Regulating Markets for Gestational Care: Comparative Perspectives on Surrogacy in the United States and India

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There are many jurisdictions in the world where there is no legislation or case law that addresses surrogacy. In those jurisdictions, people freely enter into contracts for the sale and purchase of gestational care (defined below). Eighteen U.S. states and India,² as well as at least forty countries, have no legislation or case law that permits, prohibits, or regulates surrogacy. This regulatory lacuna typically occurs either because of a failure to reach a consensus on legislation about the issue or sheer neglect of it.

While unregulated markets for surrogacy prevail in some U.S. states, the industry in even those American states without any surrogate-protective legislation have developed strong baseline protections for women who sell gestational care. For example, industry norms require that surrogates have legal representation and that intended parents pay for it. In addition, intended parents typically must pay for life insurance for the surrogate if she does not have her own. On the other hand, surrogates in India usually have no legal representation nor life insurance.

Through a comparative study of gestational care markets in India and eighteen U.S. states with unregulated surrogacy markets, I analyze why the same industry in these two regions has created such disparate norms. 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.³ 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 for Divorce, Professors Robert H. Mnookin and Lewis Kornhauser pointed out that even when parties negotiate divorce settlements outside of court, the outcome that the common law would dictate informs the relative bargaining power of the parties.⁴ The article, written in the United States context, rests on the premise that parties can easily access courts and relatively quickly obtain a judgment if the parties failed to reach a divorce settlement outside of court. I argue here that for courts to create a legal shadow, courts must be accessible to injured parties and the timeframe for adjudication of cases should be reasonably fast.

two bodies of law that are relevant to provide protections to surrogates are contract and tort law.⁵ Like American law, Indian contract and tort law are rooted in British common law and consequently share similar policing doctrines found in contract law and negligence standards in tort law. However, despite the relative similarity in Indian and American tort and contract law, American surrogacy industry actors have developed industry norms that are more protective of surrogates than Indian industry actors. The key reason industry actors in the United States operate in the “shadow of the law” while industry actors in India do not is because American courts are more accessible to American surrogates. A secondary explanation relates to the
substance of the law. For example, industry actors likely perceive that American courts tend to award higher punitive damage awards than Indian courts.

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 time-frames make adjudications less salient. It is for this reason that the common law does not cast as dark a shadow over industry actors in India as it does in the United States. Even if surrogates had greater access to courts and industry actors operated in the shadow of common law, the tort damage awards are generally less favorable to plaintiffs in India as compared to 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. 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 Mexico 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 could 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 own 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 both types there is a problem with genuine consent, non-reading, and a vulnerable party on one side of the transaction. Many countries and U.S. states already draw on solutions from the consumer contract context in order to protect surrogates. I suggest adding solutions proposed to solve problems with consumer contracts to the menu of options policymakers should consider when developing regulations for gestational care markets in India.

I have developed the term “gestational care” because our language does not have the vocabulary to talk about surrogacy in a way that imbues a surrogate with agency and values the services she provides. 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.

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.”

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 their embryo and fetus. The reason the tort term is used relates to taxes. In the United States, damages for physical injuries are not taxed. Industry actors likely 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.

As mentioned above, I use the term “gestational care” here to refer to the services a surrogate provides. 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 connection to the embryo. 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.

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. In Part II, I ask what explains the disparate industry norms in two unregulated legal environments. I argue this occurs because industry actors in the United States operate in the shadow of common law, particularly contract and tort law, while Indian courts do not play a similar disciplining function on industry actors. Thus, where common law casts a weak or no shadow at all, policymakers could 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.

Part 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 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 flourished over the last few decades. Some estimates place the value of the Indian surrogacy market at over two billion dollars. Gay male couples and infertile heterosexual couples flocked to India because their own countries prohibited
surrogacy or because it is more cost-effective. 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.\textsuperscript{14} Surrogates are often
women who do not speak English, live in slums, or are squatters.\textsuperscript{15} In a typical arrangement, both
intended parents, if they are heterosexual, and not the surrogate, are biologically related to the
child.\textsuperscript{16}

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.\textsuperscript{17} The ICMR is a body, funded by the Indian government, responsible for the
formulation, coordination, and promotion of biomedical research. Many fertility clinics today
follow the ICMR guidelines, but they are neither binding nor robust.\textsuperscript{18} 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.”\textsuperscript{19}

The Indian government proposed legalizing and regulating surrogacy under three separate
bills in 2008, 2010, and 2014, but none of them passed.\textsuperscript{20} 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.\textsuperscript{21} The ban on transnational surrogacy significantly reduced demand,
but intended parents in India continued to hire surrogates.

