

Surrogate Motherhood, Psychiatric Screening and Informed Consent, Baby Selling, and Public Policy

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Recent evidence indicates a growing demand for newborn white babies for adoption in this country as well as a decreasing supply. Increasing fertility problems among women are said to be a result of at least three factors: an increased incidence of venereal disease, side effects of contraceptive measures including birth control pills and the IUD, and couples deciding to wait until later in life to bear children.¹ The supply of newborn white babies is said to be decreasing for at least three possible reasons: increased birth control, more terminations of pregnancies (abortions), and an increased percentage of single mothers keeping their newborn babies. In any case, the net result has been an increased difficulty for infertile married couples to adopt newborn white babies. Often they have to wait many years, if they can get such newborn white babies at all. Recently such adoptions have become international with white newborns being brought from such places as South America to infertile couples in the United States; but even these sources have been less productive recently.

Where is a couple to turn? In the last few years more and more married couples with infertile wives have turned to obtaining surrogate mothers. A surrogate mother is a woman who contracts with a man to be artificially inseminated, to carry the child, and after delivery, to give all parental rights to the biological father. Usually the man is married to a woman unable to have a child.² Often the surrogate mother is paid a fee for her services, which has added another controversy to this already emotionally loaded procedure. Later, the wife of the biological father probably will want to adopt the child. The advantages to the parental couple include having a biologic child of the husband and being able to choose the biologic mother of the child.

Although the practice of using a substitute biologic mother dates back thousands of years, at least to the Old Testament days of Abraham,³ it is only in the last 5 to 10 years that the surrogate mother procedure has increased in our society. It has been highly publicized and has sent shock waves through various quarters. This has been so despite the fact that conception occurs, not as a result of sexual intercourse, but as a result of artificial insemination by donor (AID), a method used for about 100 years.

This article presents some rational and reasonable psychiatric and moral guidelines for conducting and evaluating the psychiatrist's role in surrogate

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motherhood prior to the artificial insemination. It will discuss the screening (gatekeeping) function of the psychiatrist and the matching by the participants themselves, emphasizing the use of psychiatric informed consent. The next part will describe the relationship between surrogate motherhood and baby selling and will discuss its public policy implications.

The Role of the Psychiatrist in the Surrogate Mother Process

The Screening Process In a previous article this author stated:

With an increasing number of surrogate mothers giving birth, it is clear that some thought must be given the role of the mental health professional in the surrogate mother process. Such questions as who should make the hard choices of screening and matching and what criteria should be used for such screening, require close scrutiny.⁴

Answers to these questions depend, in part, on the interaction of the mental health professional's perceptions of the specifics of a given case, the body of research data on the subject, and his/her moral judgments.⁵ We examine the following questions: (1) what parental and surrogate mother applicants, if any, should not be allowed to participate? What role should the psychiatrist play in this gatekeeping function? What criteria are appropriate?⁶ (2) Should the psychiatrist or the participants themselves do the matching? What criteria are appropriate?

A reasonable moral and ethical analysis requires starting with some basic principles. Beauchamp and Childress in *Principles of Biomedical Ethics*⁷ describe four principles of moral action guides: (1) the principle of autonomy (duty to respect the autonomy of others), (2) the principle of nonmaleficence (the duty not to inflict harm on others), (3) the principle of beneficence (duty to prevent harm, remove harmful conditions, and promote positive benefits), and (4) the principle of justice. Conflict among the various principles for a given action gives rise to situations in which the morally right action needs to be determined carefully. Interference with the autonomy of others requires justification by a greater duty to adhere to one of the other principles. We examine how the principle of beneficence can be used to justify some instances of prohibitions of the surrogate mother process in a given case.

When the psychiatrist's duty to prevent harm to others (principle of beneficence) outweighs his or her duty to respect the autonomy of others (principle of autonomy), then interference with the applicant's desires to participate is justified. This applies to the harm that might occur to the surrogate applicant's children or to the parental applicant's children, if any.⁸

Moral justification for intervention based on prevention of conception is more complicated. The alternative to the severely harmed or deficient quality of life is nonexistence; one is faced here with the issue of preventive nonexistence. Bayles describes principles that might be used to justify nonexistence:

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There is a good reason . . . to prevent the birth of persons who would lack substantial capacity to achieve or take advantage of a quality of life of level *n* or whose existence would decrease the number of people who might live with a quality of life at that level.⁹

