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COMMENTS

(Mis)regulation – the case of commercial surrogacy

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Abstract

In the most recent attempt to regulate commercial surrogacy, the Ministry of Home Affairs (MHA) has issued a notice altering the category of visa for foreign nationals entering into commercial surrogacy arrangements from "tourist" to "medical". Upon close scrutiny, it becomes clear that this measure is a far too hasty and unprincipled step. Given the varying laws across different countries, commercial surrogacy has been an area marked by a fair amount of legal ambiguity and conflict, for example, with respect to the citizenship status of the child and legally accepted parentage of commissioning parents. The MHA's step towards addressing some of the dilemmas is, however, grossly inadequate and discriminatory. In spite of its seeming advantages, of some administrative and legal oversight of the industry, the notice will impact the existing practices in questionable ways since its provisions remain to be vetted through the lens of medical ethics and social justice. The measures, which are supposed to ensure legality, disambiguation and some degree of security for the commercial surrogate, end up giving a clean chit to the industry for the time being. If the step taken by the MHA was meant to be urgent, one wonders at the lack of motivation to strengthen public debate and produce a piece of legislation that can address the various concerns and dilemmas generated by the assisted reproductive technologies (ARTs). This is especially with reference to legislation that ensures the health and democratic rights of those who are at a disadvantage due to the power imbalance in commercial surrogacy arrangements.

Introduction

For a long time, commercial surrogacy has occupied an uncomfortable space in the public imagination, with the terrain of law, ethics and morality in this sphere remaining murky and ambiguous. Debates in this realm were sparked off recently after the Ministry of Home Affairs (MHA) issued a notice (1) detailing the new requirements for the visa process for foreign nationals coming to India to enter into these arrangements. A good part of the criticism has been directed at the discriminatory provisions which permit access to these technologies only to heterosexual married couples. Most other provisions have yet to be closely scrutinised. These developments call for a dual response. One needs to question the rationale behind the "solutions" offered by the state, and also recognise that identifying isolated problems obfuscates the pressing dilemmas in the area of commercial surrogacy.

From tourist to medical

The MHA notice changes the category of visa for foreign nationals entering into surrogacy arrangements from "tourist" to "medical", and lists several provisions upon which acquiring the visa and leaving the country are conditional. The move for a "medical" visa is perhaps motivated by the necessity to identify cases of foreign nationals who enter into these arrangements. In practice, however, there is no division between medical and tourism. Hospitality and health have become a potent combination in the form of the medical tourism sector in India today, with ARTs being a recent and significant addition.

The use of the category of "medical" in the context of commercial surrogacy also conforms to the recent trend towards the pathologisation of infertility. The expanding definition of infertility and the parallel flourishing of the industry associated with it have given rise to an attitude that normalises seeking "treatment" [i]. The oft-forgotten fact is that these technologies do not cure infertility, but only assist in conception.

The MHA's notice is geared towards identifying users of other nationalities and bringing them under scrutiny. This raises the question as to why such concern has not been expressed about the practice overall, including the local users. How has it been assumed that the source of the problem is the fact that many users to whom the industry caters are foreigners? What about the concerns that persist even when the users are local?

A closer look at the provisions reveals that this attempt at regulation is motivated by the objective of making the functioning of the industry smooth and predictable, so that it is seen as a low-risk option. However, in reality, it is an unprincipled and a hasty move to address some of the complex challenges and controversies the industry has generated.

Who can be a parent?

The MHA notice states: "The foreign man and woman intending to commission surrogacy should be duly married and the marriage should have sustained for at least two years." At present, the laws regarding access to these technologies and their legality are vastly inconsistent across countries, which can potentially lead to a citizenship crisis for the child. MHA's conditionalities that seem to be a response to such a climate of ambiguity, however, are simply inadequate and downright discriminatory. And even if it were to enable this global industry to navigate the legal ambiguities it faces, is it desirable to conform to the discriminatory provisions that exist in other states? By effectively putting a ban on same-sex couples and all single persons the state has, in resonance with its larger patriarchal bias, constructed a category of people who can become parents. These conditions conform to the current legal framework, which still does not acknowledge and respect the reproductive and sexual rights of most individuals, and thus reinforce a heteronormative idea of family. Can sexual orientation and marital status be a qualification for child-rearing? [(ii)]

There is enough historical evidence of a lack of commitment to the rights of those with non-normative sexual identities, one glaring example being the recent Supreme Court ruling that declared Section 377 of the Indian Penal Code constitutional[(iii)]. Even where non-heterosexual people are paying customers, it is as if their claim to reproduction and family is not equally credible to that of heterosexual couples; socially, they still inhabit a territory of non-recognition and so their needs can be sacrificed. The requirement of a two-year-long marital relationship is possibly based on the assumption that the relationship can be considered stable if it lasts two years and the child will, therefore, not be unwanted, as might have been the case in the event of a separation or divorce. However, this requirement is completely arbitrary.

