4556163/>.

²¹ See Interview with Dr. Gupta, Gupta Clinic (April 6, 2017) (New Delhi, India).

²² The Surrogacy (Regulation) Bill, No. 257 (India 2016), available at http://164.100.47.4/BillsTexts/LSBillTexts/Asintroduced/257_LS_2016_Eng.pdf.

²³ *Id.* ch. VII, § 3.

²⁴ *Id.* ch. III, § 4(ii)(b); *id.* ch. I, § 2(b).

²⁵ LA. STAT. ANN. § 9:2720.13(B)(2) (2016) (a court, if necessary, shall "order[*d*] that the child be surrendered to the intended parents"); NEB. REV. STAT. § 25-21,200(1) (1988) (biological father of children born from surrogacy sole legal parent of resulting child); WASH. REV. CODE § 26.26.260 (1989) ("If a child is born to a surrogate mother pursuant to a surrogate parentage contract, and there is a dispute between the parties concerning custody of the child, the party having physical custody of the child may retain physical custody of the child until the superior court orders otherwise"); Michigan and New York also treat uncompensated surrogacy contracts differently than compensated surrogacy contracts. Both types of contracts are not enforceable, but actors involved in compensated surrogacy arrangements can face further criminal penalties. MICH. COMP. LAWS §§ 722.855–859 (1988); N.Y. DOM. REL. LAW § 122 (McKinney 2010).

paid for her services, a court in those states will refuse to enforce the contract.²⁶ Why is a woman who donates gestational care bound to give up the child, but a woman who is paid for it able to keep the child? This model reinforces stereotypes that women should engage in domestic work out of a sense of joy and generosity.²⁷

A standing committee of the Indian Parliament recently lambasted the 2016 Bill. They argued that compensated surrogacy, at least for Indian intended parents, should be regulated and legal.²⁸ The Cornell International Human Rights Clinic and the National Law University (Delhi) submitted a report to the standing committee, parts of which the committee incorporated into its report.²⁹ It remains to be seen whether the executive or Parliament will propose a revised bill or move forward with the existing bill to ban compensated surrogacy. In the meantime, with the regulatory lacunae, the private contracting model still prevails.

Indian medical professionals play a more significant role in the surrogacy process than their American counterparts. Many fertility specialists are involved in recruiting potential surrogates through agents and brokers (who are also sometimes former surrogates).³⁰ Once the surrogate is identified, some fertility specialists even hire intermediaries to manage homes in which pregnant surrogates are required to stay for a few days after the embryo transfer and during the later term of the pregnancy. Surrogates are sometimes required to remain in these homes for the duration of their pregnancies. In many of those residences, surrogates are not allowed to leave except under special circumstances. The residence may be far from their children and families. Doctors claim that requiring surrogates to live together in one place is the only way to ensure that women receive adequate nutrition, do not perform strenuous

²⁶ See, e.g., LA. STAT. ANN. 9:2720(C) (2016) (any contract for compensation “executed in the state of Louisiana or any other state shall be absolutely null and unenforceable in the state of Louisiana as contrary to public policy”).

²⁷ This legal model also rejects one of the key objections raised against surrogacy—that women cannot predict in advance whether or not they will be able to part with a child they give birth to. This also flies in the face of traditional contract law gift doctrine. This hybrid model creates puzzling questions, but it persists (in part) because of the discomfort society feels in placing a monetary value on gestational care.

²⁸ Parliament of India, Rajya Sabha, Department-Related Parliamentary Standing Committee on Health and Family Welfare, *One Hundred Second Report on The Surrogacy (Regulation) Bill, 2016*, available at <https://kalantry.lawschool.cornell.edu/files/2017/08/Indian-Parliament-Report-102-1qs7ole.pdf>.

²⁹ Sital Kalantry, *Indian Parliament Standing Committee Incorporates Views of Cornell International Human Rights Policy Advocacy Clinic*, CORNELL L. SCH., <https://kalantry.lawschool.cornell.edu/international-human-rights-policy-advocacy-clinic/past-projects-of-the-international-human-rights-clinic/indian-parliament-standing-committee-incorporates-views-of-cornell-international-human-rights-policy-advocacy-clinic/> (last visited Oct. 28, 2017).

³⁰ See Abby Rabinowitz, *The trouble with renting a womb*, GUARDIAN (Apr. 28, 2016), <https://www.theguardian.com/lifeandstyle/2016/apr/28/paying-for-baby-trouble-with-renting-womb-india>.

work that they are likely required to do in their homes, and generally ensure that the child will be healthy and carried to term.³¹

The same clinic often provides both the fertility treatment and the obstetric care to the surrogate. This creates a potential conflict of interest for the fertility doctors.³² In one clinic we interviewed, the doctors' fees from the intended parents was tied to the successful birth of the child.³³ This incentivizes fertility specialists to prioritize the desire of the intended parents to successfully deliver of a healthy child over the health and well-being of the surrogate (if there were a conflict between the two).

The ICMR provides a form surrogacy agreement where the great majority of the terms are obligations of the surrogate and also contains an acknowledgment by the surrogate of the medical procedures that she is undergoing, but there is no explanation of the risks involved.³⁴ Additionally, the guidelines do not mitigate the conflict of interest among doctors.³⁵ The two rights enumerated in favor of surrogates in the form contract are that the intended parent be tested for HIV/AIDS to minimize the risk of her becoming infected as a result of the embryo transfer and that the genetic parents are required to take custody of the child even if he or she has birth defects.³⁶

Despite the extensive role of fertility specialists in India in the surrogacy process, they are typically not parties to a surrogacy contract. The contracts are instead between the intended parents and the surrogate. The contract lawyers are hired by and represent the intended parents, and to the extent they interact with the surrogates, it is to explain to the surrogates their obligations under the contract.³⁷

In discussing surrogacy, the word "exploitation" is often used, particularly by opponents of surrogacy. The anti-commodification perspective holds that selling gestational care is inherently exploitative to the

³¹ See Interview with Dr. Manju Dagar (Apr. 5, 2017)(New Delhi, India); Interview with Sarita (Apr. 5, 2017) (New Delhi, India).

³² See Interview with Dr. Manju Dagar (Apr. 5, 2017) (New Delhi, India).

³³ See Interview with Surrogacy Agent, Gupta Clinic (Apr. 6, 2017) (noting that compensation is only 50% when surrogate miscarries) (New Delhi, India).

³⁴ See ICMR GUIDELINES, *supra* note 10, at 77–97.

³⁵ Foreign nationals and homosexual couples are not discussed whatsoever within the ICMR guidelines. The guidelines clearly contemplate that married couples would be the intending parents, but the guidelines explicitly allow single women to undergo ART treatment to have a child of her own. Moreover, the guidelines do not address the marital status of surrogate. See *Id.* at 1–76; Thus, India was known to be a viable option for basically anyone; the tightening of regulations in the surrogacy industry since 2012 has led to a smaller surrogacy market in India and an expanding market elsewhere, such as Nepal. Danielle Preiss & Pragati Shahi, *The Dwindling Options for Surrogacy Abroad*, ATLANTIC, May 31, 2016, <https://www.theatlantic.com/health/archive/2016/05/dwindling-options-for-surrogacy-abroad/484688/>.

³⁶ See ICMR GUIDELINES, *supra* note 10, at 92–93.

³⁷ See Interview with Apurva Agarwal (Apr. 5, 2017) (New Delhi, India).

surrogate.³⁸ Indeed, strong anti-commodification voices in India argue that surrogates exercise no real “choice” because they only become surrogates because of their poverty.³⁹ Some people in India focus on surrogacy as an example of the problems of the capitalist system more broadly. For example, the feminist group All India Democratic Women’s Association (AIDWA), which is the women’s wing of the Communist Party of India (Marxist), believes that compensated surrogacy should be banned because it exploits surrogates.⁴⁰

Some people also view surrogacy as commodification of the child. A debate also rages on about whether or not surrogacy is the sale of the child, but often technical arguments are made on both sides of the debate.⁴¹ When prohibitions on the sale of children were enacted, they did

³⁸ Deborah Zalesne, *The Intersection of Contract Law, Reproductive Technology, and the Market: Families in the Age of Art*, 51 U. Rich. L. Rev. 419–432 (2017) (describing as “anti-commodification,” the view that surrogacy could undermine the dignity of marriage, “denigrate] the emotional significance of home labor,” and “violate the norms of love that are supposed to govern marital relations” and motherhood).

