

## **9 An Introduction to the Ethical Dimensions of Reproductive Medical Tourism**

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### **INTRODUCTION**

Reproductive medical tourism is an emerging and ethically problematic phenomenon existing at the interface between commerce and clinical care. Defined by Ferraretti, Pennings, Gianaroli, Natali and Magli (2010) as “the traveling of citizens from their country of residence to another country in order to receive a specific treatment or to exercise personal reproductive choice,” reproductive tourism occurs in many parts of the world and can involve the seeking of a variety of so-called assisted reproductive technologies (ARTs), including *in vitro* fertilization (IVF), intracytoplasmic sperm injection (ICSI), pre-implantation genetic diagnosis (PGD), gamete donation and surrogacy. For the present purposes, reproductive medical tourism is defined as an instance of a human being crossing an international border to seek an assisted reproductive technology service. According to this definition, the transport of gametes does not qualify, nor does travel for the purpose of gamete donation. Most commonly, travel for IVF, ICSI, sex-selection, PGD and maternal surrogacy are considered.

When the client seeking services is from a high-income country and the jurisdiction providing the service is a low-income country there is an added threat of potential exploitation, or at least of heightened ethical concern. This may be particularly true when maternal surrogacy is the service being sought, as it most blatantly abuts issues of female autonomy and reproductive rights, which are most immediate and prevalent in the global South.

### **MOTIVATIONS OF PARTICIPANTS**

Matthias Helble of the World Trade Organization (WTO) points out that ‘human body resources’ are more available and affordable in low-income countries, where ‘poor and vulnerable’ populations are both available in large numbers and are perceived as being more willing than citizens of the global North to jeopardize their personal health for a small financial

reward (Helble, 2011). The provision of reproductive services is largely the domain of women, as ovum donation and surrogacy services are major components of the reproductive tourism industry: according to one source, 80 percent of Canadian IVF patients seeking care in the US were actually seeking donor ova (Whittaker, 2011). Further, an abundance of studies conclude that in vulnerable and economically disadvantaged populations, women tend to be the most vulnerable and powerless.

What is clear to observers is that residents of wealthy nations are travelling to less wealthy ones in increasing numbers for the purposes of seeking medical care of all types (Meghani, 2011). As Chapter 2 discusses, the exact size of the population crossing borders to seek care is unknown, but anecdotal evidence places it in the hundreds of thousands to several millions yearly (Helble, 2011). The complement seeking reproductive services specifically is unknown, but numbers in the tens of thousands in Europe alone (Whittaker, 2011) and, anecdotally, in the hundreds of thousands in Asia. While motivations vary from person to person, some generalizations can be made about the macro elements contributing to the movement of care seekers across borders: new developments in information technology that have facilitated knowledge of foreign care providers, globalization's effect on reducing travel costs, and trade liberalization policies at the state level (Helble, 2011).<sup>1</sup> Given that only 48 out of 191 member states of the World Health Organization (WHO) are known to have domestic IVF facilities (Inhorn, 2009), it stands to reason that an international reproductive tourism industry would arise.

The reasons for which individuals travel to another country for reproductive tourism are varied and include: the required services are not legal or available in their home country; they are not eligible for treatment in their home country; the efficacy of treatment is limited in their home country, or, the services in their home country have prohibitively long waiting lists or high costs (Ferraretti, 2010). The particular combination of reasons and the treatment sought will depend on the exact home country from which the person is travelling, along with the specific demographic characteristics and needs of the person desiring a child. Generally, the need to travel for ART is a combination of legal restrictions forcing people out of their home

countries and attractive services drawing patients to foreign countries to access reproductive services (Nygren, Adamson, Zegers-Hochschild & Mouzon, 2010).

Reproductive tourists seeking services relating to their own gametes share three major characteristics: the desire for a child who is genetically 'theirs'; the inability to produce this child through natural means; and, a willingness to expend significant resources to produce this child (Spar, 2005). On the other hand, the motivations for mothers in low-income countries to participate as surrogates have not been well studied. It is speculated that the primary motivation is financial, as Indian surrogates can make as much as US\$6,000 (Johnston, 2008), which is substantially more than they would earn otherwise, though it is possible that feelings of altruism are also involved. There has been some anecdotal speculation that the participation of Indian surrogates is motivated or encouraged by a religious desire to help lift the 'curse' of infertility from their clients.

## **THE NEED FOR A DISCUSSION OF ETHICS**

While this fast growing global industry has loci in the US, Eastern Europe, Latin America and Southeast Asia, India is one of the world's greatest providers, specifically of surrogate mothers. By some estimates, it is an industry worth US\$500 million (Fontanella-Khan, 2010) to US\$2.3 billion (Brenhouse, 2010). India's provision of surrogate mothers to high-income foreign clients is therefore ripe for ethical analysis, as it profoundly subtends an increasingly intimate relationship between medicine, business, finance, politics and an overall perception of the roles and rights of South Asian women.

Several attempts have been made to identify some of the factors informing an ethical analysis of this phenomenon, particularly as it applies to the case of surrogates arising from developing countries like India. The exploitation and objectification of women, the welfare of children produced through the procedure and the unregulated state of the industry have been identified as significant sources of concern (Bardale, 2009; Qadeer, 2009; Parks, 2010; Pennings, de Wert, Shenfield, Cohen, Tarlatzis, & Devroey, 2008; Humbyrd, 2009; Tieu, 2009). More

recent analyses have begun to consider the impacts on both the domestic and international public health systems (Whittaker, 2011).