Sommerville discusses the "fitness to parent" in the context of birth technology:

There are several possible tests which could be proposed for judging the suitability of persons who seek access to birth technology in order to become parents. These include whether the potential parents could adopt a child under the laws in force in the particular jurisdiction or, less stringently, whether the child would be likely to be in need of protection . . . Perhaps the least stringent test which could be envisaged would be to assess parenting capacity for the purposes of access to birth technology according to whether a child born as a result of use of that technology would have any claim in a "wrongful life" tort action, a claim for damages for having been conceived and born. [footnotes omitted]¹⁰

This author takes the moral view that the psychiatric screening (gatekeeping) function should be triggered by significant incompetency of the parties to participate in the process¹¹ and by the moral obligation to protect the unborn (and unconceived) child as well as any other children who might be harmed by the surrogate mother process. Hence, the author tends toward the least stringent standard mentioned by Sommerville. Thus, it is recommended that rejection by the psychiatrist of competent parental applicants occur only if there is a significant probability of significant harm to the potential child or other already existing children, for example, severe parental abuse or neglect.¹² This author also recommends that competent surrogate mother applicants should be rejected if there is a significant probability of significant harm to the child, for example, the fetus in utero who would be significantly harmed by the alcohol intake of the active alcoholic or by drug intake of the drug addict who would not or could not stop the drug intake. This same recommendation for rejection also should be triggered by the determination by the psychiatrist that significant harm would come to already existing children of the surrogate mother applicant as a result of her participation in this procedure, for example, by abuse or neglect.¹³

These psychiatric rejection standards of the competent parental applicants and the surrogate mother applications are based on significant unavoidable harm coming to the unconceived child or to already existing children who cannot protect their own interests. Research studies are needed to correlate characteristics of applicants with the probability of harm to the child so that reasonably accurate predictions become possible. For example, many mental health professionals would reject parental applicants with a documented history of child abuse, neglect, pedophilia, and so on. Likewise, an actively drinking alcoholic surrogate applicant probably would be rejected at that time. But what if there is a history of alcoholism (with or without hospitalization) followed by a current signifi-

cant period of abstinence? What about a surrogate mother applicant with a personal and/or family history of a psychiatric illness with a genetic component? Of these possibilities the author favors psychiatric rejection of only those competent parental applicants with a recent documented history of severe abuse, neglect, pedophilia, and the like, such that continuation of these behaviors is probable.

Another issue regarding the screening function relates to refusal of prospective parental couples or surrogate applicants to have psychiatric interviews. The author takes the position that psychiatric interviews for screening should be required for all participants even over their objections. This slight interference with their autonomy seems justified by the need to protect incompetent applicants as well as unconceived and unborn child and already existing children.

Paternalistic Interventions Childress defines paternalism as "a refusal to accept or acquiesce in another person's wishes, choices, and actions for that person's own benefit."¹⁴ Paternalism thus involves a conflict between the autonomy and beneficence principles.

Viewpoints on the moral justification of paternalistic interventions differ and range from antipaternalistic sentiments to two variations of belief in the propriety of such interventions ("weak" and "strong" paternalism). In "weak" paternalism, it is deemed morally correct to prevent self-harm only when the action is substantially nonvoluntary, when the actor is substantially incompetent or noninformed, or when temporary intervention is necessary to investigate these details. "Strong" paternalism holds that it is sometimes right to protect a person by limiting his or her liberty even when his or her consent is voluntary, competent, and informed. An important factor in either of these cases of paternalistic intervention is that only the least restrictive intrusion necessary to prevent harm is acceptable.¹⁵ In contrast to these two types of paternalism is the antipaternalistic view that such intervention is never justified.

Childress gives three conditions necessary to justify paternalistic interventions: (1) the defects, encumbrances, and limitations of a person's decision making and acting; (2) the probability of harm to that person unless there is intervention; and (3) the probable benefit of intervention should outweigh the probable harm of nonintervention.¹⁶ The first condition did not appear to be satisfied in the author's psychiatric evaluation of over 300 surrogate mother applicants and their spouses, if married, and of many parental couple applicants. They were all competent to make such a decision regardless of which test of competency was used.¹⁷ With the assistance of such a series of psychiatric interviews, surrogate applicants also were able to obtain a reasonable degree of understanding of the surrogate mother process as determined by longitudinal pilot studies of the author. At this time, there is insufficient data on which to predict harm for the surrogate or parental applicants, so that conditions 2 and 3 of Childress do not appear to be met either. Therefore, this author sees no justification to prohibit partici-