³⁹ See Bindu Shajan Perappadan, *Surrogate mothers appeal to ICMR, seek ‘dignity,’* HINDU, Nov. 6, 2015, <http://www.thehindu.com/news/national/other-states/surrogate-mothers-appeal-to-icmr-seek-dignity/article7848219.ece>; Express Web Desk, *Cabinet approves bill to prohibit commercial surrogacy, Sushma Swaraj slams celebrities for misusing practice*, INDIAN EXPRESS, Aug. 25, 2016, <http://indianexpress.com/article/india/india-news-india/surrogacy-bill-2016-sushma-swaraj-slams-celebrities-for-misusing-practice/>; Petition of Jayashree Wad to Supreme Court of India (Nov. 29, 2016) (on file with author).

⁴⁰ See Indu Agnihotri, *Commercial Surrogacy and Assisted Reproductive Technologies: Some Issues*, ALL INDIA DEMOCRATIC WOMEN’S ASS’N, Oct. 20, 2008, <http://aidwonline.org/post/commercial-surrogacy-and-assisted-reproductive-technologies-some-issues>; see also Mohan Rao, *Why All Non-Altruistic Surrogacy Should Be Banned*, ECON. & POL. WKLY., May 26, 2012.

⁴¹ Framing the argument in contract law terms, one author argues that the surrogacy contract necessarily involves the sale of the child, because any breach of contract claim would ask that the child be handed over (specific performance) and not just for monetary damages. John Tobin, *To Prohibit or Permit: What is the (Human) Rights Response to the Practice of International Commercial Surrogacy?*, 63 INT’L COMP. L.Q. 317, 318 (2014); However, this doesn’t necessarily mean that the surrogacy contract involves the sale of a child—even in sales of unique artwork or other products, courts would grant specific performance and not just monetary damages. Richard A. Epstein, *Surrogacy: The Case for Full Contractual Enforcement*, 81 VA. L. REV. 2305, 2337 (1995) (“In cases involving the sale of land, which is generally regarded as ‘unique,’ and certain specialized goods, the remedy of specific performance is routinely awarded”).

Often responding in criminal law terms, pro-surrogacy advocates argue that surrogacy contracts do not involve the sale of a child because in the most common form of surrogacy today, gestational surrogacy, intended parents are gaining legal custody of the child that is genetically connected to them. Many courts in the United States grant what are called “pre-birth orders” that recognize the intended parents are the legal parents and that allow the names of both intended parents to appear on the birth certificate of the child. Thus, custody of the child is transferred even prior to birth. *E.g.*, CAL. FAM. CODE. § 7962(e) (West 2018) (“An action to establish the parent-child relationship between the intended parent or parents and the child as to a child conceived pursuant to an assisted reproduction agreement for gestational carriers may be filed before the child’s birth”); On the other hand, anti-surrogacy advocates argue that those who favor surrogacy are wrong because they make technical legal argu-

not account for surrogacy so arguing within the existing legal framework may not be useful.⁴² Jurisdictions who want to legalize surrogacy could create an exception for surrogacy under existing laws that otherwise prohibit the sale of children. Other authors make dignity-based arguments against the sale of gestational care.⁴³

I also suggest that the surrogates are exploited in India, but I focus on the problems surrogates face as they agree to become surrogates and issues they face during the pregnancy and childbirth. I frame these problems as procedural and substantive contract issues.

There are numerous procedural problems in the surrogacy contract formation process. First, some surrogates and agents told us that the contracts signed by the surrogates were not reviewed by anyone providing legal counsel to the surrogates.⁴⁴ Second, many surrogates did not know

ments or create legal fictions (like pre-birth orders) to characterize the transaction as not involving the sale of a child or arbitrarily drawing the line at conception. See David M. Smolin, *Surrogacy as the Sale of Children: Applying Lessons Learned from Adoption to the Regulation of the Surrogacy Industry's Global Marketing of Children*, 43 PEPP. L. REV. 265, 322–24 (2016).

⁴² Prohibitions on child sale exist (in part) to prevent people from selling their own children out of economic necessity. If we allowed selling and purchasing children, we can imagine a world where poor people sold one or more of their children to support themselves economically. I do not think we want a society where people sell children that they intended to raise because they cannot afford it. They can and should be able to give away their children through adoption.

⁴³ See, e.g., Yasmine Ergas, *Babies Without Borders: Human Rights, Human Dignity and the Regulation of International Commercial Surrogacy*, 27 EMORY INT'L L. REV. 117, 154 (2013); several European countries limit the sale of gestational care on this ground. They object to commoditizing gestational care, but this argument does not provide any explanation because it appears to be based on a moral position. I believe any discussion about whether or not surrogacy harms the dignity of women should consult the surrogates themselves. In the United States, there is no evidence that most surrogates feel their dignity is harmed by selling gestational care; rather, they feel they have been able to do something very meaningful. Helena Ragoné's interviews with twenty-eight American surrogates finds that surrogates feel they could play a useful role in the lives of others. She states that "women who chose to become surrogate mothers did so as a way to transcend the limitations of their domestic roles as wives, mothers, and homemakers while concomitantly attesting to the importance of those roles and to the satisfaction they derived from them." Helena Ragoné, *Chasing the Blood Tie: Surrogate Mothers, Adoptive Mothers and Fathers*, 23 AM. ETHNOLOGIST 2, 352, 357 (1996); See also Catherine London, *Advancing a Surrogate-Focused Model of Gestational Surrogacy Contracts*, 18 CARDOZO J.L. & GENDER 391, 392 (2012).

The surrogates we met in India were also happy to be providing gestational care. One surrogate we interviewed in India told us, "The thought of giving a child to someone else is incomparable, there is nothing else that makes me so happy. I also wanted to make money for my child's future. . . . I did not consider it to be bad. There is nothing better than what we are doing." Interview with Shanta and Kanta, April 7, 2017 (Anand, Gujarat). The correct focus of the dignity-based concerns should be the women who undertake the practice and in both the United States and India. There is no evidence that women feel that selling gestational care violates their sense of dignity.

⁴⁴ Interview with Sharda and Meera, April 3, 2017 (Anand, Gujarat). Even if they were provided with counsel, there is still a risk that the lawyers will not provide robust representation.

the content of their contracts.⁴⁵ One surrogate that we interviewed was unsure about her compensation amount, whether she was receiving any monthly payments, and how she would receive payment.⁴⁶ Another surrogate we spoke with told us that her contract had been in English, not Hindi, and that she could not read it.⁴⁷ Finally, several surrogates noted that the agent physically held all of the contracts and the women did not have copies.⁴⁸ Indeed, one of the agents we interviewed showed us a contract that stated explicitly that the surrogate would not be allowed to keep a copy.⁴⁹

There were also substantive fairness concerns about the actual terms included in and excluded from the contract. First, the majority of surrogates surveyed by the Center for Social Research were promised payment only for a successful pregnancy and were not compensated for undergoing medical procedures if no pregnancy resulted.⁵⁰ This practice occurs despite the fact that the ICMR form contract recommends that the surrogate receive five percent of the total compensation promised at the time of the embryo transfer.⁵¹ Second, only about twenty percent of the contracts reviewed by the Center for Social Research discussed compensation at all.⁵² Third, almost none of the contracts addressed whether medical care would be provided for the surrogate after the birth of the child.⁵³ Fourth, women did not have a say in how they would deliver the babies and told us that the prevailing method was Caesarean sections (C-sections).⁵⁴ Finally, if women die during the surrogacy process, there is no life insurance or other monetary compensation for their family.