The Surrogacy (Regulation) Bill of 2016 (the “2016 Bill”)\textsuperscript{22} is the first legislation
proposed to prohibit compensated surrogacy completely.\textsuperscript{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.\textsuperscript{24} Similarly, in Louisiana, Nebraska, New Jersey, and Washington,\textsuperscript{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 paid for her services, a court in those states will refuse to enforce the
contract.\textsuperscript{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.\textsuperscript{27}

A standing committee of the Indian Parliament recently lambasted the bill. They argued
that compensated surrogacy, at least for Indian intended parents, should be regulated and legal.\textsuperscript{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.\textsuperscript{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).\textsuperscript{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 these residences, surrogates are not allowed to leave except under special circumstances. The residence may be far from their children and families. Doctors claim this practice is the only way to ensure that women receive adequate nutrition, do not perform strenuous work, and generally ensure that the child will be healthy and carried to term.  

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. In one clinic we interviewed, the doctors’ compensation was tied to the successful birth of the child. This potentially incentivizes fertility specialists to prioritize the desire of the intended parents, which is the successful delivery of a child, over the health and well-being of the surrogate.

The ICMR provides a form surrogacy agreement where the great majority of the terms are simply the surrogate’s obligations and also contains an acknowledgment by the surrogate of the medical procedures that she is undergoing without any explanation of the risks involved. Additionally, the guidelines do not mitigate the conflict of interest among doctors. The two rights of the surrogate specified 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 will be required to take custody of the child even if he or she has birth defects.

Despite the extensive role of fertility specialists, 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.

In discussing surrogacy, the word “exploitation” is often used to mean two things. First, the view often referred to as an “anti-commodification” perspective holds that selling gestational care is inherently exploitative to the surrogate. Indeed, strong anti-commodification voices in India have always argued that surrogates exercise no real “choice” because they only become surrogates because of their poverty. 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.

People who view surrogacy as commodification either of the woman or the child would want to prohibit surrogacy even if it were carried out in a way that was fair to surrogates. While it is beyond the scope of this article, I do not share the view that surrogacy, when undertaken with appropriate protections, is inherently degrading to a surrogate. A debate rages on about whether or not surrogacy is the sale of the child. Ultimately, when prohibitions on the sale of children were enacted, they did not account for surrogacy and thus they should not be used as a reason to ban it.
The second way in which people use “exploitation” in reference to problems surrogates face in practice. I focus on those problems here by framing them 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. Second, many surrogates did not know the content of their contracts. One surrogate that we interviewed was unsure about her compensation amount, whether she was receiving any monthly payments, and how she would receive payment. Another surrogate we spoke with told us that her contract had been in English, not Hindi, and that she could not read it, although she signed it after her husband read it. Finally, several surrogates noted that the agent physically held all of the contracts and the women did not have copies. 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.

There were also substantive fairness concerns about the actual terms included in and omitted from the final 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. 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. Second, only about twenty percent of the contracts reviewed by the Center for Social Research discussed compensation at all. Third, almost none of the contracts addressed whether medical care would be provided for the surrogate after the birth of the child. Fourth, women did not have a say in how they would deliver the babies and told us that the prevailing method was Caesarean sections. Finally, if women die during the surrogacy process, there is no life insurance or other monetary protections 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, the other surrogates are given abortifacients, often without their knowledge. Those surrogates whose pregnancies are terminated likely receive no compensation at all. Others have argued that surrogates have not provided informed consent—they are not aware of the medical procedures they are undergoing or generally informed about the potential adverse consequences of the medications.

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. 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. 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. Around that time, some feminists argued that surrogacy would be one more way that poor and minority women would be exploited by rich and Caucasian people, much like the fictional world of The Handmaid’s Tale. That dystopian novel was published in 1985, the year before the New Jersey Supreme Court declared the surrogacy contract between Stern and Whitehead unenforceable.