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pation on a purely paternalistic basis of either surrogate mother or parental applicants who demonstrate a competent, voluntary, and informed consent (CVIC). Once surrogate mother and parental applicants have passed the admission threshold, the role of the psychiatrist prior to the artificial insemination should be to assist and assure this CVIC.¹⁸

Psychiatric Competent, Voluntary, and Informed Consent (CVIC) Recent emphasis has been given to greater participation by patients in the decision-making process regarding medical treatment and research. Such participation has been fostered by the use of the legally imposed doctrine of informed consent. The courts have ruled that the physician has an affirmative duty to inform patients of the possible advantages, disadvantages, and alternatives to the particular medical procedure. Meisel *et al.*¹⁹ discuss the question of what constitutes a "legally valid decision" and state:

The components of a valid decision consist of three main variables (provision of information, competency, and understanding), one precondition (voluntariness), and one consequence of the process (consent or refusal).

The doctrine of informed consent appears to result in many therapeutic advantages, as Meisel states:

The doctrine recognizes that what is a risk and what is a benefit is not clear-cut. A particular consequence of a medical intervention may be viewed as beneficial by one person but harmful by another. Rarely is there a single risk and a single benefit to treatment. There are often clusters of risks and benefits having varying probabilities of occurrence. The assessment of the net value of any such cluster of risks and benefits discounted by the various probabilities of occurrence is a thoroughly subjective undertaking, and since it is the patient who will bear the net result, it is the patient who should determine whether the game is worth the candle.²⁰

Thus, these decisions are based, in part, on the personal value system of the individual. Therefore, to maximize the benefits from the procedure, the choice should be made by the patient. In this author's judgment, this psychiatric competent, voluntary, informed consent (CVIC) should be considered a necessary part of the customary medical practice of the surrogate mother procedure.

The doctrine of informed consent also "both reflects and enforces the ancient concern of Anglo-American law with the individual's right to be free from the conduct of others that affronts bodily integrity, privacy, and individual autonomy."²¹ By requiring voluntariness, the informed consent doctrine requires that the individual is free from coercion and unfair influence. Besides satisfying standards of "fairness," this voluntariness probably will also result in more beneficial results, at least insofar as psychological functioning is concerned.

Until recently no psychiatric standards have been proposed regarding the specific nature of the informed consent in the surrogate mother procedure. In a previous paper,²² the author proposed certain procedures for obtaining and insuring as much as possible an informed consent, using the

participation of a psychiatrist. As part of this procedure it was recommended that psychiatric interviews and an evaluation be conducted on all participants including the surrogate mother and her spouse, if any, as well as the parental applicants. The psychiatric participation also would be used to help insure that the two participants in the contract (the surrogate mother and the biologic father) are voluntarily and freely making an informed choice for the two decisions to be made—to participate in the surrogate mother process itself and to select the specific other party with whom they will participate.

The psychiatric involvement should be a necessary prerequisite to the informed consent that should be obtained by the physician who artificially inseminates the surrogate mother with the biologic father's sperm. The psychiatrist would help to assure a reasonable degree of voluntariness (freedom from coercion and undue influence, for example, from excessive desire for and susceptibility to financial gain to the point of not being considered to be a free and voluntary choice). As presented, the psychiatrist would not weigh the advantages and disadvantages, but would help the participants themselves identify and reasonably weigh the factors. The significance of any information gathered as part of the evaluation that would be relevant to the two decisions at hand would be discussed with that party.

Releases of information would be obtained to provide psychiatric information about a particular surrogate mother applicant to the parental couples and vice versa to aid in their choice of each other. In this structure of the surrogate mother process, the participants would select each other. As part of the interviews with each party, the specific psychiatric information about the other party that was desired to be known would be transmitted by the psychiatrist. Thus, he or she would serve as a conduit of psychiatric data from one party to another.

The psychiatrist would discuss motivations with the surrogate mother applicant such as financial gain, desire to be pregnant, and the desire and need to experience relinquishing a child to a given parental applicant.²³ Her potential psychological response to the pregnancy and to the relinquishment would be reviewed. Her potential for changing her mind about relinquishing the baby after delivery and keeping the newborn also would be discussed in detail. Other issues to be discussed would include the nature and extent of the surrogate's desired relationship with the parental applicant and with the child after the surrogate gives birth. Her feelings about various possible medical and legal outcomes would be discussed. Possible influences on her relationship with her husband, if any, would be reviewed with the surrogate mother applicant and her spouse. These same factors would also be discussed with the surrogate applicant's husband who besides being psychologically involved, would be legally involved.