Other abusive situations exist in the Indian surrogacy industry. Multiple surrogates are known to have been implanted with different embryos of the same intended parents, and if more than one surrogate becomes pregnant, some surrogates are given abortifacients, sometimes without their knowledge.⁵⁵ Those surrogates whose pregnancies are terminated likely receive no compensation at all.⁵⁶ In addition, many surrogates are not provided informed consent—they are not aware of the

45 RANJANA KUMARI, CENTRE FOR SOCIAL RESEARCH, SURROGATE MOTHERHOOD-ETHICAL OR COMMERCIAL, 63 (2013).

46 Interview with Maichili Devi, in New Delhi, India (Apr. 5, 2017).

47 *Id.*

48 Interview with Sharda and Meera (April 3, 2017) in Anand Gujrat.

49 Interview with Agent, Surrogacy Home, in Gurgaon, India (Apr. 5, 2017).

50 See KUMARI, *supra* note 45, at 70.

51 See ICMR GUIDELINES, *supra* note 10, at 84.

52 KUMARI, *supra* note 45, at 156.

53 See ICMR GUIDELINES, *supra* note 10, at 65.

54 Interview with Sharda and Meera (April 3, 2017) in Anand Gujrat.; Interview with Shanta and Kanta (April 3, 2017) in Anand Gujrat. .

55 In one study, less than 2.9% of those who had undergone abortions had been asked for their consent. KUMARI, *supra* note 45, at 61.

56 *Id.*

medical procedures they are undergoing or generally informed about the potential adverse consequences of the medications.⁵⁷

In many cases the surrogacy process goes as planned—the embryo transfer successfully leads to a pregnancy, surrogates give birth, surrogates receive compensation and do not face adverse health consequences. Some medical professionals view themselves as providing a public service.⁵⁸ They provide post-natal care even when they are not legally obligated to do so, and other doctors provide educational classes to surrogates that go beyond what is required by the contract.⁵⁹ But even in cases where everything goes as planned, the allocation of risk clearly reveals the failures in the contractual process.

B. *Gestational Care Markets and Regulation in the United States*

Feminist writing on surrogacy in the United States was arguably at its peak during the custody battle between Mary Beth Whitehead, a surrogate mother, and Richard Stern, the intended father, over a child known as Baby M. Some feminists argued that surrogacy would be one more way that poor and minority women would be exploited by rich and Caucasian people, like the fictional world of *The Handmaid's Tale*.⁶⁰ That dystopian novel was published in 1985, the year before the New

⁵⁷ See SAMA-RESOURCE GROUP FOR WOMEN AND HEALTH, *BIRTHING A MARKET: A STUDY ON COMMERCIAL SURROGACY* 64 (2012) (“Almost no information was provided to surrogates about the procedures nor about the techniques that they underwent, apparent from the lack of details and description about the medical procedures that they experienced”); Pinki Virani, *POLITICS OF THE WOMB: THE PERILS OF IVF, SURROGACY AND MODIFIED BABIES* (2016); see also Interview with Anand Grover (Apr. 3, 2017) in New Delhi, India (“Often they show documents stating that the woman consented. We must ask ourselves if documents are sufficient to establish informed consent”).

⁵⁸ See SAMA-RESOURCE GROUP FOR WOMEN AND HEALTH, *BIRTHING A MARKET: A STUDY ON COMMERCIAL SURROGACY* 64 (2012) (“Almost no information was provided to surrogates about the procedures nor about the techniques that they underwent, apparent from the lack of details and description about the medical procedures that they experienced”).

⁵⁹ See e.g., Dr. Nayana H. Patel, Medical Director of Akanksha Hospital & Research Institute in Anand, Gujarat, India, <http://ivf-surrogate.com/DrNayanaPatel>.

⁶⁰ See, e.g., Gena Corea, *THE MOTHER MACHINE: REPRODUCTIVE TECHNOLOGIES FROM ARTIFICIAL INSEMINATION TO ARTIFICIAL WOMBS* 213–49, 272–82 (1988); Lorillard, *supra* note 41, at 250; Mary Lyndon Shanley, “*Surrogate Mothering*” and *Women’s Freedom: A Critique of Contracts for Human Reproduction*, 18 *SIGNS: J. WOMEN CULTURE & SOC’Y* 618, 618 (1993); Martha A. Field, *SURROGATE MOTHERHOOD: THE LEGAL AND HUMAN ISSUES* (1988); Janice G. Raymond, *WOMEN AS WOMBS: REPRODUCTIVE TECHNOLOGIES AND THE BATTLE OVER WOMEN’S FREEDOM* (1993); Anita L. Allen, *The Socio-Economic Struggle for Equality: The Black Surrogate Mother*, 8 *HARV. BLACKLETTER J.* 17, 17 (1991); Christine L. Kerian, *Surrogacy: A Last Resort Alternative for Infertile Women or Commodification of Women’s Bodies and Children?*, 12 *WIS. WOMEN’S L.J.* 113, 163 (1997); New York banned surrogacy upon the recommendation of an influential commission, the New York Task Force on Life and the Law, whose report also noted concerns about this. See *NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, SURROGATE PARENTING: ANALYSIS AND RECOMMENDATIONS FOR PUBLIC POLICY* 85 (1988).

Jersey Supreme Court declared the surrogacy contract between Stern and Whitehead unenforceable.⁶¹

Similarly, other feminist commentators argued that women would never voluntarily choose to sell gestational care; they would only do so because of economic desperation.⁶² However, these fears have not materialized. Empirical studies of surrogates do not reveal that they are disproportionately minority or from poorer economic classes.⁶³ As further discussed below, this may be, in part, because matching entities exclude poor women from gestational care markets.

Today most American states have moved away from New Jersey's prohibitionist approach. The laws relevant to gestational care markets—tort, contract, and family law—are within the domain of state law. Of the fifty U.S. states, twenty-four recognize surrogacy contracts by statute or case law.⁶⁴ In New Jersey, the *Baby M* case still requires courts to invalidate compensated surrogacy contracts, but contracts where women receive reasonable living expenses are generally permissible.⁶⁵ In New Jersey and three other states that do not permit compensation for gestational care, the reasonable living expenses could be inflated to account for the sale of gestational care. On the other hand, four states specifically prohibit the enforcement of compensated surrogacy contracts.⁶⁶

Eighteen states have no legislation or administrative rules prohibiting or regulating surrogacy.⁶⁷ I focus on how surrogates fare in those gestational care markets since they are the closest analogue to the Indian regulatory environment (i.e., there is no legislation or administrative

⁶¹ Nadine Taub, *Surrogacy: Sorting Through the Alternatives*, 4 BERKELEY WOMEN'S L.J. 285, 288 (1989) ("Given the limited employment, educational and other options available to many women, it seems almost inevitable that the intended parents will have greater social and economic resources than the prospective birth mother. This imbalance can only increase as embryo transfer from one woman to another makes the use of women of color for gestation of white fetuses more likely").

⁶² See Lisa L. Behm, *Legal, Moral & International Perspectives on Surrogate Motherhood: The Call for a Uniform Regulatory Scheme in the United States*, 2 DEPAUL J. HEALTH CARE L. 557, 578 (1999); see also Glenda Labadie-Jackson, *The Reproductive Rights of Latinas and Commercial Surrogacy Contracts - English Translation*, 14 TEX. HISP. J.L. & POL'Y 49, 61 (2008); Kerian, *supra* note 60, at 160.

⁶³ Janice C. Ciccarelli & Linda J. Beckman, *Navigating Rough Waters: An Overview of Psychological Aspects of Surrogacy*, 61 J. SOC. ISSUES 21, 31 (2005).

⁶⁴ NEW YORK REPORT 2017 at 35 n.47.

⁶⁵ See *In re Baby M*, 537 A.2d 1227, 1241 (N.J. 1988).

⁶⁶ Arizona and Indiana will not enforce compensated surrogacy contracts or uncompensated surrogacy contracts. See ARIZ. REV. STAT. ANN. § 25-218 (2011) (stating that no person may enter into or assist in creating a surrogacy contract); IND. CODE § 31-20-1-1 (2006); Michigan and New York do not enforce any surrogacy contract and also impose criminal penalties. MICH. COMP. LAWS §§ 722.855-859 (1988) (making surrogacy contracts void and unenforceable and criminalizes surrogacy for compensation); N.Y. DOM. REL. LAW § 122 (McKinney 2010).