Virtually all ethical analyses of medical tourism employ a Western liberal ethical framework, considering elements of autonomy and individual rights as suitable guideposts. The same approach is applied in this chapter, due mostly to the fact that informed consent, which can be considered to be a product mostly of the Western liberal framework, is a recurring theme surrounding surrogacy rights. There are, however, many limitations in employing this framework too narrowly for a global phenomenon because the Western liberal framework may be inadequate for application to all of medical tourism, “due to its over-individualistic nature” (Widdows, 2011a).

In some ways, reproductive tourism presents an excellent opportunity to both examine the conflict between Western and Eastern ethical frameworks, and to begin the process of developing a more global framework, which might be informed by the evolving constructs and concepts of universal human rights. A necessary first step is an acknowledgement of the existing ethical issues, presented from the well understood perspective of the Western liberal framework, which holds individual autonomy at its core. This chapter, as such, constitutes an initial presentation of these issues.

## **ETHICAL ISSUES**

### Misdirection of financial resources

Those who seek services abroad deny their resources (i.e., outgoing funds) to their home community, and instead offer them to clinics in destination countries (Turner, 2007). This aspect of the phenomenon applies, regardless of whether source and destination countries are of comparable wealth, and has rarely been discussed in the literature. When considered from the perspective of the ‘tourist,’ the issue becomes one of subtle libertarianism: one is free to spend one’s money where one sees fit. However, from a policymaker’s perspective, it is conceivable that a sufficiently robust global medical tourism industry may be seen as a financial negative for the society providing more tourists than it does service providers.

In one sense, reliance on another nation to provide healthcare for one's citizens frees the source nation from having to expend resources on its own domestic healthcare system. But medical tourists often spend their money more than just on medical services. The seeking of an invasive procedure, like a surgery or a pregnancy, likely requires a lengthy stay in the destination country, leading to further expenditures on that country's hotel and restaurant industry (Johnston, Crooks, Snyder & Kingsbury, 2010).

Thus, potentially, the departure of large numbers of citizens to seek care in another jurisdiction may be perceived as contributing to the budgetary deficit of the source country, by virtue of the tourists' failure to re-invest portions of their income into their home service industries; or otherwise contributing to trade imbalances that more recently have become a major concern with respect to global macroeconomic stability.

However, inasmuch as this transfer of wealth also applies equally to all types of tourism, whether medical or recreational, and given the present small scale of medical tourism, relative to other factors affecting most Western economies, this concern is likely trivial.

#### Misdirection of medical resources

While a clinician in a destination country is providing services to 'medical tourists,' they are, at that time, not providing services to their home community, even though citizens of the local community provided the investments and conditions that permitted the clinicians to assume their current status (de Arellano, 2007).

This aspect is well discussed in the literature. Oft cited is the Indian government's decision to use public resources to help develop that nation's robust medical tourism industry (Cortez, 2008). Those resources might have been more rightfully expended providing services to the Indian taxpayers. The obvious counter-argument is an economic one: that investment in developing services for medical tourists will eventually lead to greater economic wealth for a larger segment of the destination country, which will in turn lead to greater tax revenue and thus more resources for the betterment of the destination country's taxpayers. However, the author was unable to find empirical evidence of such trickle-down effects being demonstrated.

From a policymaker's perspective, the challenge is in distinguishing between the priorities of competing stakeholders. On the one hand, there is the need to encourage

independence in commerce and freedom to exercise one's skills set for the betterment of a wide clientele. On the other hand, there is the need to reserve resources for the citizens who, it can be argued, are part owners of the services their taxes helped to subsidize.

The issue is further complicated when it is considered that failure to provide medical services to foreigners may mean that those individuals may never receive services (depending upon their reasons for seeking cross-border care). When such services are medically necessary, then it can be argued that a practitioner has a moral obligation to provide them, regardless of the country of origin of the patient.

Clearly, how this issue is perceived depends upon the agenda and expectations of the agent whose perspective is under consideration. The priorities, responsibilities and ethical obligations of a policymaker are different from those of a clinician and those of the general citizen.

#### Implications of insufficiency

The act of 'tourists' seeking services abroad, implies that services are insufficient in quantity, type, timing or affordability, in the home country. When seating this observation as an ethical issue, the implicit assumption is that residents of the home country have a right to the services that they seek abroad. Failure to satisfy those rights, then, represents a moral failure on the part of the source nation's leadership.

Clearly, such an argument cannot apply to all forms of medical tourism. The "health as a human right" movement typically refers to basic healthcare only (Mpinga, 2011). When tourists are seeking exotic services deemed illegal in their home country, such as child sex-selection for Canadians (Department of Justice Canada, 2004), then their societies have explicitly stated, through an instrument of criminal law, that they in fact do not have a right to that service.

On the other hand, the seeking of life-saving interventions, such as surgeries or consultations with specialists, may be indicative of a deeper issue plaguing the source country; long waiting lists for life-saving therapies are a good example.