The several concerns and challenges related to surrogacy require urgent and careful consideration, and the notice of the MHA does nothing to address them. On the other hand, it simply opens up another avenue of discrimination and bias.

A question of biology

Surrogacy arrangements have split the hitherto linear process of biological reproduction in an unprecedented way, such that the contribution of the sperm and ovum or egg, and gestating of the child can involve multiple actors. In addition, there are cases in which the commissioning parents may make no bodily contribution. Yet, the MHA has declared that the child will be claimed as the "biological" child of the commissioning parents. This illustrates how new definitions of categories such as "biological" are actively constructed, and in this case, be used to establish the claim of the commissioning parents over the child. A recent study by Sama (2) revealed that "biological" often translates into according privilege to the child's genetic link with one or both of the commissioning parents while undermining the bodily contribution of the surrogate (gestation). Even when there is no genetic link between the commissioning parents and the child, the link between the surrogate and the child is undermined on the ground that she has no genetic link with the child. Such an approach to ensure the relinquishment of the child forecloses any debate regarding the surrogate's perspective and consent in relinquishing the child, that could vary through the pregnancy or even afterwards and poses challenges to conceptualising the terms of a financial transaction. It is ultimately the procreative intent of the paying customer that is held to be of paramount importance. This furthers the interest of the industry, which has aggressively marketed the possibility of having "your own child" despite infertility. Secrecy, too, increases the marketability of the services, given the stigma attached to infertility.

ART clinic- the neutral bystander?

The ART clinic will now be required to give the commissioning parents a certificate stating that their liabilities towards the surrogate have been fully discharged. Through this clause, the state has projected the ART clinic, the visible face of the industry, as a neutral actor, recognising that it has the ability and authority to decide on the extent to which the commissioning parents are to be held responsible for the care of the child and on the remuneration offered to the surrogate. It is important to question the rationale behind assigning this role to the ART providers, who operate as part of a privatised industry that considers the commissioning parents the consumers and legitimate patients. Sama's study revealed that the process of decision-making on the choice of technologies to be used and procedures that the surrogate will be required to undergo, remuneration, relinquishment of the child, and living conditions of the surrogate (commissioning parents often state their preferences regarding the surrogate's lifestyle during the time of the pregnancy) often excludes the surrogate herself, with other actors, such as the commissioning parents, doctors and agents, playing a prominent role. The study also revealed that in the hospital set-up, surrogates often feel alienated due to a hierarchy which orders communication and the channels of information in such a way that participation becomes difficult for them. Often, the commissioning parents' wishes regarding the time of delivery, preference for immediate relinquishment, refusal of breastfeeding for the infant and preference for breaking contact with the surrogate after the child's birth are considered legitimate demands. The doctors accept these as "standard" practice. Further, many commissioning parents enter these arrangements through packages offered by medical tourism agencies or independent agents. In this case, the agent/agency mediates between the surrogate and the commissioning parents and doctors, and the latter are often unaware of the conditions agreed upon by the agent/agency and surrogate.

Liabilities and entitlements

The notice declares that the commissioning parents can leave the country only after they have discharged all the liabilities towards the Indian surrogate, as stated in the agreement. Here, one needs to clarify what "liabilities" refers to, what the nature of this agreement is, and who sets the terms. Sama's research revealed that in most cases, the surrogates cannot read the contract, which is written in English. They are informed about its contents verbally and loosely before their signature is to be taken. The only point that is emphasised is that they must agree to give up the child to the commissioning parents after birth (2). The contract becomes a one-sided tool to provide security to the commissioning parents regarding the relinquishment of the child. The agreements do not address several aspects of the arrangement, such as the remuneration offered to the surrogate, expectations regarding her lifestyle, the medical "treatment" and procedures that she will be required to undergo, health insurance, the terms of relinquishment and future contact with the child. Surrogates often negotiate these terms informally, if at all. In an industry that is thriving on women performing reproductive labour at low costs, there is no acknowledgement of or clarity on the entitlements of the surrogate. In such a context, to insert a clause on the discharging of liabilities – a clause that considers the signed agreement as the cornerstone of ethical and legal practice – does nothing to defend or secure her interests.