⁶⁷ See *supra* CREATIVE FAMILY CONNECTIONS.

rules about surrogacy). It should be noted that in some of the American states that have adopted legislation to legalize surrogacy, the statutes provide protections to surrogates. For example, legislation in Illinois requires that the surrogate have a health insurance policy that covers the pregnancy and post-partum period.⁶⁸

Generally, three sets of actors in the surrogacy process mediate the relationship between the intended parents and the surrogates—fertility specialists, matching entities, and surrogacy lawyers. Matching entities act as intermediaries connecting intended parents to surrogates.⁶⁹ However, surrogates and intended parents also self-match.⁷⁰

In the United States, unlike in India, fertility specialists do not typically recruit surrogates and connect them to intended parents, but rather provide only fertility treatment. Nevertheless, there is still a potential conflict of interest given that the intended parents typically pay for fertility services, but the surrogate is the patient of the fertility specialist.⁷¹ The voluntary association of reproductive specialists, the American Society of Reproductive Medicine (ASRM), has issued clear guidelines that state that the person undergoing the fertility treatment (i.e., the surrogate) is considered the patient, even if the intended parents are paying the bills.⁷² Notwithstanding these guidelines, however, some surrogacy lawyers still include express acknowledgements of this potential conflict in the agreement between the intended parents and the surrogate so that the surrogate is aware of it.⁷³

Once a pregnancy occurs, it is nearly always the surrogate who chooses the obstetrician that will monitor the pregnancy and provide prenatal care.⁷⁴ Surrogates also typically choose the hospital where the delivery occurs.⁷⁵ Because the providers of the fertility treatment and prenatal care are different and compensation is paid only for medical services, the risk for a conflict of interest for medical professionals is lower

⁶⁸ 750 ILL. COMP. STAT. §§ 47/20 (2005).

⁶⁹ Some examples of matching entities: Center for Surrogate Parenting, Inc., <http://www.creatingfamilies.com/>; Circle Surrogacy, <http://www.circlesurrogacy.com/>; Agency for Surrogacy Solutions, Inc., <https://www.surrogacysolutionsinc.com/>.

⁷⁰ Zsuzsa Berend, *The Romance of Surrogacy*, 27 Soc. F. 913, 920 (2012) (“Increasingly, there is self-matching between surrogates and [intended parents], and those who choose an agency are better informed and not infrequently have specific expectations and requests”).

⁷¹ Traditional surrogacy involves artificial insemination of sperm into the uterus and is less complicated than gestational surrogacy, but even then fertility specialists are likely to be involved. E-mail from Bruce Hale, surrogacy lawyer practicing in Massachusetts (Sept. 6, 2017) at 12.52 pm (on file with author).

⁷² See American Society for Reproductive Medicine & Society for Assisted Reproductive Technology, *Recommendations for practices utilizing gestational carriers: an ASRM Practice Committee guideline*, 97 FERTILITY & STERILITY 1301 (2012).

⁷³ E-mail from Surrogacy Lawyer in Massachusetts (Sept. 6, 2017) (on file with author).

⁷⁴ *Id.*

⁷⁵ *Id.*

in the United States than in India. In other words, the obstetrician can provide pre-natal care for the surrogate without considering the desires or needs of the intended parents in situations where those interests may conflict. For example, when the surrogate's health may be jeopardized by carrying the pregnancy to term.

Industry standards require that a surrogate be represented by a lawyer. The code of ethics of the American Academy of Assisted Reproductive Technology Attorneys, a voluntary organization of lawyers, states that lawyers can undertake legal representation in surrogacy contracts only when the surrogate has independent legal representation.⁷⁶ The ASRM guidelines on surrogacy also mandate that fertility specialists work with surrogates only if both the intended parents and surrogates have legal representation.⁷⁷ Finally, the websites of surrogacy matching agencies also state that the intended parents must pay for a surrogate's lawyers.⁷⁸

Matching entities vet women who want to become surrogates. They often provide compensation guidelines.⁷⁹ One agency that operates in two unregulated states—Oregon and Colorado—indicates on its website that intended parents must: (1) provide life insurance if the surrogates do not have it; (2) give monthly compensation to surrogates; (3) pay surrogates a fee at the time of the embryo transfer; (4) pay for a surrogate's medical and psychological screening; and (5) in some cases, pay for a surrogate's lost wages, childcare, and housekeeping.⁸⁰

We do not observe systematic problems in gestational care markets in the United States. Industry actors have developed customary norms and standards that provide basic rights and protections to surrogates. Industry standards require intended parents (among other things) to provide

⁷⁶ American Academy of Adoption Attorney & American Academy of Assistive Reproductive Attorneys, Academy Code of Ethics § 16(a) (“No Fellow may represent any Party in an ART Matter in which the Surrogate or Donor does not have legal representation, except in an uncontested Process to Establish Parentage in which no conflict of interest exists or is likely to arise among the Parties to that proceeding, or except where good faith efforts have been made to ensure such representation without success”).

⁷⁷ See American Society for Reproductive Medicine & Society for Assisted Reproductive Technology, *Recommendations for practices utilizing gestational carriers: a committee opinion*, 107 FERTILITY & STERILITY e3, e6 (2017).

⁷⁸ See, e.g., *Estimated Costs for Gestational Surrogacy with In Vitro Fertilization*, CENTER FOR SURROGATE PARENTING, <http://www.creatingfamilies.com/surrogacy/surrogacy-costs-gestational-surrogacy-in-vitro-fertilization.aspx> (last visited Dec. 2, 2017).

⁷⁹ See e.g., *Surrogacy Fees*, INTENDED PARENTS, <http://intendedparents.com/Fees.asp> (last visited Sept. 17, 2017); *Approximate Timeline of the Surrogacy Process for Surrogates*, ALL THINGS SURROGACY, <https://allthingsurrogacy.org/timeline-of-the-surrogacy-process/> (last visited Sept. 17, 2017).

⁸⁰ *Surrogate Compensation Oregon and Colorado*, NW SURROGACY CENTER, https://nw-surrogacycenter.com/pdf/NWSC_Surrogate_Compensation_OR_and_CO_030117.pdf (last visited Sept. 17, 2017).

life insurance to surrogates, to pay for independent legal representation for surrogates, and to pay increased costs for C-sections or other health complications.⁸¹

If there were systematic abuse of surrogates, anti-commodification opponents of surrogacy would likely draw attention to it. The Center for Bioethics and Culture is one of the most vocal opponents of surrogacy in the United States, yet it does not provide any information about systematic abuse of surrogates. By pointing to the experiences of some women, they argue that surrogates are harmed when they have to give up the child. However, psychological studies of surrogates do not support the argument that surrogates suffer trauma from the separation with the child.⁸² The Center also argues that surrogates are paid very little for their work. According to that organization, taking into account every hour of the pregnancy, a surrogate is paid about \$3.00 per hour of gestational care.⁸³ This suggests that the rates set by matching entities for gestational care may be too low and should be increased, but not necessarily that surrogacy should be banned completely.

I do not mean to suggest that there are no problematic situations in the gestational care markets in the United States. Pregnancy is inherently risky. Women have died while working as surrogates.⁸⁴ In Oregon, an agency defrauded intended parents and surrogates of money.⁸⁵ An American-based surrogacy agent was recently sentenced to jail for defrauding intended parents.⁸⁶

⁸¹ NEW YORK REPORT, *supra* note 64, at 15–17.

⁸² One study of twenty-four surrogates in the United Kingdom found that none had trouble relinquishing the child and many handed the child over immediately. The author concludes the surrogates showed no evidence of psychopathology. Olga van den Akker, *Genetic and gestational surrogate mothers' experience of surrogacy*, 21 J. REPROD. & INFANT PSYCHOL. 145, 152 (2003); Another recent study that surveyed surrogates ten years after they gave birth also found that they scored within the normal-range for self-esteem and did not show signs of depression according to the Beck Depression Inventory. None expressed regrets about surrogacy. V. Jadva, S. Imrie, & S. Golombok, *Surrogate mothers 10 years on: a longitudinal study of psychological well-being and relationships with the parents and child*, 30 HUM. REPROD. 373, 376 (2015).

⁸³ *Surrogacy*, CENTER FOR BIOETHICS & CULTURE NETWORK, <http://www.cbc-network.org/issues/making-life/surrogacy/> (last visited Sept. 17, 2017).

⁸⁴ *E.g.*, Mirah Riben, *American Surrogate Death: NOT the First*, HUFFINGTON POST, Oct. 15, 2015, http://www.huffingtonpost.com/mirah-riben/american-surrogate-death-_b_8298930.html.

⁸⁵ See Telephone Interview with Oregon Lawyer, March 2017, Ithaca N.Y. (“Thus now I make sure there is independent escrow”).