Similarly, other feminist commentators argued that women would never voluntarily choose to sell gestational care; they would only do so because of economic desperation. However, these fears have not materialized. Empirical studies of surrogates do not reveal that they are disproportionately minority or from poorer economic classes. 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. In New Jersey, the Baby M case still requires courts to invalidate compensated surrogacy contracts, but contracts where women receive compensation “reasonable living expenses” are generally permissible. 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. Four states specifically prohibit the enforcement of compensated surrogacy contracts.

Eighteen states have no legislation or administrative rules prohibiting or regulating surrogacy. This means that there is freedom of contract within the limits of common law and no regulations on contracts for the sale of gestational care or on the actors involved in the industry. I focus on how surrogates fare in these gestational care markets since they are the closest analogue to the Indian regulatory environment (i.e., there is no legislation or administrative rules about surrogacy). It should be noted that in some American states where there is legislation, it does often 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.

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. However, surrogates and intended parents also self-match. Industry norms in the United States generally, including in states where there is no legislation on surrogacy, provide basic levels of protections to surrogates.

In the United States, unlike in India, fertility specialists do not typically recruit surrogates and connect them to intended parents but rather just provide the fertility treatment. Nevertheless, there is still a potential conflict of interest when the intended parents are paying for fertility
services and the surrogate is a patient of the fertility specialist. The voluntary association of reproductive specialists, the American Society of Reproductive Medicine (ASRM), has issued clear guidelines that state that even when fertility doctors provide medical services to both the intended mother and surrogate, the person undergoing the fertility treatment (i.e., the surrogate) is considered the patient, even if the intended parents are paying the bills. 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.

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

Lawyers are often involved in advising the formation of surrogacy contracts. It is not unusual in contract negotiations in the United States that one party has legal representation and the other party does not. A voluntary association of surrogacy lawyers, the American Academy of Assisted Reproductive Technology Attorneys, proposed a code of ethics that suggests that lawyers can undertake legal representation in surrogacy contracts only when the surrogate has independent legal representation. The ASRM guidelines on surrogacy also mandate that fertility specialists work with surrogates only if both the intended parents and surrogates have legal representation. Finally, the websites of surrogacy matching agencies also state that the intended parents must pay for a surrogate’s lawyers.

Matching entities vet women who want to become surrogates. They often provide compensation guidelines. 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 does 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.

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

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. Their strongest women-protective argument against surrogacy is that surrogacy harms mothers. Psychological studies on surrogates have largely
disproven the argument that surrogates suffer trauma from the separation.\textsuperscript{77} They also argue 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.\textsuperscript{78} This suggests that the rates set by matching entities for gestational care may be too low.

I do not mean to suggest that there are no problematic situations in the gestational care markets in the United States. Women have died while working as surrogates.\textsuperscript{79} In Oregon, an agency defrauded intended parents and surrogates of money.\textsuperscript{80} An American-based surrogacy agent was recently sentenced to jail for defrauding intended parents.\textsuperscript{81} When there is a tort or criminal fraud, there is more likely to be accountability for it.

**Part 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 in 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-protecting than those in India. In this section, I compare the legal context of India and the United States to help understand 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. The ability of surrogates to access courts and the perception of industry actors that surrogates can access courts explains 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.\textsuperscript{82} Moreover, voluntary organizations of surrogacy industry professionals, including surrogacy lawyers and fertility doctors, have developed surrogate-protective norms and ethical standards. Lawyers and doctors who are part of the industry are 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.\textsuperscript{83} Although 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.\textsuperscript{84} In addition, doctors who comply with ASRM guidelines would strengthen their argument that they have met their standard of care in a tort suit against them. Thus, in an effort to avoid lawsuits and large tort damages, fertility doctors are incentivized to follow industry guidelines and standards.