(Mis)regulation

The various attempts to regulate the ART industry till now have been ineffectual. The ICMR Guidelines 2005 (3) are non-enforceable and virtually not adopted in practice. The Draft ART (Regulation) Bill, introduced in 2008 (4) and revised in 2010 (5), has not yet been tabled in Parliament. The result is a completely unregulated industry, which has grown exponentially in recent years and that too, in a scenario in which laws vary considerably across countries. The MHA notice is a severely inadequate attempt to address some of the potential legal conflicts. Regarding those who want to become commissioning parents, it has different standards for foreign nationals, on the one hand, and non-resident Indians and the local population, on the other. Moreover, it indirectly legitimises several aspects of the arrangements made in commercial surrogacy without any critical inquiry.

The MHA notice has also been widely criticised by many ART specialists and providers (6). Predictably, their sole focus has been the fact that the access of same-sex couples to these services has been restricted, since this harms the interests of the industry by reducing the number of its consumers. ART specialists and providers are also in favour of the regulation of the industry and have sought the passage of the proposed Draft ART (Regulation) Bill, 2010, the perception being that the Bill adequately addresses the various aspects and secures the interests of all parties involved, including the protections offered to surrogates.

However, the Draft ART (Regulation) Bill, 2010 itself is fraught with several problems. For example, in addressing the challenges that ARTs have posed in terms of the way we look at reproduction, the changing contours of the family and women's work, its clauses reflect a strong patriarchal bias. There is ambiguity regarding same-sex couples, with the matter of who can access these technologies being dealt with in multiple clauses. The provisions regarding anonymity, relinquishment and payment to the surrogate seem to be tilted in favour of commissioning parents. For instance, a large share of the payment to the surrogate is contingent on the birth of a live child, there is no clarity regarding health insurance coverage, and the birth certificate is to bear only the commissioning parents' name. The Bill also turns a blind eye to the role of actors such as agents, medical tourism agencies and surrogacy hostels – a growing phenomenon in this transnational industry. The ways in which these operate often determine flows of information, interactions and negotiations between the commissioning parents, surrogates and providers. Another concern is the inadequate protection for the surrogates against malpractice.

Given this scenario, there is an urgent need for intense public scrutiny and debate before we can enact a piece of legislation which can adequately regulate this industry. However, though the need is to strengthen this process and move towards principled regulation by the state, sporadic guidelines that do not live up to the desirable goals and standards have been drawn up and are being legally enforced. The provisions of both the MHA and the Draft Bill are lopsided, with the needs and entitlements of the commissioning parents (the paying customers) and the industry's concern for a conducive legal environment being given more weightage. By overlooking the disadvantageous position in which the surrogates often find themselves, responding to the challenges of the international policy climate with haste and perpetuating the prevalent prejudices, they leave much to be desired from the point of view of medical ethics and social justice.

Acknowledgement

This article has emerged from the work done by Sama on assisted reproductive technologies and commercial surrogacy over the past eight years. More information is available from: www.samawomenshealth.org

Notes

[i] The Indian Council of Medical Research defines infertility as "failure to conceive after at least one year of unprotected coitus". This is in line with the definition of the World Health Organization, which revised the definition, as it stood till 1975, from failure to conceive from unprotected sex after five years to two years, and then reduced it further to one year in 2005. (Sama – Resource Group for Women and Health: *ARTs and women – assistance in reproduction or subjugation?* New Delhi: Sama 2006).