⁸⁶ *Surrogacy agency founder gets prison for exploiting desperate parents*, FOX 5 SAN DIEGO, Aug. 7, 2017, <http://fox5sandiego.com/2017/08/07/surrogacy-agency-founder-gets-prison-for-exploiting-desperate-parents/>.

II. COMPARATIVE PERSPECTIVES ON GESTATIONAL CARE MARKETS

As mentioned above, in India and eighteen U.S. states, a private contract model free of any legislative or administrative regulation prevails for the sale and purchase of gestational care. Yet there are significantly different customary practices in the gestational care markets in India and the United States. The customary norms in the United States are more surrogate-protective than those in India. In this section, I argue that the legal context of India and the United States helps to explain these differing outcomes.

First, in the United States (both in unregulated and regulated states), industry actors, medical doctors, matching entities, and lawyers operate in an environment where they have good reason to believe that a surrogate could sue them for malpractice or sue intended parents to invalidate the surrogacy contract. American legal practice permits contingent fees, and as a result tort lawyers may be willing to represent surrogates and intended parents with no upfront cost to the surrogate. The ability of surrogates to access courts and the perception of industry actors that surrogates can access courts helps explain why the industry developed substantively fairer contract terms and a procedurally fairer contract formation process than exists in India. Time frames for adjudication are relatively speedy—it takes approximately one year for a lower court to reach a decision.⁸⁷ Moreover, voluntary organizations of surrogacy industry professionals, including surrogacy lawyers and fertility doctors, have developed surrogate-protective norms and certain ethical standards. Lawyers and doctors who are part of the industry may be motivated by a sense of justice and fairness, but are also concerned about their own liability when they develop standards of care.

Second, industry actors, particularly medical professionals, are concerned not only about the prospect of being sued, but are also worried about large damages awards. Indeed, American courts are known to award significant punitive damages.⁸⁸ Professor Eisenberg has noted that the perception about the number of cases and the amount of punitive damages awarded exceed what actually happens in practice.⁸⁹ In addition, doctors are incentivized to comply with the surrogate-protective ASRM guidelines since doing so would strengthen their argument that they have met their standard of care in a tort suit against them. Thus, in

⁸⁷ Mattia Landoni, *Justice Delayed. . . An Overview of the Options to Speed Up Federal Justice*, 18 J. PUB. & INT'L AFFAIRS 127, 127 (2007).

⁸⁸ See W. Kip Viscusi, *The Blockbuster Punitive Damages Awards*, HARV. L. SCH., April 2004, at 1–4 (analyzing 64 punitive damages awards of at least \$100 million).

⁸⁹ See, e.g., Theodore Eisenberg et al., *The Predictability of Punitive Damages*, 26 J. LEGAL STUD. 623, 623 (1997).

an effort to avoid lawsuits and large tort damages, fertility doctors are likely to follow industry guidelines and standards.

Lawyers as well as doctors are likely worried about malpractice lawsuits. According to a lawyer who practices in a state that regulates surrogacy through legislation, agencies and lawyers take extra precautions when dealing with surrogacies as they are concerned about lawsuits against themselves.⁹⁰ Both agencies and lawyers tend to go beyond their state's legal requirements for surrogacy contracts and representation. Similarly, in unregulated states, it is likely that industry actors create industry norms and standards that are well within the shadow of the common law.

Third, industry actors in the United States may also create surrogate-protective norms because they worry that courts will invalidate unfair surrogacy contracts using policing doctrines such as duress and unconscionability. With the *Baby M* case looming in the background, lawyers that represent intended parents and matching agencies will likely advise their clients not to include extremely unfair contract provisions to ensure procedural fairness in the process. If a surrogate brings a lawsuit against the intended parents, a court might invalidate a surrogacy contract altogether if it finds it to be procedurally or substantively unfair.

In India, on the other hand, industry actors do not operate in a similarly litigious environment. While litigation rates are increasing in India as the economy grows, the per capita litigation rate is still relatively low.⁹¹ First, access to the justice system in India is much more difficult for poor surrogates. This is, in part, because lawyers in India cannot base their fees on the outcome of the litigation. The Bar Council of India, the body that regulates lawyers, prohibits lawyers from taking contingent fees.⁹² This essentially means that poor people who cannot afford lawyers' fees will never be able to bring a lawsuit. Even if a surrogate were to sue, the resolution of the case could take so long that defendants would not have an imminent fear of liability, and lengthy time frames for

⁹⁰ See Telephone Interview with Delaware Lawyer from Ithaca, N.Y. (Mar. 29, 2017).

⁹¹ See Sital Kalantry, Theodore Eisenberg & Nick Robinson, *Litigation as a Measure of Well-Being*, 62 DEPAUL L. REV. 247, 248 (2013) (“[M]ore prosperous Indian states have, for decades, had higher litigation rates than less prosperous states”); Marc Galanter & Jayanth K. Krishnan, “*Bread for the Poor*”: *Access to Justice and the Rights of the Needy in India*, 55 HASTINGS L.J. 789, 789–90 n.1 (2004) (“India is among the lowest in the world in per capita use of civil courts. . . . Maharashtra, one of India’s most industrialized states . . . ranked thirty-second of [] thirty-five jurisdictions with an annual per capita rate of 3.5 filings per 1000 persons”).

⁹² Bar Council of India Rules: Part VI, Chapter II, Section II, Rule 20 (“An advocate shall not stipulate for a fee contingent on the results of litigation or agree to share the proceeds thereof”).

adjudication further deter those who would otherwise sue.⁹³ In an empirical study of five years of Indian Supreme Court cases, my co-authors and I found that an average of thirteen years passes from the time a case is brought in a trial court to the time the Supreme Court issues a judgment.⁹⁴ For lower court decisions, more than 22.8 percent of all cases before subordinate courts were more than five years old in 2015.⁹⁵

Second, not only are medical professionals not overly concerned about being sued, they also do not face the possibility of any meaningfully large monetary judgment against them if they are sued. Indian courts historically do not award high punitive damage awards.⁹⁶ Any medical negligence claim must instead be brought to consumer protection courts pursuant to the consumer protection act.⁹⁷ In addition, there is no agency similar to the ASRM among Indian fertility doctors that promulgates ethical guidelines.⁹⁸ As discussed above, the guidelines set by the ICMR, a governmental body, provides little protection for surrogates.

Third, while both Indian and American common law have policing doctrines (such as duress and unconscionability) and substantially similar legal tests for negligence, the lack of access to the courts and lengthy

⁹³ See Rukmini S., 'District courts will take 10 years to clear cases,' HINDU, Sept. 27, 2015, <http://www.thehindu.com/data/district-courts-will-take-10-years-to-clear-cases/article7692850.ece>.

⁹⁴ APARNA CHANDRA, WILLIAM HUBBARD, & SITAL KALANTRY, EMPIRICAL ANALYSIS OF INDIAN SUPREME COURT DECISIONS FROM 2010 TO 2014 (Gerry Rosenberg & Sudhir Krishnaswamy eds.) (forthcoming).

⁹⁵ Vrinda Bhandari, *India's Criminal Justice System: Example of Justice Delayed, Justice Denied*, FIRSTPOST, <http://www.firstpost.com/long-reads/indias-criminal-justice-system-an-example-of-justice-delayed-justice-denied-3475630.html> (last visited Oct. 28, 2017).

⁹⁶ *Punitive Damages: India is behind the curve*, LIVEMINT (July 23, 2014, 6:06 PM), <http://www.livemint.com/Opinion/rOpy1dDyF7Lxn8Yzr70EaN/Punitive-damages-India-is-behind-the-curve.html>; While high punitive damages awards are rare in India, in one notable medical negligence case, the plaintiff was awarded \$1 million. In that case, the wife of an American doctor of Indian descent died in India as a result of the Indian doctors' negligence. Her husband sought and received American-style damage awards from Indian courts. *Balram Prasad v. Kunal Saha*, (2012) 1 SCC 384 (India); Gayathri Vaidyanathan, *A Landmark Turn in India's Medical Negligence Law*, N.Y. TIMES, Oct. 31, 2013, https://india.blogs.nytimes.com/2013/10/31/a-landmark-turn-in-indias-medical-negligence-law/?_r=0.

⁹⁷ S. V. Joga Rao, *Medical negligence liability under the consumer protection act: A review of judicial perspective*, 25 INDIAN J. UROLOGY 361, 361–63 (2009).