Lawyers as well as doctors could be 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.\textsuperscript{85} Both agencies and lawyers tend to go beyond their state’s legal requirements for surrogacy contracts and representation.\textsuperscript{86} 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 have incentives to ensure that courts will not invalidate surrogacy contracts using policing doctrines such as duress and unconscionability. With knowledge that courts could invalidate provisions in contracts and that some courts have been particularly critical of surrogacy contracts, 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. This is because lawyers worry that if a surrogate brings a lawsuit against the intended parents, a court might invalidate the 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.\textsuperscript{87} 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.\textsuperscript{88} 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 adjudication further deter those who would otherwise sue.\textsuperscript{89} 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.\textsuperscript{90} For lower court decisions, more than 22.8 percent of all cases before subordinate courts are more than five years old in 2015.\textsuperscript{91}

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.\textsuperscript{92} Any medical negligence claim must instead be brought to consumer protection courts pursuant to the consumer protection act.\textsuperscript{93} But that case is the exception rather than the rule. In addition, there is no agency similar to the ASRM among Indian fertility doctors that creates its own ethical guidelines and best practices.\textsuperscript{94} As discussed above, the guidelines set by the Bar Council and the ICMR 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 judgments in India effectively prevent any such judgments.\textsuperscript{95} It should be noted that in the United States, contract law or 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.\textsuperscript{96}

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 substantive 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 (particularly when the intended parents are foreign), 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 or even worried that a surrogate would be able to sue in the first place. And even if the suit moved forward, the delay in a final verdict would be significant.

There have been well-publicized surrogacy cases at the Indian Supreme Court, such as the Baby Manji case and the Jan Balaz case. 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. In other cases, intended parents have sought and received judgments of parentage. There are no cases I am aware of where a surrogate sued because of the 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 or named a plaintiff), asking the Indian Supreme Court to prohibit all gestational care markets. The goal of her litigation was not to seek compensation for any surrogate who did not receive the money she was promised, suffered negative health consequences, or other harms, but rather it was to ban surrogacy all together based on anti-commodification reasoning.

One could argue that the “shadow of the law” is not 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. As stated above, American surrogates are not from the poorest classes in the United States. Certainly, the vast social inequality in Indian society, further heightened by caste and economic disparities, plays a role in the 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. The fact that poor women are excluded from gestational care markets in the United States but not in India may itself reflect the “shadow of the law.” 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
shadow of the law and the post-Baby M concerns raised by feminists. Even if the matching entities started to consider applications for poor women, intended parents are likely to not select certain classes of women. Women below the federal poverty level may be perceived to have worse nutritional and lifestyle habits than women who are not poor.

In India, most 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 but are still recruited to provide gestational care. Recognizing that intended parents may be worried about the quality of gestational care poor women are able to provide, industry actors require surrogates to live in homes where doctors can ensure that they are eating enough, taking vitamins, and not exerting themselves.

On the other hand, in the United States there are no surrogacy homes. Industry actors in the United States would worry about the liability that they would face by running such homes. Indeed, one lawyer advises 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 law 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 is the reason gestational care markets should be banned. However, through a comparative study of gestational care markets in India and the United States, I argue that the abusive conditions occur because of the reliance on the private contractual model and the fact that 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 and does not necessarily have to prohibit surrogacy completely.

Where the common law’s shadow is weak and consequently does not influence industry actors to adopt baseline levels of protections for surrogates, jurisdictions should consider adopting legislation that creates a baseline of protections for surrogates. In the next section I discuss the panoply of regulatory tools available to ensure that 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.

Part 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.

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. The contract law model is often associated with freedom of contract without state interference, but the contract law framework is actually 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 on the strength of the shadow of common law rules (as well as a host of other factors). Below, I discuss the contract law spectrum and argue that regulations adopted to rectify inequities in consumer contracts and the consumer contracting process can (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. He would allow intended parents to prevent surrogates from terminating the pregnancy. He argues that the terms of surrogacy contracts should be based on market factors. 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.

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

In gestational care markets, relational inequalities are possible between the intended parents, fertility specialists, and matching agencies, on the one hand, and women who have chosen to become surrogates, on the other. When courts are not accessible or court action takes too long, legislation is needed to set out a minimum level of protections for surrogates. In India, industry actors are operating outside the shadow of the common law, and they 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. Everyone knows that most consumers sign boilerplate contracts without reading them, but American courts generally bind consumers to those terms. 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: 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. Even though a surrogate must be provided with legal representation, often there is a cap on how much the intended parents will pay. 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, 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.

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 significant proposals. First, Professors Hillman and O’Rourke suggest increased disclosure as a way to address the problems they see with consumer contracts. The ALI’s Principles of the Law of Software Contracts also suggests that increased disclosure requirements would benefit consumers. 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. 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. 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.