Implications of insufficiency are not so much an ethical issue as they are an indicator of a state's unmet responsibility. From a source country's policymaker's perspective, then, the very existence of medical tourism can be considered to be a sign of ineffectual policymaking. Failure

to act on such an indicator might subsequently be considered a moral failing or even a violation of legal obligations under international human rights treaties.

### Criminality

If service seeking abroad is done to avoid prohibitions at home, then, in some circumstances, the provision of services to such a medical tourist might constitute the abetting of criminal behaviour. An argument can be made that if the activity is not illegal in the destination country, then no criminal activity has taken place. However, some societies have chosen to redefine the scope of criminality to include activities undertaken by a member of a society outside of that society's geographical limits.

The obvious analogy is to sex tourism. Many countries have enacted laws that enable their law enforcement to penalize citizens who go abroad and procure sex with minors. The United States' PROTECT Act of 2003 is an example of such a law (United States Government Printing Office, 2003). Clearly, it is possible to conceptualize the commission of a criminal act in a jurisdiction where that act is nonetheless legal.

The ethical transgression in the case of reproductive tourism can be examined from three perspectives. Firstly, given that the source country has deemed an act to be illegal (such as sex-selection, in the case of Canada) and therefore likely immoral, then, much like the case of child sex tourism, that nation may be ethically compelled to enforce its law upon all its citizens, regardless of their location.

Secondly, the tourists themselves, by virtue of seeking to avoid the technical criminality of their behaviour by changing jurisdictions, while nonetheless persisting in the moral transgression of the behaviour, may be considered to be acting in an unethical manner.

Lastly, the destination country is least complicit in this transgression, since its directives are internally defined according to the values of its citizenry and culture. Discussion of the potential complicity of the destination country leads to the unavoidable question of whether there exists a universal morality against which all local moralities may be judged. The framing of trans-border prosecution instruments, like the PROTECT Act, implicitly assumes universal morality, and thus denies a destination country the freedom to protect all within its borders from foreign prosecution.

This issue is most relevant when the source and destination countries are of unequal power, either in terms of wealth or international prestige. The inability to marshal a responsive judiciary or law enforcement, which is often a situation faced by less developed nations, presents an opportunity to establish a unidirectional flow of clientele from a more legally restrictive and wealthier jurisdiction to a less restrictive and poorer one. Again, the example of international sex tourism is most pertinent here, which the media tends to characterize as a flow of sex-seeking clients from rich nations to poorer ones.

However, gradients in legal restrictiveness can also exist between nations of comparable wealth and power. A good example is the phenomenon of abortion tourism. In 1998, more than 6,000 Irish women travelled to Britain to seek abortions, due to the latter's less restrictive policies (Payne, 1999). On a global scale, the wealth difference between Ireland and Great Britain is negligible.

From a strictly practical standpoint, the sidestepping of criminality is unlikely to be a strong issue with respect to medical tourism. The moral transgressions perceived to be implicit in the seeking of restricted medical procedures are likely not sufficiently inciting to warrant such extreme measures as trans-border prosecution. Even if they were, with the exception of specific surgical or organ transplant procedures, it would be extremely problematic to detect, prove and punish transgressions. For example, how does a prosecutor prove that a cross-border abortion took place, without first finding sufficient reason to conduct an invasive medical examination? And if an illegal reproductive service was sought, what does the prosecutor then do with the resulting child?

While criminality is theoretically problematic in the case of general medical tourism, it is a definitive ethical challenge for a case of reproductive tourism that transgresses a domestic law, and that results in the birth of a child. Policymakers would then be compelled to decide upon the disposition of the child, in the event that its creation was deemed to be illegal. It is an ethically, politically and legally chilling scenario.

#### Quality control

Inconsistencies in the quality of medical services will occur between jurisdictions. A tourist seeking a service in a foreign jurisdiction may not receive the same standard of care he



would have expected in the home country. A resident of Canada, for example, may feel compelled by the long waiting lists at home to seek surgery in India, and may experience a different standard of surgical skill and post-operative care. Patients seeking transplant tourism require a regimen of immunosuppressive post-operative care that might not be as robust in a developing world setting as it is in the home country (Schiano & Rhodes, 2010; Polcari et al., 2010). The agents acting in this moral framework are the governments of both the source and destination nations, and the emerging medical tourism brokerage and insurance companies that serve as intermediaries between domestic clients and foreign patients. In the case of reproductive tourism, often tourists are emotionally vulnerable and thus susceptible to inflated success rates marketed by less circumspect clinics. The extent to which source governments have a responsibility to protect their citizens who go abroad to seek such care is debatable, but may constitute the essence of the government's responsibility to its immediate stakeholders, its citizenry.

Similarly, the extent to which destination governments and clinics are responsible for moderating expectations, in terms of both success rates, pleasantness of the medical care environment and comprehensiveness of post-intervention care relative to the standards expected in source nations, constitutes the core of their ethical responsibility to the arriving patient, which is separate from their responsibilities to the clinicians who operate under their rubric and to the surrogates or gamete donors who are their immediate constituents. In cases in which the source country is wealthier than the destination country, client expectations with respect to hygiene, pollution, diversity of services and diet, and other luxuries taken for granted in the developed world must be managed by the clinician and indeed by the destination culture. The extent to which a poorer nation can meet the standards expected by the wealthier client can be considered the joint responsibility of both the clinician and the destination state.