⁹⁸ One voluntary organization of fertility specialists in India is the Indian Society for Assisted Reproduction (ISAR). Under ISAR's webpage for medical practitioners, it simply provides a link to the 2005 ICMR guidelines that provide little protection for surrogates. See INDIAN SOCIETY FOR ASSISTED REPRODUCTION, <http://www.isarindia.net/> (last visited Sept. 17, 2017); A new organization, the Indian Society for Third Party Assisted Reproduction, consisting of doctors who focus on surrogacy, held their first Annual Conference in Mumbai in 2014. INDIAN SOCIETY FOR THIRD PARTY ASSISTED REPRODUCTION, <http://instar.co.in/index.html> (last visited Sept. 17, 2017); see also <http://instarorg.blogspot.com/>.

judgments in India effectively prevent any such judgments.⁹⁹ It should be noted that in the United States, contract and tort law is governed exclusively by states and state courts and there can be significant variation in doctrine among the states. In India, there is a unitary court system—one set of courts adjudicate all disputes. Some areas of common law such as contract law have also been codified by statutes.¹⁰⁰

For all the reasons discussed above, gestational care markets in the United States operate in a strong shadow of the law created by easier access for surrogates to courts and relatively faster adjudication time frames compared to India. The common law rules in whose shadow industry actors operate include doctrines such as duress, unconscionability, and public policy that demand that surrogacy contracts and the contracting process be procedurally and substantively fair. Courts and juries sometimes award eye-popping punitive damage awards, which play a role in guiding the behavior of industry actors that provide professional services. Fear of a contract being invalidated, large tort awards, and malpractice suits encourage industry actors to self-regulate and ensure that contracts are procedurally and substantively fair and that surrogates receive informed consent.

On the other hand, the common law does not cast as wide or long of a shadow over industry actors in India. Because most surrogates will never be able to bring a suit against industry actors or intended parents, industry actors and intended parents are not worried that courts might invalidate procedurally and substantively unfair contracts or situations. Lawyers and doctors in the gestational care market are not concerned about large tort awards assuming a surrogate would be able to sue in the first place. And even if the suit moved forward, the delay in a final verdict diminishes the significance of the verdict to the injured party.

There have been well-publicized surrogacy cases at the Indian Supreme Court, such as the Baby Manji case and the Jan Balaz case.¹⁰¹ But those cases involved the custody of children whose parentage and citizenship were in legal limbo due to a conflict of laws between India and the intended parents' country of residence.¹⁰² In other cases, intended parents have sought and received judgments of parentage.¹⁰³ There are

⁹⁹ See Jayanth K. Krishnan et al., *Grappling at the Grassroots: Access to Justice in India's Lower Tier*, 27 HARV. HUM. RTS. J. 151, 171, 179 (2014); Sital Kalantry, *Access to Justice in India's Lower Courts*, INTLAWGRRRLS (Jan. 5, 2014), <https://ilg2.org/2014/01/05/access-to-justice-in-indias-lower-courts/>.

¹⁰⁰ See e.g., Indian Contract Act, 1872, No. 9, Acts of Parliament, 1872 (India).

¹⁰¹ Baby Manji Yamada v. Union of India & Anr. AIR 2008 SC 6964 (India); Union of India v. Jan Balaz, AIR 2010 Gujarat 21 (India).

¹⁰² Baby Manji Yamada v. Union of India & Anr. AIR 2008 SC 6964 (India); Union of India v. Jan Balaz, AIR 2010 Gujarat 21 (India).

¹⁰³ Witzleb, *supra* note 12, at 177.

no cases that I am aware of where a surrogate sued because of procedural or substantive contract problems or for medical malpractice. Jayashree Wad, a senior Indian lawyer, did bring a public-interest litigation on behalf of surrogates (though no surrogate was consulted nor named as a plaintiff), asking the Indian Supreme Court to prohibit all gestational care markets.¹⁰⁴ The goal of her litigation, however, was not to seek damages for any individual surrogate, but rather to ban surrogacy all together based on anti-commodification reasoning.¹⁰⁵

The “shadow of the law” may not be the only explanation for why unregulated gestational care markets in India have led to systematic abuses of surrogates. Another plausible explanation is the social context of India. Notably, surrogates in India are from poorer economic classes than surrogates in the United States. The vast social inequality in Indian society, further heightened by caste and economic disparities, probably also plays a role in creating abusive conditions for surrogates.

But the fact that extremely poor women are allowed to become surrogates in India and not in the United States may itself be due to the “shadow of the law.” In the United States, some matching agencies specifically exclude women below the federal poverty line.¹⁰⁶ Agencies might prevent poor women from selling gestational care because they are concerned that courts will view those contracts as exploitative and invalidate them. American matching agencies may be overcorrecting in response to the *Baby M* case. Even if matching entities started to consider applications from poor women, intended parents might not select a poor woman as a surrogate. Women below the federal poverty level may be perceived to live in an unsafe environment and have worse nutritional and lifestyle habits than women who are not poor.

However, in India many of the women who provide gestational care are so poor that they likely eat last in their families, sleep on the floor, and do strenuous labor, yet they are still recruited to provide gestational care.¹⁰⁷ Recognizing that intended parents may be worried about the quality of gestational care poor women are able to provide, industry ac-

¹⁰⁴ Bhadra Sinha, ‘*It amounts to sale of motherhood*’: Surrogacy warrior who moved SC speaks up, HINDUSTAN TIMES, Aug. 26, 2016, <http://www.hindustantimes.com/india-news/magazine-article-led-78-year-old-surrogacy-warrior-to-move-supreme-court/story-Yj6VytKEooOC hZTVV3KDmK.html>.

¹⁰⁵ *Id.*

¹⁰⁶ *Intended Parents*, CENTER FOR SURROGATE PARENTING, <http://www.creatingfamilies.com/intended-parents/> (“We only accept surrogate mothers who are financially independent or employed, or whose husband or partner is employed. CSP does not accept any applicants for surrogacy whose income falls below the Federal Poverty Level guidelines”) (last visited Oct. 28, 2017).

¹⁰⁷ Interview with Dr Gupta, Gupta Clinic (Apr 6, 2017) in New Delhi, India.

tors require surrogates to live in homes where doctors can ensure that they are eating enough, taking vitamins, and not exerting themselves.¹⁰⁸

On the other hand, in the United States there are no such surrogacy homes. Industry actors in the United States would worry about the liability that they would face by running such homes. Indeed, one lawyer goes so far as to advise intended parents not to demand too many restrictions on a surrogate's lifestyle for fear that the surrogate might be considered an employee of the intended parent. Thus, the fact that poor women do not become surrogates in the United States is related to the shadow of the law (they are excluded by matching entities in an effort to avoid "exploitation"). The lack of shadow of the common law in India allows industry actors to create surrogacy homes thereby including poor women in gestational care markets.

Many commentators and policymakers in India have argued that the abusive conditions faced by surrogates are the reason gestational care markets should be banned.¹⁰⁹ However, through a comparative study of gestational care markets in India and the United States, I argue that the abusive conditions occur because Indian industry actors do not generally operate under the shadow of the common law. Given this, the Indian government should enact legislation that provides protections to surrogates.

In the next section, I discuss the panoply of regulatory tools available to ensure that the terms of the sale of gestational care are procedurally and substantively fair to the sellers of gestational care. I propose consumer protection laws as an appropriate framework from which to understand contracts for the sale of gestational care.

III. LEGALIZING AND REGULATING GESTATIONAL CARE MARKETS

Discussions about surrogacy often focus only on whether or not it should be prohibited. Thereafter, without resolution, the discussion ends. In Part II, I argue that surrogates face numerous procedural and substantive fairness concerns in surrogacy contracts in India. But this is not a reason to ban surrogacy—it is a reason to regulate it.

¹⁰⁸ Witzleb, *supra* note 12, at 172.