A third approach to consumer protection involves the use of mandatory rules. Margaret Radin proposes mandatory rules for all rights essential to consumer protection. 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. Delaware further requires that consideration must be “reasonable” and that funds must be placed in escrow before an embryo transfer occurs. 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.
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. 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. No surrogacy can take place without the court confirming the agreement or after the lapse of eighteen months from confirmation. The surrogacy bill proposed in India also creates a regulatory body to monitor all surrogacy arrangements. One of the alternatives proposed in the American Bar Association’s model surrogacy act requires each surrogacy contract to be approved by a court. 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. 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 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 regulation of surrogacy contracts is a labor law model. Anthropologist Amrita Pande describes transnational surrogacy in India as factory work in the Global South. 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. Even though transnational surrogacy has ended in India for the moment at least, the labor analogy is still relevant.

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.” A labor model is also useful because it allows jurisdictions to regulate industry actors that would otherwise not be covered by contract-law regulations. Regulating only the contractual relationship (which exists between the surrogate and 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. For India, a model that heavily regulates the contract and the actors who are not party to the contracts is necessary to better protect surrogates.

Conclusion

Global demand for surrogacy opened up gestational care markets in emerging economies like Cambodia, Thailand, Mexico, Nepal, and India over the last several years. Gestational care markets have existed in the United States for many decades. Eighteen American states have not adopted legislation that directly addresses surrogacy nor have courts of those states declared surrogacy contracts void. The private contract law model that prevails in some U.S. states was adopted in many of the newly emerging gestational care markets, including India.

Even where there is no legislation that directly regulates surrogacy, industry actors in the United States have developed customary terms and norms that provide a basic level of rights and protections to surrogates. However, industry norms have not evolved to 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 do not serve to cause industry actors to self-regulate.

Consequently, the Indian government should enact legislation that creates protections for surrogates, such as a requiring that intended parents pay for life insurance, post-natal care, and independent legal representation. In addition, surrogates should be provided with better disclosure of the consequences of the medical procedures they 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 that are included by intended parents in surrogacy contracts or require that mandatory provisions be included to protect surrogates. Where a regulatory regime should land on the contract-freedom spectrum depends on an evaluation of the circumstances of the country.

Those familiar with law and policy in India will respond to my proposal by pointing out that even legislative acts are not complied with or enforced in India. In other words, they will argue 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 law is sometimes not followed in India does not mean that appropriate laws should not be crafted or adopted. Moreover, unlike issues where gender rights are implicated (such as dowry, inheritance, etc..), there is not likely to be widespread violation of laws. Surrogacy industry actors would be motivated to comply with legislation that 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. The medical procedures involved in surrogacy require some degree of knowledge, technology, and lab facilities, which makes it difficult for many people who are not experts to engage in it and it is harder to go undetected than black markets for illegal sex detection using ultrasounds for example. While illegal practices may exist even if surrogacy is legalized and regulated, they will also exist if there was a full prohibition on surrogacy.130

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


3 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. Cornell Law School, In “Global Classroom,” Students Study Surrogacy Law and Policy in India and the United States, May 1, 2017, http://www.lawschool.cornell.edu/spotlights/In-Global-Classroom-Students-Study-Surrogacy-Law-and-Policy-in-India-and-the-United-States.cfm.


5 I do not discuss family law here. Even though family law principles are used to determine parentage and custody in some surrogacy cases, these come into play only if a surrogate disputes parentage and custody. Jurisdictions that are friendly to surrogacy allow intended parents to be considered the legal parents immediately upon birth of the child. In India, the intended parents are listed on the birth certificate of the child, and many American state courts grant “pre-birth” orders that ensure parentage of the intended parents. A robust surrogacy industry is not likely to develop in states where legal parentage of intended parents is difficult to establish. If the surrogate wants to retain custody of the child, then some courts could also use family law principles to decide custody but only if they first invalidated the contract. This occurs in rare circumstances.


7 See Amrita Pande, Commercial Surrogacy in India: Manufacturing a Perfect Mother-Worker, 35 SIGNS: J. OF WOMEN IN CULTURE & SOCIETY 969, 975 (2010). Women are seen as “empty vessels,” “walking wombs,” or “breeders.” 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). However, 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.” Interview with Hemu Sahu in India (Apr. 7, 2017).