On this topic, the literature has focused on the role of brokerage and insurance companies, as in Turner's paper on regulatory oversight of medical tourism companies (Turner, 2011). In brief, establishing high standards of oversight for such companies can reduce their role in skewing tourists' expectations and thus their risk.

It can be argued, however, that there is an overt responsibility on the part of destination policymakers to manage client expectations, inasmuch as failure to do so may constitute 'false advertising' and thus a kind of passive coercion. Similarly, there is a rational expectation by the citizenry of the source nation that its policymakers will take seriously the possibility that travelling citizens may be harmed by the poorer medical quality offered in foreign clinics.

### Coercion

The seeking of trans-border care is an extreme response to particular medical duress. A seeker of care is therefore vulnerable to coercion and exploitation. For example, when one is seeking life-saving surgery abroad (perhaps due to lengthy waiting lists at home), one is more likely to accept the heightened risk of receiving that surgery at a less experienced or less well equipped clinic, in exchange for a shorter wait time. Clearly, this is related to informed consent; ideally, an element of that consent must include a true understanding of a procedure's risk, untainted by one's extreme emotional state. In the presence of a tourist's emotion, it is possible for a less circumspect clinic or broker to minimize or avoid discussion of the limitations or risks of their service provision.

Moreover, in the case of reproductive tourism, unlike other forms of medical tourism, care seeking is most often done by couples or families, and not by individuals. This introduces the problematic possibility of a spouse placing undue pressure on his partner to seek risky services. The extent to which providers or brokers manage this possibility is profoundly uncertain. In this context, a broker can be an insurance company that mediates between a tourist and the destination clinic, a third party that finds and negotiates for gamete donation or surrogacy service, or indeed the gamete donor or surrogate herself.

Within the Western liberal framework, coercion of any kind is an ethical violation (except, it can be argued, in some cases in which a degree of coercion or misdirection is employed to encourage someone to seek needed care that he or she would otherwise not receive). Overt coercion is easily identified. But it might also be argued that systemic factors can produce a coercive environment such that there is an illusion of choice, as in the case of an environment of poverty removing any real choice from a woman who must turn to prostitution to earn a living. Organ transplant tourism has been identified in the literature as a phenomenon

that is particularly vulnerable to coercion (Stephan, Barbari & Younan, 2007). The responsibilities of consanguinity or appeals to guilt can be used to coerce participation.

More immediately, coercion is oft masked by informed consent, as will be discussed in further depth later in this paper. In her critique of the Western framework's fit with current and emerging global trends, Widdows suggests that informed consent, as it is commonly practiced, "fails to take account of the context and commitments of individuals which may constitute inducement and coercion" (Widdows, 2011a, p. 83). She argues that focus on the individual makes the concerns of others invisible, an argument that has relevance in medical tourism scenarios involving the provision of services by members of non-Western communities. Organ donors and surrogate mothers are good examples of individuals whose decisions, while individualistically defensible, may have impacts on their non-consenting community members. In other words, to recognize coercion in all its forms, it is necessary to also recognize structural and context-related ethical injustices.

#### Violation of destination country's moral paradigm

Cultural change can arise from the introduction of new technologies. Reproductive technologies in particular have the potential to introduce secular and individualistic concepts and behaviours to societies unfamiliar or uncomfortable with such developments. Examples include ART's power to easily create single parent households and same-sex parented families.

India is a good example of a nation whose communities are experiencing rapid change, often as a result of external forces. While homosexual unions have recently been decriminalized under Indian law, there are reports that the Indian government is preparing a Bill that would prohibit same sex foreign couples from using surrogacy services in India, so long as same-sex marriages remain unlawful in India (Wade & Walters, 2010). This suggests that reproductive tourism is introducing social patterns that are unfamiliar, and in some circles undesirable, to the destination society. The economic gradient represented by the industry is perhaps accelerating the introduction of these issues to societies that otherwise would have discovered them at their own pace.

The extent to which this is indeed an ethical issue depends upon whether one considers prevailing or majority cultural norms to be sacrosanct. If so, then all agents involved in the

transaction are transgressing the destination country's moral paradigm, from the tourist to the service provider and both of their accommodating governments. On the other hand, if cultural relativism is not in play, or if one accepts that a culture is not defined by its most conservative or indeed its majority viewpoint, then the cultural change brought about by medical tourism is not an ethical concern, but rather a social catalyst that accelerates a change that likely would have occurred eventually anyway.

One cannot fully consider this issue without abutting the greater question of whether there exists a universal morality, or at least a shared set of values toward which all nations should tend. This is, in some ways, a neo-colonial manifestation of the Western liberal framework, inasmuch as the acceptance of a universal morality necessarily vitiates any sense of cultural relativism while simultaneously celebrating the rights of the individual. Universal same-sex rights are an example of this tension: if these rights are indeed universal, then reproductive tourism is a tool of liberation; if they are not universal, then the industry is a tool of imperialism, or at least of problematic social disruption.