¹⁰⁹ Commentators have also argued that surrogacy harms children and psychological harms women who have to separate from the children they gave birth to. *See, e.g.*, Matthew Tieu, *Oh Baby Baby: The Problem of Surrogacy*, 19 *BIOETHICS RES. NOTES* 1, 9 (2007) ("[S]urrogacy ignores the fact that foetal/early infant development is a critical determinant of a child's welfare, whereby the biological and psychological bond between the surrogate and her child is of crucial significance for this development"); Many empirical studies have not found that separation harms the child. *See, e.g.*, Susan Golombok, *Families Created Through Surrogacy: Mother-child Relationships and Children's Psychological Adjustment at Age 7*, 47 *DEVELOPMENTAL PSYCHOL.* 1579, 1579 (2011) ("No differences were found for maternal negativity, maternal positivity, or child adjustment").

Actors in the unregulated gestational care markets in the United States have developed customary norms that provide a basic level of protections to surrogates, whereas unregulated gestational markets have failed to provide similar protections in India. But this is not a reason to dispense with the contract law framework completely. Contract law presents a spectrum of possibilities: from full freedom of contract to a heavily regulated model like consumer contracts. Where in the spectrum, a jurisdiction decides to place its mark will depend (in part) on the strength of the shadow of common law rules. Below, I discuss the contract law spectrum and argue that regulations adopted to rectify inequities in consumer contracts and the consumer contracting process should be (and are already) used by some jurisdictions to regulate surrogacy contracts.

Libertarians contend that the state should not interfere with privately negotiated agreements even in the context of surrogacy. Richard Epstein, for example, argues for full enforcement of surrogacy contracts without any limitations.¹¹⁰ He would allow intended parents to prevent surrogates from terminating the pregnancy.¹¹¹ He argues that the terms of surrogacy contracts should be based on market factors.¹¹² Judge Posner justifies freedom of contract in surrogacy contracts on efficiency grounds. To Judge Posner, surrogacy contracts are win-win situations—intended parents receive gestational care and a child, and a surrogate gets money.¹¹³

Hanoch Dagan and Michael Heller's more pragmatic "choice theory" approach would allow for greater regulation of surrogacy contracts.¹¹⁴ They suggest that regulation in certain cases can actually enhance autonomy. Most relevant for surrogacy are relational interests.¹¹⁵ Dagan and Heller are conscious that too much freedom can lead to unconscionable contracts and unfair bargaining.¹¹⁶ Thus, the state can intervene to regulate contracts when relational inequities exist.

In gestational care markets, relational inequalities are possible between the intended parents, fertility specialists, and matching agencies,

¹¹⁰ Epstein, *supra* note 41, at 2308–09.

¹¹¹ Epstein, *supra* note 41, at 2336 (“[I]t cannot be regarded as unjust or unwise that his decision should determine whether the abortion should take place”).

¹¹² Epstein, *supra* note 41, at 2306–07.

¹¹³ Richard A. Posner, *The Ethics and Economics of Enforcing Contracts of Surrogate Motherhood*, 5 J. CONTEMP. HEALTH L. & POL'Y 21, 22 (1989) (“The case for allowing people to make legally enforceable contracts of surrogate motherhood is straightforward. Such contracts would not be made unless the parties to them believed that surrogacy would be mutually beneficial”).

¹¹⁴ HANOCH DAGAN & MICHAEL HELLER, *THE CHOICE THEORY OF CONTRACTS* xi–xiii (2017).

¹¹⁵ *Id.* at 59.

¹¹⁶ *Id.* at 77–78.

on the one hand, and women who are surrogates, on the other. When courts are not accessible or court action takes too long, legislation is needed to set out minimum level of protections for surrogates. In India, industry actors are operating outside the shadow of the common law, and do not fear any negative consequences for failing to rectify procedural and substantive contracting concerns nor do they generally worry about tort litigation against them.

I suggest that state regulatory approaches to consumer contracts are relevant models for jurisdictions to consider when developing regulations for gestational care markets. A consumer contract typically involves the sale of services or goods by a large business to individual consumers. Consumers have no ability to negotiate terms of the contract.¹¹⁷ Everyone knows that most consumers sign boilerplate contracts without reading them, but American courts generally bind consumers to those terms anyway.¹¹⁸ Sometimes policing doctrines can be used in egregious cases to invalidate the contracts, but consumers have a collective action problem and the most aggrieved consumers probably do not even approach courts.

In the Indian context, there are many similarities between surrogacy contracts and consumer contracts. There is great inequality in bargaining power between the parties. In addition, many surrogates do not read or understand their contracts, they have no legal representation, and they are given form contracts with little ability to negotiate any terms. Even in the United States, the intended parents' lawyer typically creates the first draft of the contract. This gives them significant advantages. While industry standards require that a surrogate be provided with legal representation, often there is a cap on how much the intended parents are required to pay for that legal representation. Consequently, a first-time surrogate may not have the same information and knowledge as intended parents.

Surrogacy contracts are different from consumer contracts in several important ways. In surrogacy contracts, unlike consumer contracts, the vulnerable party is the provider of the services rather than the service recipient. Surrogacy contracts are between individuals, unlike consumer contracts, which are between businesses and individuals. Yet bargaining power asymmetries still exist in surrogacy contracts. Fertility specialists, matching agencies, and surrogacy lawyers have a vested interest in promoting surrogacy. Agencies play a strong role in setting contract terms and mediating the relationship between the surrogates and intended parents.

¹¹⁷ See Ian Ayres & Alan Schwartz, *The No-Reading Problem in Consumer Contract Law*, 66 STAN. L. REV. 545, 545–46 (2014).

¹¹⁸ *Id.* at 548–49.

There are similar concerns in the consumer contracting and in the surrogacy contracting process (particularly in India). Consequently, proposals for reforming consumer contracting to address concerns raised in that context can be useful in rectifying similar problems in the surrogacy contracting process. Indeed, those jurisdictions that have adopted legislation to regulate surrogacy have already incorporated many of the proposals that scholars have suggested to reform the consumer contracting process.

While there is no universal agreement among scholars about the correct approach to regulating consumer contracts, I outline some important proposals. First, Professors Hillman and O'Rourke suggest increased disclosure as a way to address the problems they see with consumer contracts.¹¹⁹ The ALI's Principles of the Law of Software Contracts also suggests that increased disclosure requirements would benefit consumers.¹²⁰ Hillman and O'Rourke argue that even if consumers do not read the new disclosed terms, non-profit consumer advocacy organizations may read and flag them for consumers.¹²¹ Similarly, jurisdictions could require that the potential adverse consequences of the medications and medical procedures surrogates will undergo be disclosed in writing or published.

A second approach involves creating a list of presumptively unenforceable terms. The European Union has adopted this approach in their Directive on Unfair Terms, which creates a non-exhaustive list of unenforceable terms.¹²² A similar list could be useful in the surrogacy contract context to prevent unfair terms against surrogates. For example, the proposed New York bill to legalize surrogacy invalidates surrogacy contract provisions that prevent a woman from terminating her pregnancy.¹²³

A third approach to consumer protection involves the use of mandatory rules. Margaret Radin proposes mandatory rules for all rights essential to consumer protection.¹²⁴ Some jurisdictions already have adopted mandatory rules in surrogacy contracts. California requires that a contract contains the means to cover the surrogate's financial expenses, either by the intended parents or the surrogate's own health insurance.¹²⁵

¹¹⁹ Robert A. Hillman & Maureen O'Rourke, *Defending Disclosure in Software Licensing*, 78 U. CHI. L. REV. 95, 103–04 (2011).

¹²⁰ *Id.* at 103–09.

¹²¹ *Id.*

¹²² Council Directive 93/13, art. 3(3) Annex, 1993 O.J. (L 95) 29 (EU).

¹²³ Child-Parent Security Act, A-6959A, 2017-2018 Reg. Sess. § 581–401 (N.Y. 2017).

¹²⁴ Margaret Jane Radin, *BOILERPLATE: THE FINE PRINT, VANISHING RIGHTS AND THE RULE OF LAW* 213 (2013) (“[M]y preliminary suggestion is that a purported contract containing offending boilerplate should be declared invalid in toto, and recipients should instead be governed by the background legal default rules”).

¹²⁵ CAL. FAM. CODE § 7962(a)(4) (West 2018) (the statute also requires that the contract contain: (i) the date on which the assisted reproduction agreement for gestational carriers was

Delaware further requires that consideration must be “reasonable” and that funds must be placed in escrow before an embryo transfer occurs.¹²⁶ Along the lines of mandatory rules, one author suggests that, like in an adoption setting where parents have the right to change their minds, surrogates should have the unilateral right to terminate the contract within a limited window of time and keep the baby.¹²⁷ Another possible mandatory rule a jurisdiction could enact is to require intended parents pay for independent legal representation for a surrogate.