9 26 U.S.C. § 104(a)(2) (2012) (“[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.”).


12 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]. Commercially surrogacy was legalized in...


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

17 Id.

18 See ICMR GUIDELINES, supra note 12.


23 Id. ch. VII, § 35.

24 Id. ch. III, § 4(i)(b); Id. ch. III, § 4(ii)(b).

25 LA. STAT. ANN. 9.2720.13 (2016) (a court, if necessary, shall “order[] that the child be surrendered to the intended parents.”); NEB. REV. STAT. 25—21, 200 (2007) (biological father of children born from surrogacy sole legal parent of resulting child); [not sure if we should include NJ in this list]; WASH. REV. CODE § 26.26.260 (“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).

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.

There is nothing better than what we are doing.” Interview with Shanta and Kanta The correct focus of the dignity
interviewed in India told us

See Interview with Dr. Manju Dagar (Apr. 5, 2017); Interview with Sarita (Apr. 5, 2017).
See also Interview with Dr. Manju Dagar (Apr. 5, 2017).
See also Interview with Surrogacy Agent, Gupta Clinic (noting that compensation is only 50% when surrogate

See ICMR GUIDELINES 77, supra note 12.
See Interview with Apurva Agarwal (Apr. 5, 2017).


Bruce Hale has pointed out that in negotiations about transnational surrogacy regulation, arguments about the
exploitation of surrogates in the Global South are often used by people who hold moral objections to surrogacy for
other reasons. Bruce Hale, Regulation of International Surrogacy Arrangements: Do We Regulate the Market, or

Some make dignity-based arguments against the sale of gestational care. 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 mother 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.” Helen a 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 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.
41 See Christine Metteer Lorillard, Informed Choices and Uniform Decisions: Adopting the ABA’s Self-Enforcing Administrative Model to Ensure Successful Surrogacy Arrangements, 16 CARDOZO J.L. & GENDER 237, 251 (2010). 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 and not just that monetary damages be provided. John William Tobin, To Prohibit or Permit: What is the (Human) Rights Response to the Practice of International Commercial Surrogacy?, MELBOURNE L. STUDIES RESEARCH PAPER No. 689 (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 as the legal parents and that allow the names of both intended parents to appear on the birth certificate of the child. E.g., CAL. FAM. CODE. § 7962(e) (“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 . . . .”). Thus, custody of the child is transferred even prior to birth. On the other hand, anti-surrogacy advocates argue that those who favor surrogacy are wrong because they make technical legal arguments 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. 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 (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. Thus, laws against child-selling were not designed to address surrogacy.

43 Interview with Sharda and Meera. Even if they were provided by counsel, there is still a risk that the lawyers will not provide robust representation.

44 Interview with Maichili Devi, New Delhi, India (Apr. 5, 2017).
45 Interview with Maichili Devi, New Delhi, India (Apr. 5, 2017).
46 Interview with Sharda and Meera.
48 Centre for Social Research, Surrogate Motherhood, Ethical or Commercial at 41, 58–60.
49 See ICMR GUIDELINES 84, supra note 12.
50 Centre for Social Research, Surrogate Motherhood, Ethical or Commercial at 156.
51 See ICMR GUIDELINES 65, supra note 12.
52 Interview with Sharda and Meera; Interview with Shanta and Kanta.
53 In one study, less than 2.9% of those who had undergone abortions had been asked for their consent. Centre for Social Research, Surrogate Motherhood, Ethical or Commercial at 79.
54 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) (“Often they show documents stating that the woman consented. We must ask ourselves if documents are sufficient to establish informed consent.”).
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57 Nadine Taub, Surrogacy: Sorting Through the Alternatives, 4 BERKELEY WOMEN’S L.J., 285, 288 (1989-1990) (“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.”).


60 NEW YORK REPORT 2017 at 29 n.47.


63 See supra note 2.

64 750 ILL. COMP. STAT. §§ 47/1–75 (2005).


66 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.”).

67 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. Email communication with surrogacy lawyer in Massachusetts (Sept. 6, 2017).


69 Email communication with surrogacy lawyer in Massachusetts (Sept. 6, 2017).

70 Email communication with surrogacy lawyer in Massachusetts (Sept. 6, 2017).

71 Email communication with surrogacy lawyer in Massachusetts (Sept. 6, 2017).

72 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.”).