#### Applicability of the adoption standard

In most nations, the state, as custodians of society's values, insists upon vetting parents for fitness when individuals seek to adopt. The criteria vary, but tend to involve measures of psychological fitness, economic health and stability of the home life. In the case of an individual or couple using ART to obtain a child, however, no such formal governmental vetting process is applied in most countries. In Western clinics, psychological screening is done at the discretion of the clinic.

The two scenarios differ in that one involves the welfare of a child who already exists, but whose care is managed *in loco parentis* by the state prior to adoption. In the other case, the point of the intervention is to biologically create a child. They are similar, though, in one key sense: in both scenarios, an external party is required to allow the suitor to achieve parenthood. In the first case, that party is the state and an adoption agency; in the second, it is the fertility clinic, in some ways acting as an agent of the state.

When assisting a client to create a child, there is the ethical question of how much responsibility the clinic or the state accepts in determining how qualified a patient is to be a

parent. A history of abusive behaviour is an obvious example as a potential disqualifier; but softer criteria, such as economic wherewithal, may also be applicable, as they are when considering an individual's fitness to be an adoptive parent.

In the case of reproductive tourism, it is possible that both the states of the source country and the destination country bear responsibility for assessing the suitability of a 'tourist' to essentially be given a child through the intervention of ART. This is a most profound ethical question that relates to the oft-heard cry for the welfare of the child to be more carefully considered when developing ART regulations (Bardale, 2009). Welfare concerns include the economic health of the household, the mental health history of the parent, and the extent of family support, emotional and otherwise, available to the child.

This issue is contextualized within the larger debate of whether parenthood is a right or a privilege. Proponents of the former also argue that aspects of ART, possibly even extending to support for reproductive tourism, should be paid for by the state, whose responsibility it is to ensure that all citizens' rights are upheld. But the correlate to this position is that acknowledging the state's responsibilities necessarily allows the state to apply "non-medical considerations into account in determining whether or not an applicant is entitled to this service, particularly in cases where the applicant seems to lack mothering ability" (Statman, 2003, p. 224).

#### Robustness of informed consent

Informed consent is in many ways the fundament that seats these analyses within the Western liberal, or individualistic, framework. Legal requirements and definitions will vary between jurisdictions, affecting the extent and nature of risk communication. The adequacy of such communication represents a challenge to the robustness of the informed consent of the reproductive tourist. Many documented instances abound of medical informed consent being variably applied across different nations and populations (Krosin, Klitzman, Levin, Cheng & Ranney, 2006). There is no certainty that a tourist will receive the same level of health communication that she would have expected in her home country, and therefore no certainty that her consent to receive therapies that may carry risk would indeed qualify as informed, by Western standards.

Informed consent, as it pertains to the surrogate, is quite separate from that pertaining to the 'tourist.' Traditionally, informed consent involves the communication of risks and benefits contextualized within the medical domain (American Medical Association, 1995). Challenges to informed consent have tended to focus on the quality and clarity of communication and the avoidance of coercion, subtle or overt (Krogstad et al., 2010); though, as discussed above, consent can be used to hide some kinds of coercion. These factors are certainly at play with respect to reproductive tourism, especially given surrogates' tendency to be economically vulnerable, illiterate, and susceptible to the neo-colonial motivator of an impressive medical authority figure.

Given the centrality of informed consent to almost any argument in favour of purchasing the reproductive services of poor, developing-world women, it is unavoidable that the industry will tend to be conceptualized within a Western liberal framework. Ultimately, the discourse concerns the tension between the individual rights of the surrogate and 'tourist' to negotiate a commercial relationship, and the responsibilities of policymakers, clinicians and civil society to ensure that the industry is not simply a new face of neo-colonial exploitation.

The legacy of colonialism is difficult to disentangle from the experience of reproductive tourism, especially when the destination country is a former European colony, such as India. Perspectives from Africa suggest that a combination of poor literacy and a colonial heritage combine to make informed consent problematic (Gong et al., 2008). The same forces apply in India, where an authority figure modelled on an image of Western power, such as a doctor, is afforded automatic deference.

An additional concern is the failure of the medical informed consent model to consider that downstream social risks and impacts must also be communicated; simply expressing the biological risks may not be sufficient to attain full, defensible consent. Surrogates are known to face the risk of social shunning (Lycett, 2009). Examples include the possibility that a surrogate's community, spouse or family may object to her carrying the child of a man other than that of her husband, or the child of a homosexual couple. Media reports suggest that rural surrogates are often accused of adultery and face being ostracized by their community (Hochschild, 2009).

Arguably, the risk of shunning or of other kinds of unpleasant experiences should be encapsulated within the process of acquiring the informed consent of the surrogate.

The obvious legal concern that arises if the informed consent process does indeed manage to include discussion of all possible dangers, including social and emotional risk, is that an individualistic legal system might conclude that an expression of autonomy includes the right to exercise one's autonomy to allow one's own exploitation. In other words, the legal expression of informed consent not only gives the surrogate a better sense of the real risks she will face, it also provides legal cover for the clinicians and 'tourist' who will then place her in a position of danger. Informed consent can be used to vitiate legal responsibility, which is often misunderstood as a vitiation of moral responsibility, as well.