A fourth approach would be to require pre-approval of individual contracts. Israel has adopted this method for surrogacy contracts.¹²⁸ Similarly, South Africa, which permits only uncompensated surrogacy, requires surrogacy agreements to be confirmed by the High Court in the jurisdiction the intended parents are domiciled.¹²⁹ No surrogacy can take place without the court confirming the agreement or after the lapse of eighteen months from confirmation.¹³⁰ The surrogacy bill proposed in India also creates a regulatory body to monitor all surrogacy arrangements.¹³¹ One of the alternatives proposed in the American Bar Association’s model surrogacy act requires each surrogacy contract to be approved by a court.¹³² Another model statute created by the National Conference of Commissioners on Uniform State Laws also proposed a similar solution in its prior version, but the more recent version suggests that contract validation is required only for genetic surrogacy and not for gestational surrogacy.¹³³ The risk with such an approach is that the body that pre-approves contracts may not have the competence to do so or may simply “rubber-stamp” the contract. This level of state involvement may also be unnecessary in contexts where courts are accessible and the common law protects surrogates.

A fifth approach, like that of the American Consumer Protection Bureau, is to create an agency that takes consumer complaints and promulgates regulations to enhance consumer protections. This may be

executed; (ii) the persons from which the gametes originated, unless donated gametes were used; and (iii) the identity of the intended parent or parents).

¹²⁶ 79 Del. Laws tit. 13, ch. 8 § 8-807(d)(3) (2013) (“The agreement of the intended parent or parents to pay the gestational carrier reasonable compensation”).

¹²⁷ Smolin, *supra* note 41, at 339.

¹²⁸ Embryo Carrying Agreements Law (Approval of the Agreement and the Status of the Child), 5756-1996, SH No. 1577 (Isr.).

¹²⁹ Children’s Act 38 of 2005; *Ex parte WH* 2011 (6) SA 514 at para. 31 (GNP) (S. Afr.).

¹³⁰ Children’s Act 38 of 2005; *Ex parte WH* 2011 (6) SA 514 at para. 31 (GNP) (S. Afr.).

¹³¹ The Surrogacy (Regulation) Bill (India 2016), available at http://164.100.47.4/BillsTexts/LSBillTexts/Asintroduced/257_LS_2016_Eng.pdf.

¹³² *American Bar Association Model Act Governing Assisted Reproductive Technology*, 2008 AM. BAR ASSOC. SEC. FAM. L. COMMITTEE REPROD. & GENETIC TECH. 1.

¹³³ UNIFORM PARENTAGE ACT, § 813, cmt., (NAT’L CONFERENCE OF COMM’RS ON UNIF. STATE LAWS 2017), http://www.uniformlaws.org/shared/docs/parentage/UPA2017_Final_2017sep22.pdf.

particularly valuable for gestational care markets if regulations include key players in the industry that are not party to the contract, such as agents and fertility specialists. The agency could ensure that fertility specialists give surrogates enough information to ensure that their consent is truly informed. The costs of operating the agency could be paid through a tax on the profits of industry actors.

Another approach to regulating surrogacy contracts is a labor law model. Anthropologist Amrita Pande describes transnational surrogacy in India as factory work in the Global South.¹³⁴ Like the maquiladora factory workers in Mexico, surrogates in India labor for people in the Global North. In line with this framing, legal scholar Cyra Choudhury proposes a labor law model.¹³⁵ Even though transnational surrogacy has ended in India for the moment at least, the labor analogy is still relevant.¹³⁶

Indeed, surrogacy contracts are similar to employment contracts. In surrogacy contracts, like employment contracts, the vulnerable party is typically the provider of services and the one in need of protection. As Choudhury observed, “the state can intervene to equalize some of the bargaining disparities . . . through worker rights and mandatory contractual requirements.”¹³⁷ A labor model is also useful because it allows jurisdictions to regulate industry actors that would not otherwise be covered by contract-law regulations. Regulating only the contractual relationship (which exists between the surrogate and the intended parents) will not hold matching entities and fertility specialists accountable. Jurisdictions should consider enacting regulations to directly address their behavior to ensure that they act in ways that are fair to surrogates.

In sum, the types of regulations used to address inequities in consumer contracts can be useful tools to mitigate the abuses surrogates face in unregulated gestational care markets. The proposals above are not exclusive options and jurisdictions can “mix and match” among the suggestions. Countries are best suited to determine what level and type of regulation is most suitable in their circumstances. Where the common law does not create a long and wide shadow over the industry actors, unregulated surrogacy markets have not led to surrogate-protective industry norms. Thus, in India, a model that heavily regulates the contract and the actors who are not party to the contracts is necessary to better protect surrogates.

¹³⁴ AMRITA PANDE, *WOMBS IN LABOR: TRANSNATIONAL COMMERCIAL SURROGACY IN INDIA* (2014).

¹³⁵ Cyra Akila Choudhury, *The Political Economy and Legal Regulation of Transnational Commercial Surrogate Labor*, 48 *VAND. J. TRANSNAT'L L.* 1, 2 (2015).

¹³⁶ *Id.* at 22.

¹³⁷ *Id.* at 62.

CONCLUSION

Many newly emerging surrogacy markets imported the American-style free market model to surrogacy, but this model has led to exploitation and abuse of surrogates even though similar abuses were not observed in the United States. It is interesting that even in U.S. states where there is no legislation that directly regulates surrogacy, industry actors have developed customary terms and norms that provide a basic level of rights and protections to surrogates. However, industry norms do not similarly protect surrogates in India.

I argue that industry actors in the United States are incentivized to create such protective norms because they have legitimate concerns that courts might invalidate contracts using policing doctrines or that surrogates will bring malpractice suits against them for large damage awards. Doctors, lawyers, intended parents, and matching entities operate in the shadow of the common law in the United States. On the other hand, surrogates in India generally lack access to courts, judgments take long periods of time, and large tort awards are less common. Thus, the common law rules that would otherwise protect them do not serve to force industry actors to self-regulate.

Rather than simply importing the free contract model that prevails in many states in the United States, in countries like India where the shadow of the common law is weak, governments should enact legislation that creates protections for surrogates. These protections could include requiring intended parents to pay for life insurance, post-natal care, and independent legal representation for surrogates. In addition, surrogates should be provided with better disclosure of the consequences of the medical procedures they will undergo. In developing regulations for gestational care markets, India and other jurisdictions can borrow from tools suggested to address inequalities in the consumer contracting process. For example, Indian legislation might invalidate certain provisions in surrogacy contracts or require that mandatory provisions be included in such contracts to protect surrogates.

Where a regulatory regime lands on the contract-freedom spectrum should turn on an evaluation of the circumstances of the country.¹³⁸ In

¹³⁸ Those familiar with law and policy in India will respond to my proposal by arguing that even if India were to adopt state-of-the-art legislation to protect all the vulnerable parties in a surrogacy arrangement, surrogacy law would be flouted just like many other laws in India. But just because some laws are ignored by people in India does not mean that appropriate laws should not be crafted or adopted. In the context of women's rights, laws that are regularly violated are laws that attempt to change private behavior such as anti-dowry law. On the other hand, laws regulating surrogacy involve more public transactions between medical professionals, intended parents, and an unrelated third party (the surrogacy). This makes it more difficult to hide than private transactions as well as other medical transactions (such as sex determination). Finally, surrogacy industry actors would be motivated to comply with legislation that

countries where the common law rules are structured such that they give adequate bargaining power to surrogates and where courts are accessible to surrogates, the circumstances are ripe for a surrogacy industry to develop surrogate-protective norms without any legislative intervention. On the other hand, countries, where the common law rules do not cast a shadow over the bargaining process, countries should enact legislation that guarantees minimum protections to surrogates.

regulates the industry. Fertility doctors are likely to follow legal regulations as they would still make significant profits even with increased regulation. Intended parents want to ensure parentage rights and thus would be motivated to follow legal rules. Finally, the medical procedures involved in surrogacy require some degree of knowledge, technology, and lab facilities, which makes it difficult for people who are not experts to engage in it. While illegal practices may exist even if surrogacy is legalized and regulated, they will also exist if there was a full prohibition on surrogacy.