One study of twenty-four surrogates in the United Kingdom where fifteen had successfully given birth stated that none had trouble relinquishing the child and many handed the child over immediately. Olga Van Den Akker, Genetic and gestational surrogate mothers’ experience of surrogacy, 21 J. REPROD. & INFANT PSYCHOL. 145, 152 (2003). The author concludes the surrogates showed no evidence of psychopathology. 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 the Beck Depression Inventory. Jadva et al., Surrogate mothers 10 years on: a longitudinal study of psychological well-being and relationships with the parents and child, 30 HUMAN REPROD. 373, 376 (2015). None expressed regrets about surrogacy. Id.


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

See Interview with Delaware Lawyer (Mar. 29, 2017).

Even people who are not the most affluent have the ability to pursue an injustice and afford a lawyer through the use of contingency fees. So, on top of the already natural desire to do good, responsible work, the threat of legal action gives agencies and lawyers an extra incentive to handle matters related to surrogacy carefully and thoroughly. Sital Kalantry, Theodore Eisenberg & Nick Robison, Litigation as a Measure of Well-Being, 62 DEPAUL L.R. 247, 28 (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 (2003-2004) (“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.”).

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.”).

See Rukumi 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.


Punitive Damages: India is behind the curve, LIVEMINT (July 23, 2014, 6:06 AM), http://www.livemint.com/Opinion/rOpylDvF7Lx8Yz70EnN/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. Balram Prasad v. Kunal Saha, (2012) 1 SCC 384 (India); Gayatri 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. 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. Id.


97 Another explanation for the more advantageous bargaining position of American surrogates as compared to Indian surrogates may be that there are greater information exchange networks among American surrogates. American surrogates communicate over social media and blogs and can learn what terms other surrogates received. On the other hand, in India most surrogates likely do not have access to the Internet, but some have suggested that in communities where surrogacy is popular there is more information sharing among surrogates. Even if American surrogates may be able to enhance their bargaining position by learning about the terms other surrogates received, this does not explain why the baseline levels of protection in India are much lower than in the United States.

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


101 Intended Parents, CENTER FOR SURROGATE PARENTING, INC., 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).

102 Interview with Gupta Clinic.

103 Normann Witzeb & Anurag Chawla, Surrogacy in India: Strong Demand, Weak Laws, in SURROGACY, LAW AND HUMAN RIGHTS 172 (Paula Gerber & Katie O’Byrne eds., 2015).

104 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 (Mar. 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 disproven this thesis. See, e.g., Susan Golombok, Families created through surrogacy: Mother-child relationships and children’s psychological adjustment at age 7, 47 DEVELOPMENTAL PSYCHOL. 1579 (2011) (“No differences were found for maternal negativity, maternal positivity, or child adjustment.”).

105 Richard A. Epstein, Surrogacy: The Case for Full Contractual Enforcement, 81 VA. L. REV. 2305, 2336 (1995) (“[I]t cannot be regarded as unjust or unwise that his decision should determine whether the abortion should take place, . . .”).


107 Hon. Richard A. Posner, The Ethics and Economics of Enforcing Contracts of Surrogate Motherhood, 51 J. CONTEMP. HEALTH & PUB. 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.”).

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118 See generally, Margaret Jane Radin, Boilerplate: The Fine Print, Vanishing Rights and the Rule of Law (2013) at 213 (“[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.”).
119 Cal. Fam. Code § 7962 (a)(4). The statute also requires that the contract contain: (i) the date on which the assisted reproduction agreement for gestational carriers was executed; (ii) the persons from which the gametes originated, unless donated gametes were used; and (iii) the identity of the intended parent or parents.
122 Embryo Carrying Agreements (Approval of the Agreement and the Status of the Child) Law, SH No. 1577 (Isr.).
123 Children’s Act 38 of 2005; Ex parte WH 2011 6 SA 514.
130 While I argue that countries should legalize gestational care markets and where appropriate regulate it, I do not specifically address transnational surrogacy in this article. Transnational surrogacy arrangements are more complicated than domestic surrogacy arrangements, because they can create situations of legal limbo for children and makes it harder to vet intended parents.