The psychiatrist also would talk with the parental applicants. Issues to be discussed would include their reasons for choosing the surrogate mother procedure rather than any other reproductive alternative including adoption, their feelings about the wife's infertility and the influence that this has

had on their relationship, their own potential emotional responses to this procedure, the characteristics of the surrogate they would like and why, the nature and extent of their desired relationship with the surrogate, their ability to care for a child conceived via this procedure, and the influence of any emotional response to this procedure on this ability (for example, How will the parental mother feel raising a child that is biologically related *only* to her husband?).

Will this proposed psychiatric involvement with informed consent for the surrogate mother procedure reliably assure that all parties will exercise voluntary, rational, and informed choices? Preliminary data obtained by the author indicate the psychiatrist can assist the parties in achieving a voluntary and informed choice. However, certain problems with the extent of the informed nature of the choices seemed to be present. One is that at this time no data exist regarding what the probability of a given advantage or disadvantage (psychological or medical) occurring might be to the surrogate mother, the parental couple, the children born from this procedure, or those children existing. Longitudinal studies presently are being conducted by the author to attempt to correlate the psychological outcomes with certain personality and demographic factors, motivational factors, and the specific arrangements of the surrogate mother process.

Is it reasonable to expect anyone to predict successfully how they will feel about anything if they have never experienced it? How well can a surrogate mother applicant understand and comprehend, prior to the artificial insemination, how she will feel when she relinquishes the child? Will she know if she will feel angry, depressed, or want to keep the child? Can a surrogate mother applicant adequately know how she will feel about this entire process if she has never been pregnant or has never given birth? Will it be helpful to her to anticipate her response if she previously relinquished a child or had an abortion? Will it be helpful to meet with surrogates who have experienced the pregnancy, given birth, and relinquished the child?

How can an infertile woman anticipate what it will be like to raise a child biologically related to her husband but not to her? Can she successfully predict her emotional response to the surrogate's carrying her husband's child while she was unable to do so? Preliminary evidence of the author indicates that only a few of the surrogates and the parental couples who experienced the CVIC felt surprised either by their own psychological responses after delivery and the relinquishment or by the other party's response. Clearly, further research needs to be done on the adequacy of the various techniques to help assure the informed nature of the consent for the psychological issues.

In another paper, the author stated:

As a result of interviewing over 225 surrogate mother applicants, I have discovered that most of these women have not previously sufficiently explored their own motivations and the possible advantages and disadvantages of their involvement. In my judgment, they needed the added experi-

ence of psychiatric interviews to help them give a competent, voluntary, informed consent.²⁴

But what should the psychiatrist do, if, during the informed consent interview, the surrogate applicant or parental applicant requests nondisclosure of information about themselves or the other party? Under what conditions should the waiver be accepted? What constitutes a competent, voluntary, and informed waiver? Under what conditions should the "informed" aspect of the CVIC be forced on the surrogate applicant or parental applicant at the expense of the voluntariness of the CVIC? The author takes the position that high standards for a competent, voluntary, and informed waiver should be required of all parties due to the unknown potential dangers to themselves and to their children as well as to the unconceived and unborn child. The applicants should understand that by not knowing certain information about themselves or the other party they might make a choice that could result in harm not only to themselves but also to the "surrogate child" or to their own existing children. For example, the particular surrogate may wish to continue the relationship with the couple after delivery, which may surprise the couple and seriously disturb the couple's feelings and relationship to their existing children as well as to their newborn child from the surrogate mother process.²⁵

In summary, both the surrogate mother applicant (and her spouse) and the parental couple applicant have two questions the psychiatrist should help them answer: "Do I want to participate in the surrogate mother process?" and "Do I want to participate with this particular surrogate or couple?" The psychiatrist helps each party answer the first question by looking at psychiatric data and issues about her/himself from her/his own psychiatric interviews. The psychiatrist assists each party in choosing the other participant by looking at data from the psychiatric interviews of the other party as well as from their own interviews.