In many ways, informed consent is the philosophical battlefield on which a new ethical framework for reproductive tourism must be won. Presently, the individualistic Western model prevails and holds that so long as a surrogate expresses understanding of her risks, and so long as the clinician, 'tourist,' state and brokers make a reasonable effort to fully convey those risks without a sense of overt coercion—and reasonably believe that their words were understood—then the procedure, however risky, is sufficiently ethical.

However, several factors confound that perspective: three are most pertinent. First, as mentioned, social risks and emotional risks can be as damaging as physical ones; communication of all kinds of risk, not just the biological, is indicated. Second, since many surrogates, especially those provided by Indian clinics, are poor and possibly illiterate, the economic and power differential between surrogate and clinician, or 'tourist,' is extreme. In such instances, the traditional threshold for accepting consent may not be high enough; additional and perhaps extensive measures are perhaps required to better ensure complete communication of risk, complete understanding of risk, and appropriate balance of real risk against the blinding lure of life-changing compensation.

And third, when dealing with a cross-cultural transaction, the Western perspective of individual autonomy may need to give way to the possibility of including the voices of other stakeholders in the provision of informed consent. The surrogate's existing children, husband, greater family and indeed her neighbours may have a stake in the decision she makes. In the

new bioethics that may emerge as reproduction tourism faces its legal and social challenges, the individualistic elements that presently characterize Medicine's legal and ethical practice may need to be enhanced by some context—and community-based elements — if informed consent is to have any real meaning on this new front.

### Custody rights

Laws concerning the custody rights of a surrogate vary from country to country and sometimes between provinces or states within a single country. For example, the US State of Michigan's Surrogate Parenting Act (Michigan Legislature, 1988) does not allow for courts to recognize surrogate parentage contracts, meaning that the surrogate has strong rights with respect to potential custody. On the other hand, Indian law has been quite robust in recognizing the legality of the surrogate contract (Ramasubramanian, 2011), thus providing more assurance for the reproductive 'tourist.'

Arguably, a nation with laws disfavoring the surrogate and favoring the client is a more attractive destination for a reproductive 'tourist' seeking the smallest set of legal barriers to receiving a child. As reproductive tourism grows in economic importance, the extent to which a nation's custody and adoption laws become informed and influenced by the needs of the reproductive tourism industry need to be considered.

This is potentially an ethical concern because the responsiveness of the destination state to the needs of its citizenry may be co-opted by the needs of the industry. While the influence of big business on government policy is not unusual, it is nonetheless regrettable when the rights and needs of poor and vulnerable women are in play. Both source and destination societies should be on guard for the creep of commercial interest into the passing of laws meant to address societal values beyond mere financial wherewithal.

### Quality of surrogate care

While it is likely that different clinics embrace different models of care, it remains uncertain to what extent a surrogate's health is maintained beyond her gestational role. It is reasonable to expect the client to fund the nutritional requirements of the surrogate, as her physical health relates directly to the health of the child she gestates. But her needs probably extend beyond the physical. What of her social and mental health? If her role as a surrogate



requires her to change her diet and perhaps alter her daily physical activities, it is possible that these changes impart an emotional impact. Moreover, her regular domestic familial duties may be affected by her role as a surrogate; the extent to which the stresses of these dual roles are dealt with by the client and clinician constitute an ethical question.

Unfortunately, it is difficult to find concrete examples of actual transgressions in this category. There are very few published studies of the care and home conditions of surrogates in the developing world. But even just theoretically, it is clearly foreseeable that a commercial model that employs a surrogate as a means for the creation of a child will have financial disincentives for expending resources on her beyond that which is necessary to produce a healthy child.

#### Limits of surrogate care

Related to the issue of quality of care is the point at which surrogate care ceases. While the surrogate's medical health is of prime importance during pregnancy, there is a moral argument for assuring that that care extends beyond the delivery. Given the likelihood of postpartum injury or depression, it remains uncertain who is ultimately responsible for assuring that a surrogate is given sufficient care to recover from such conditions. Obstetric anal injury (Marsh, Lynne, Christine & Alison, 2010) and postpartum haemorrhaging (Gei-Guardia, Soto-Herrera, Gei-Brealey & Chen-Ku, 2010) are examples of post-delivery health threats that would not be uncommon.

Postpartum injury is the direct result of a process begun by the tourist and clinician for the purposes of achieving a biological product for the tourist. It can be argued that, since such injury is a foreseeable consequence of the overall process, both avoiding and repairing such injury is the logical responsibility of all agents involved, and not just of the surrogate herself.

A corollary to this issue is the question of the economic incentives for maintaining a surrogate's health well past delivery. A woman with proven gestational ability is an asset to a clinic that employs surrogates; thus, it is rational for that clinic to ensure her continued health and gestational capacity. It is interesting that an economic argument would perhaps be more compelling than an altruistic one for ensuring proper extended care for a post-delivery surrogate.

### Remuneration

One likely reason that a reproductive ‘tourist’ seeks service abroad is reduced cost, made possible in part by the lesser financial demands of surrogates who may live in economically distressed circumstances. The economic gradient that is at the heart of this commercial enterprise is ultimately subject to the forces of globalization. But while remuneration for the surrogate is likely above what she would otherwise earn, it is likely below the global average. The concept of “fair trade international surrogacy” (Humbyrd, 2009) addresses the choices that the client can make to improve the probability of an ethical transaction, but could be further enhanced by including an argument for either voluntary or compulsory standardization of global surrogacy fees, thus reducing the economic gradient.