[ii] In Queensland, an initial proposal that sought to prevent single persons and same-sex couples from entering into altruistic surrogacy arrangements as intended parents faced severe criticism from political parties as well as civil society for being homophobic and discriminatory, and was eventually shelved. While altruistic surrogacy has been decriminalised, commercial surrogacy remains illegal in Queensland. (http://www.brisbanetimes.com.au/queensland/surrogacy-reforms-should-not-exclude-gay-couples-group-20100210-nquc.html) (http://www.brisbanetimes.com.au/queensland/government-shelves-surrogacy-ban-plans-20130326-2gs5q.html)

[iii] The Supreme Court's 2013 judgment that overturned the Delhi High Court's 2009 verdict to decriminalise non-normative sexual acts would also prohibit access of same-sex couples from India to ARTs under the proposed Draft ART Bill (2010). The Bill defines a couple as two persons "having a sexual relationship that is legal in India".

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Preventive lipostasis: spawning lipochondria

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Preventive lipostasis, ie lowering/controlling the various lipid levels to protect the coronaries from atherosclerosis, is firmly entrenched in modern therapeutics, to the point of being an almost knee-jerk prescription to every cardiac patient, a genureflexopathy of some sort. Enforced lipostasis through dietary measures and drugs has spawned a new syndrome characterised by an obsession with lowering the levels of lipids with the much-celebrated statins and by a fanatical abstinence from fats, and as a by-product, it has robbed cuisines of the joys of fat. Alex Comfort, better known for his best-selling *The joys of sex*, had penned another mini-classic, *The anxiety makers – the curious preoccupation of the medical profession*. The new syndrome has been named lipochondria, the sound of which harmonises well with that of the well-recognised hypochondria. A reassessment of lipostasis, lipophobia and lipochondria seems overdue.

For over 50 years now, the syndrome of lipochondria has been making increasing inroads into the minds of the public and physicians. It is characterised by an obsession on the part of all people – regardless of age, whether heterosexual or bisexual, whether lay or learned – with the cholesterol and lipids circulating silently, innocently and helpfully in our blood. Cholesterol and lipids are classified into good or bad and heavy or light; and their levels are measured regularly and chased to extinction, or to an assumed normal value, with the help of one dietary do not after another and one statin after another. All this in the name of primary/secondary prevention of coronary artery disease and heart attack. Lipochondria is a malady spawned and pampered by medicos, the media and manufacturers, not just of tests or drugs, but of low- or no-cholesterol food and beverages, a trillion-dollar-worth industry.

Lipochondria reeks of counterintuitiveness and counterproductiveness. Anatomical and/or physiological facts do not justify the logic of lipophobia. The relentless efforts to lower the levels of lipids and indiscriminate prescription of statins produce a plethora of side-effects. Lipophobia has been discussed, documented and disseminated so extensively and repetitiously as to be an article of faith. To question it is to court trouble and invite sneers. Lipophobes, a term which can be used for those who support lipochondria, heavily outnumber the opponents of lipochondria, who may be called lipophiles.

The mother-event of lipophobia (1) took place in 1913, when the Russian pathologist, Anitschkow, overfed rabbits with a cholesterol-rich diet. Lipid streaks were found in the rabbits' aortic intima at post-mortem.

Post-Anitschkow, there was no looking back for lipophobia, lipodisdain and lipochondria. The thought-leaders in the field, wryly called the cholesterol mafia (2), have progressively lowered the acceptable, normal levels of cholesterol and lipids to the point that the only good cholesterol is almost no cholesterol. The progressive succession of official reductions in levels has crossed the dozen mark (2), each reduction highlighted by cacophony and a media blitz.

Current Medical Diagnosis and Treatment (3), Lange, USA is an annually revised and expanded tome, the 50th edition of which came out in 2011. Its 34th edition (1995) contains a chapter titled "Lipid disorders" by Browner, whose unusual candour is not seen in subsequent editions. We present a few excerpts from the chapter, punctuatim, starting with the very first paragraph.

1. *A major problem for clinicians is that current therapies for high blood cholesterol do not reduce total mortality, in part because their use has been associated with an unexplained increase in deaths from non-cardiovascualar causes.*
2. *There is no "normal" range for serum lipids.*
3. *As with most primary prevention interventions, however, large numbers of healthy patients* (!) *need to be treated to present a single event: for cholesterol lowering, it may be necessary to treatment* (sic) *more than 600 patients for several years to prevent a single coronary death or five or six non-fatal coronary events.* (Over six years an aggregate of 3 million meals need to be killjoyed for a doubtful statistical gain!)
4. *Beneficial effects on the risk of coronary heart disease have been seen with bile acid binding resins and with gemfibrozil; the evidences for benefit from dietary reduction of cholesterol*