Public Policy Regarding Surrogate Motherhood and Baby Selling

Constitutional Issues The Supreme Court has stated, "If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."²⁶ This definition talks of the "decision whether to bear or beget a child"—it does not mention whether this fundamental right applies to the "means" of such procreation. For example, do infertile married couples or any individuals have a "fundamental right" to procreate by artificial means, for example, artificial insemination of a surrogate mother? In other words, has (or will) the Supreme Court expressed a fundamental right to procreate? Robertson states:

The right not to procreate, through contraception and abortion, is now firmly established. A likely implication of these cases, supported by rulings

in other cases, is that married persons (and possibly single persons) have a right to bear, beget, birth, and parent children by natural coital means and such technological aids (microsurgery and in vitro fertilization for example) as are medically available. It should follow that married persons also have a right to engage in noncoital, collaborative reproduction at least where natural reproduction is not possible. The right of a couple to raise a child should not depend on their luck in the natural lottery, if they can obtain the missing factor of reproduction from others [citations omitted].²⁷

The Court has given guidelines for state's authority to regulate the exercise of the individual's fundamental rights. Such statutes must be narrowly drawn so that they are *necessary* to achieve only a "compelling state interest." In other words, only the least restrictive intrusion necessary to achieve the compelling state interest would be acceptable.²⁸ If no fundamental right is involved, then the Court has ruled that the statute must be "rationally related" to a permissible state objective.

What type of "compelling state interest" is needed to justify governmental intrusion into the fundamental right of privacy? If surrogate motherhood is indeed an expression of a fundamental right, then what compelling state interests might warrant an intrusion? This question may one day be answered by the Supreme Court. Its views will no doubt be governed in part by moral and scientific considerations similar to those described earlier.²⁹ The prevention of serious harm to existing children and potential children probably would be considered a part of the compelling state interest of protecting public health.³⁰

Surrogate Motherhood and Baby Selling in the Legal System One of the most widely used legal and moral arguments for total prohibition of surrogate motherhood for a fee has been to consider it an example of baby selling.³¹ How important has the issue of baby selling been in the rationale of judges, states' attorneys general, and legislators? The use of the baby selling concept will be analyzed and discussed.

The Attorney General of Kentucky brought a complaint for the dissolution of Surrogate Parenting Associates, Inc., a medical clinic designed specifically to assist infertile couples by using surrogate mothers who receive a fee. The complaint asked that in the alternative, the court grant a permanent injunction against the clinic "to prohibit it from engaging in any business in connection with a surrogate parenting process."³² It further said that the contracts or agreements used would violate certain statutes prohibiting consents to adoption or petitions to terminate parental rights made prior to five days after childbirth. The complaint went on to state:

These violations are in addition to the proscription engendered by a strong public policy against the buying and selling of children; and that no such contract or agreement relating to surrogate parenthood in Kentucky is legal and enforceable.³³

The complaint stated the clinic "will thereby abuse and misuse its corporate power to the detriment of the interest and welfare of this Commonwealth

and its citizens."³⁴

The Attorney General referred to one of his official advisory opinions. In the conclusion of the opinion he said:

It is the opinion of this office that because of the existence of the above-mentioned Kentucky statutes and the strong public policy against the buying and selling of children, contracts involving surrogate parenthood are illegal and unenforceable in the Commonwealth of Kentucky.³⁵

This reference to surrogate parenthood as an example of "the buying and selling of children" is contained throughout this opinion.

In our opinion the strongest legal prohibition against surrogate parenting in Kentucky is found in the strong public policy against the buying and selling of children. Courts in many states have held that as a matter of public policy children are not to be bought and sold; that is, monetary consideration other than for medical expenses is not to be made to the natural parents who have placed their children up for adoption [citations omitted]. Self-seeking on the part of the natural mother is condemned.³⁶

The Attorney General then quoted the Kentucky statute that prohibits any person, agency, or institution not licensed to "charge a fee or accept remuneration for the procurement of any child for adoption purposes."³⁷ He then stated:

It is the opinion of this office that this statute precludes not only the surrogate mother from receiving payments for giving up her child for adoption but also includes all who are involved in the surrogate transaction.³⁸

The Attorney General also quoted another source who said: "It is . . . clear legislative policy that no one shall profit economically from the adoption process" [citations omitted].³⁹