Humbyrd’s ‘fair trade surrogacy’ model seeks to apply the lessons of ‘fair trade coffee’ to the reproductive tourism industry. In short, pricing would be set to “a fair price in the regional or local context” (Humbyrd, 2009). The ‘fair trade’ label would presumably then be used to market the service to more equity-minded clients. It is unclear whether such a model would indeed alter the present pricing dynamic; and concerns exist over the potential for ‘fair trade’ labelling generally to be used as a marketing tool that, using coffee as the exemplar commodity, maximizes profits along the value chain but only minimally improves returns for the original producer (Bando & de los Rios, 2007).

### Multiple Embryo Transfers and Abortion

Selective reduction is not an uncommon occurrence in ART (Min et al., 2010), especially in instances where multiple embryos are desired. The extent to which a surrogate is encouraged to accept multiple embryos, in order to maximize the probability of a successful implantation and thus reduce the costs to the client, is a factor influencing both the autonomy of the surrogate and the nature of her informed consent. Related is the possibility for a selective reduction abortion, done for several medically defensible reasons. It remains unknown whether surrogates from conservative cultures are either aware or culturally responsive to this likelihood.

This issue is an overlap between the earlier discussed issues of insufficient informed consent and potential coercion. Being informed of the risks of multiple embryo transfers and of

the likelihood of selective reduction is important, though whether an uneducated rural dweller with limited exposure to biotechnologies would truly grasp the risks being communicated is always an issue.

Coercion may manifest as pressure to accept multiple embryos. A multiple pregnancy is a dangerous medical condition that is avoided by fertility doctors in the West (Schieve et al., 2002). Yet it is attractive as a cost saving measure, since more transfers raises the chance of a pregnancy and reduces the number of attempts needed to become pregnant (Hurst, Shafir, & Lancaster, 1997). Thus there exists the possibility that tourists will view a poor foreign surrogate as an opportunity to confer risk upon someone else while simultaneously reducing the cost of the venture.

### Medical advocacy

Perhaps the most blatantly problematic, and ironically the most easily addressed, of the likely ethical pitfalls of surrogacy tourism is the model for clinical supervision of the pregnancy: the clinic receives payment from one party (the 'tourist') and performs a procedure on a second party (the surrogate). In other words, the clinic as an entity represents both the paying client and the paid surrogate. But several stakeholders, with potentially competing interests, are at play: the primary client ('tourist'), his or her spouse, the surrogate and, of course, the child resulting from the process (Deonandan, Green, & van Beinum, in press).

The potential is great for conflicts of interest, especially when clinical decisions must be made that weigh monetary cost to the 'tourist' against the physical well-being of the surrogate. In such scenarios, the cynic would suspect that the interests of the paying 'tourist' will prevail, even to the detriment of the health of the surrogate. At the very least, the incentive for such favouritism is financial, whereas the sole disincentive is moral. (As a corollary, perhaps this conflict of interest, or the extent to which it represents a potential risk to the health of the surrogate, is one of the dangers that should enter into the informed consent process.)

In the absence of an independent advocate, the surrogate is essentially being treated as an independent contractor who must bring her own expertise and resources to the business relationship. The clinic, in this sense, acts as a negotiation arbitrator or an intermediary through which a commercial transaction takes place. Beyond the clinic's legal and professional

requirements of good care, conceptually the surrogate's interests are limited to those which she manages to negotiate a priori.

In this scenario, the ethics at play are business ethics, not medical ethics. In business ethics, so long as full disclosure and fair play are in effect, all actors must be content with the scenario negotiated before the actual act of business; and all actors are expected to consider only their own needs, not the needs of the other party. The arbitrator's role is to enforce fairness. But in medical ethics, a clinic's role is to provide continual good care throughout the duration of the patient's presence within that clinic's sphere, always acting in that patient's best interests. A clinic is not equipped legally or experientially to act in the role of broker or arbitrator, nor is it empowered to do so via the tradition of medical ethics that has evolved over the past decades and centuries.

Beyond the confusion relating to informed consent, herein lies the second major challenge faced by reproductive tourism: to find a comfortable space between medicine and commerce, utilizing a hybrid ethical framework that refuses to compromise the essential role of a clinician, which is to always act in the best interests of the person under care, with respect to her health.

One possible solution is to assure that each surrogate is given the support of a separate medical advocate to counterbalance the great power held by the 'tourist' to influence decisions made about the surrogate's health. The evolution of such an advocacy model has yet to begin.

#### Exploitation of the Poor

When one hears of travellers from the developed world paying very poor women in the developing world to carry their babies, it is difficult not to wonder if this is a case of exploitation. There is a tension here between the libertarian view of free choice versus the sense that choice may be economically coerced. Fundamentally, the question is, is it moral to leverage poverty to receive a service that might not otherwise be offered or be affordable?

Similar arguments have been put forward for condemning prostitution, especially amongst impoverished peoples. The assumption underlying this condemnation is that no one would choose to sell sex, or to rent their wombs, if there were any other economic options.

This is, of course, the core of the Western liberal ethical framework, to consider the individual's right of unhindered choice to be sacrosanct. In other words, so long as the provider of the service, whether it is a womb or sex for money, does so of her own free will, then the transaction is likely ethical. It is the nature of choice that is philosophically problematic: can there be genuine choice between two options if one of the options is profoundly unbearable, such as starvation? In the case of surrogacy tourism, it is the extent to which financial need plays a role in the surrogate's choice to participate that remains in question, as well as whether that extent really is a rational metric to employ when making an ethical determination.

There are most definitely instances of altruistic surrogacy, especially in nations like Canada in which paid surrogacy is illegal. So the temptation is to assess each instance of cross-border surrogacy on a case-to-case basis, which is both impractical and ultimately misleading, since there are indeed larger population observations that can shed light on the phenomenon. For instance, Indian surrogates are seemingly universally poor (Bardale, 2009), suggesting that the prime motivator is indeed economic, not altruistic.

Given that financial need is indeed the basis for surrogates' eagerness to participate, is it then ethical to use this need to encourage participation? Conversely, is it ethical to deny an impoverished prospective surrogate the opportunity to lift herself and her family out of poverty simply because one decides that financial need is an inappropriate lever? Is that, too, not a kind of neo-colonial arrogance, perhaps masquerading as 'liberal guilt?'

To use someone's poor state in life to leverage an outcome or behaviour that that person would not otherwise offer is indeed exploitation. Viewed from a business ethics standpoint, this is fair play, as the game of commerce is about negotiation from a position of power. However, as in the case of medical advocacy above, it is clear that reproductive tourism represents a grey frontier on which the ethical frameworks of business, medicine, human rights, and cultural collisions dance to an unsteady rhythm. Is it possible, then, to be simultaneously both exploitative and ethical?

In the spirit of that question, Humbyrd suggests that we need to distinguish between harmful exploitation and mutually beneficial exploitation, and feels that reproductive tourism is of the latter camp (Humbyrd, 2009). He concludes that the international surrogacy market

needs to be regulated to ensure that the exploitation continues to be a mutually advantageous one. While it remains uncertain whether the purchasing of the reproductive capacities of impoverished women is indeed ethical, it is abundantly clear that consideration of this issue is complicated by the competing frameworks and paradigms of different professions and traditions. Even if reproductive tourism, and notably the use of Indian surrogates, is found to be unethical for any of the reasons discussed in this chapter, the market for such surrogacy already exists, the poverty driving Indian women to act as surrogates is not going to disappear in the near term, and regulating the practice towards more mutually beneficial and less unethical ends may be the most ethical 'second-best' alternative.

## CONCLUSION

While this analysis has been largely critical of the reproductive tourism industry, it is important to point out the benefits that the industry represents. In addition to providing possibly extraordinary income to poor surrogates who might otherwise be destitute, the industry provides an affordable opportunity for addressing the infertility of clients who would otherwise not have their needs fulfilled. In addition, destination communities receive foreign currency, create new job opportunities for locals through linkages with tourism, insurance, hotel and services business, and the retention of specialists who might otherwise emigrate for lack of wealth-generating opportunities (Whittaker, 2011).

Ethical questions around procreative tourism have heretofore focused on the tension between autonomy at one end of a spectrum of choice, and exploitation at the other end. In other words, the extent to which freedom of choice justifies the risks posed by these activities has been examined (Deech, 2003). The role of government is also oft discussed (Deech, 2003; Mulay & Gibson, 2006). Some effort has been made to explore the ethical dimensions related to restricting the industry (Pennings et al., 2008), and to describing the role of the client in examining her own role in ensuring an ethical reproductive transaction (Storrow, 2005).

The most pressing concerns are the limits and genuineness of informed consent for both the 'tourist' and the putative surrogate, and the uncertainty surrounding the extent of

independent advocacy enjoyed by the various stakeholders in the process, the surrogate prime among them. The latter is an issue that can be readily addressed by law or by voluntary policy changes at the clinic level; or indeed by choice of the client, who can insist that any engaged surrogate be given independent counsel, the price of whom would be included in the client's package.

As the global reproductive tourism industry expands, it becomes increasingly incumbent upon both government and civil society to take immediate steps to explore options for mitigating the many ethical challenges with which the phenomenon presents us.

The employment of a Western liberal ethical analytical framework is limiting to the extent that the cultures providing these services may not abide by the same value system. A useful subsequent analysis would be a comparison of ethical observations, within the reproductive tourism domain, from both Western liberal (individualistic) and community-focused (or non-Western approaches, the latter as defined by Widdows (Widdows, 2011b)).

The reproductive tourism industry is new, but growing rapidly. Many have moral and ethical concerns, while others see opportunity and the potential to both treat infertility and to alleviate poverty. What is clear is that the phenomenon shows no signs of disappearing. Thus, the elucidation, acknowledgement and analysis of existing and potential ethical transgressions is a vital phase in the evolution of a global culture for the monitoring and control of the industry, as well as for the protection of all stakeholders.

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<sup>1</sup> However, as the chapter by Blouin in this volume discusses, most of the 'trade' in medical tourism is taking place outside of any formal trade liberalization agreements. The one exception to this may be the role played by bilateral investment treaties or Mode 3 commitments under the WTO's General Agreement on Trade in Services in facilitating foreign investment in commercial health facilities catering to international patients.

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