In the Michigan case of *Doe v Kelley*,⁴⁰ the plaintiff (a potential parental couple and a parental surrogate mother to whom they would like to pay a \$5,000 fee plus medical expenses), filed a complaint for declaratory judgment in which they asked that certain Michigan statutes be declared unconstitutional and to enjoin the defendants (Attorney General Kelley of Michigan and the Wayne County Prosecutor) from prosecuting them. These statutes state in part:

Except for charges and fees approved by the court, a person shall not offer, give, or receive any money or other consideration or thing of value in connection with any of the following:

- a) The placing of a child for adoption
- c) A release [of parental rights].⁴¹

The constitutional challenges were that the statute was void due to vagueness; they also maintained that the statute fell within the constitutional fundamental right of privacy with no compelling state interest to justify intruding into the privacy of those concerned. The plaintiffs also stated that the statute was not drawn sufficiently narrow.

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The circuit court judge ruled in favor of the defendants by denying the plaintiff's motion. The court ruled: "The right to adopt a child based upon the payment of \$5,000 is not a fundamental personal right."⁴² It then went on to assume for the sake of argument that the constitutional right to privacy was applicable and said:

The State's interest expressed in the statutes at issue here is to prevent commercialism from affecting a mother's decision to execute a consent to the adoption of her child.⁴³

The court continued at great length that surrogate motherhood was "baby bartering."

"Baby bartering" is against the public policy of this State and the State's interest in preventing such conduct is sufficiently compelling and meets the test set forth in *Roe* . . .

It is a fundamental principle that children should not and cannot be bought and sold. The sale of children is illegal in all states.⁴⁴ . . .

The evils attendant to the mix of lucre and the adoption process are self-evident and the temptations of dealing in "money market babies" exist whether the parties be strangers or friends. The statute seeks to prevent a money market for the adoption of babies.⁴⁵

The court implied that it considered the prevention of baby bartering (and therefore, surrogate motherhood for a fee) necessary to promote a compelling state interest. Although the court does not specify what it thinks the compelling state interest to be, it hints when it says:

Mercenary considerations used to create a parent-child relationship and its impact on the family unit, strikes at the very foundation of human society and is patently and necessarily injurious to the community.⁴⁶

The Michigan Court of Appeals affirmed the trial court's decision and stated:

While the decision to bear or beget a child has thus been found to be a fundamental interest protected by the right of privacy [citations omitted], we do not view this right as a valid prohibition to state interference in the plaintiffs' contractual arrangement. The statute in question does not *directly* prohibit John Doe and Mary Roe from having the child as planned. It acts instead to preclude plaintiffs from paying consideration in conjunction with their use of the state's adoption procedures. In effect, the plaintiffs' contractual agreement discloses a desire to use the adoption to change the legal status of the child—*i.e.*, its right to support, intestate succession, etc. We do not perceive this goal as within the realm of fundamental interests protected by the right to privacy from reasonable governmental regulation [emphasis added].⁴⁷

Both the Supreme Courts of the State of Michigan and the United States have refused to hear the case.⁴⁸

Proposed prohibitory surrogate mother legislation in Michigan also viewed the process as baby selling:

[W]e should not legalize by regulation, a business arrangement that treats babies as a commodity to be sold to the highest bidder or returned if the product is defective. We cannot sanction such dehumanization. We cannot promote, by legislation, the brokerage of children.

We will have issued a clear message that Michigan does not endorse the buying and selling of babies for the financial gain of attorneys, doctors, and women who regard their bodies as manufacturing plants.⁴⁹

The above two legal cases, as well as the proposed prohibitory legislation, equate surrogate motherhood for a fee with baby selling. The logic of their argument is as follows:

- (1) Surrogate motherhood for a fee is a case of baby selling.
- (2) All baby selling is (should be) illegal.
- (3) Therefore, surrogate motherhood for a fee is (should be) illegal.

Analysis of Surrogate Motherhood as Baby Selling First it should be clarified that in present day Western society, the term "baby selling" is a misnomer. The baby (even in the black market), is not really being sold as an object or slave. Rather, the parental rights and responsibilities are being purchased. The child still has the right not to be abused and neglected; he or she cannot be treated as a slave. The buying and selling of babies as objects and slaves is, of course, prohibited and objectionable because it negates the humanness of the child. It would permanently and totally violate the autonomy principle and is not justifiable. However, even the buying and selling of parental rights also has been generally prohibited.⁵⁰ One objection given by some is that a parental rights ("baby") market would tend to destroy the traditional family with its traditional values by having money and profit play a role. This argument contends that tender loving feelings of the parental couple toward the child would be contaminated by "purchase" of their child. It often portrays the child as permanently emotionally scarred by being "sold" in this way.⁵¹ Besides these objections, there is additional opposition to the illegal black market because "the welfare of the babies and the natural mother, as well as the fitness of the adoptive parents, are subordinated to the profit motive of the black marketeer."⁵²

Should surrogate motherhood for a fee be treated the same as the prohibited black market for parental rights ("babies")? Usually the woman who supplies the child in the black market situation has become pregnant accidentally by sexual intercourse. Although probably conflicted about her pregnancy, she has rejected abortion and experiences the pregnancy as her own in every way. After delivery she may not be sure about her desire to relinquish the child and may be highly susceptible to the undue influence of large sums of money. She has not had the advantage of a procedure to assist her in making a competent, voluntary, and informed consent (CVIC) to relinquish the child. She will usually be relinquishing a child to a couple who is not related biologically to the child. Further, she probably has not had an opportunity to meet and evaluate the adopting couple to establish in her own mind that her child will be well cared for.

In contrast, the surrogate mother has consciously and voluntarily made an informed choice assisted by professionals. She has planned from the beginning to be artificially inseminated, carry the child, and relinquish the child to its biologic father who generally has an infertile wife. She probably has met or otherwise established an idealized empathic relationship with this couple whom she feels will be very capable and loving parents to the child she is relinquishing. Because of these significant differences in the structure of the process, and the possible (or even probable) differences in the experiences and risks to the participants, this author takes the position that surrogate motherhood should be treated differently under the law than the black market for parental rights ("babies").

Is surrogate motherhood for a fee an example of providing a service for a fee and/or a case of selling parental rights ("baby selling")? It does appear that with lump-sum payments after delivery, the surrogate mother is receiving a fee both for her services (insemination, pregnancy, labor, and delivery) as well as for relinquishing custody and parental rights. Should a fee for such services be prohibited? The surrogate mother being the biologic mother in this case would appear to "own" half the parental rights and responsibilities to the child she carries. Assuming the surrogate mother is competent and relinquishes both custody and her parental rights in a voluntary and informed manner to the biologic (artificially inseminating) father, what moral and legal justification exists to absolutely prohibit her from receiving money in exchange for these parental rights? If surrogate motherhood is an expression of a fundamental right, then what compelling state interest necessitates the total or even partial prohibition of money being paid to the surrogate? This article does not deal with all aspects of these moral and legal questions. Rather, it gives psychiatric input (including preliminary data) the author believes is necessary for a rational and reasonable analysis.

The assessment of the influence the payment of money has on the surrogate mother process necessitates an examination of the result of this payment, in and of itself, on the psychological functioning of the surrogate mother, the parental couple, the existing children of both of these parties, and the child who is to be conceived and born. A study of these issues must differentiate between payment for (1) out-of-pocket expenses due to this particular procedure, (2) a fee for services (for example, insemination, pregnancy, labor, and delivery), (3) opportunity costs (that is, "the value to her of the opportunities she foregoes by not terminating the pregnancy or alternatively by not keeping the child"),⁵³ and (4) fees for parental rights and responsibilities. Payment for any combination of these four factors may have different effects on each of the parties.

The possibility of money unduly influencing a woman to become a surrogate mother is a realistic concern that merits examination.⁵⁴ About 90 percent of the surrogate applicants require a fee above and beyond expenses, with \$5,000 being the most frequently mentioned figure. However, it was never totally sufficient, and at least two other motivational factors contributed to their decision to become a surrogate mother. These include

the women's enjoyment of the state of pregnancy and the satisfaction gained by giving the "gift of a child" to an infertile couple—and/or their desire and need to reexperience the previous voluntary loss of a fetus or child by abortion or relinquishment. In any case, even when the fee was a major and significant motivating factor, a CVIC was possible when accompanied by a series of at least two psychiatric interviews. Thus, prohibition of a fee is not necessary to achieve a CVIC.⁵⁵

Another aspect of the effects of payment in the surrogate-mother process involves the response of the surrogate mother herself. Preliminary unpublished data of the author indicate that even prior to the artificial insemination, the surrogates stated they did not think of the \$10,000 lump-sum payment after delivery as a fee in exchange for their parental rights and responsibilities. Rather, they described the payment as a fee for services. This payment became less important to them as a motivating factor as their pregnancies progressed; a significant determinant appeared to be the development of an idealized empathic relationship with the parental couple. After delivery, the fee usually became unimportant to the surrogate as a motivation for relinquishment. She usually felt a sense of duty and a need to please the parental couple by relinquishing a healthy baby for them to "parent" in a loving and caring way. Her cooperation in the legal process regarding relinquishment of her parental rights continued well after she received the lump-sum payment. Further preliminary data of the author revealed no significant difference in the short-term psychological outcomes between surrogate mothers who receive the lump-sum fee after delivery, compared with those who receive no fee at all.⁵⁶

Short-term and long-term effects of a payment on the psychological functioning of the husband and wife (parental couple) toward each other, other children, and the newborn child, need to be studied. Will payment lead to feelings of guilt? What will a child feel knowing money has played a role in his/her existence? Will it matter to this child which of the four reasons for payment were used? Would it matter to a child if a fee for services and/or for the parental rights is paid in addition to expenses? How will existing children of the surrogate and the parental couple deal with these same issues?

All these questions of the effect of money on the surrogate-mother process need to be studied to make rational and reasonable psychiatric, legal, moral, and policy judgments about this extremely controversial reproductive alternative.⁵⁷ As to the legal and policy issues, this author would give particular emphasis to the effects of the money on the psychological development of the children. This author views prevention of serious harm (both physical and psychological) to the various children as a compelling state interest warranting any necessary degree of regulation or prohibition.

Conclusion

The author sees no evidence at this time to indicate that total and complete prohibition of surrogate motherhood for payment is necessary to

promote any compelling state interest. Rather, regulatory legislation appears to be the least restrictive intrusion necessary to specifically deal with the surrogate-mother process that includes payment to the surrogate. Ongoing longitudinal studies may shed further light on the nature and extent of the state regulation necessary to promote any compelling state interests; these studies should include the effects of the four types of payments to the surrogate: (1) related expenses, (2) fees for services, (3) opportunity costs, and (4) fees for the parental rights and responsibilities. Existing evidence indicates that state regulation should require individual evaluation of all participants by a psychiatrist to ascertain certain justifiable qualifying criteria are met. Once these criteria are satisfied, regulatory legislation should include provisions to achieve via psychiatric interviews, a competent, voluntary, and informed consent by all parties on two questions: "Do they want to be involved at all in the surrogate mother process?" and "Do they want to participate with a given particular surrogate mother or parental couple?"⁵⁸

References

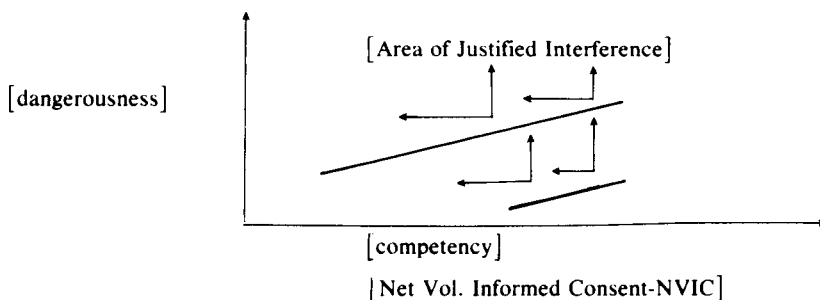
1. There is also some speculation that couples may be more willing to report such fertility problems.
2. For the sake of convenience, this paper will discuss surrogate motherhood as if the parental applicant were a man married to an infertile woman. Also, in this paper, the term 'surrogate mother' refers to the case in which a woman carries a child derived from her own egg. (Another possibility is for the surrogate to carry a child which is not biologically related to her. See Parker, *Surrogate Motherhood: The Interaction of Litigation, Legislation and Psychiatry*, 5 Int'l J of Law and Psychiatry 341 (1982) [hereinafter cited as Parker-Surrogate Motherhood].)
3. Infertile Sarah encouraged Abraham to have sexual relations with her handmaiden, Hagar, to bear a child.
4. Parker-Surrogate Motherhood, *supra* note 2, at 352
5. The nature and influences of unconscious fantasies and distorted perceptions of feelings and attitudes regarding surrogate motherhood and other reproductive alternatives will be presented in a future paper tentatively titled "Surrogate Motherhood and Baby Bringing, Stealing, and Selling—Some Psychodynamic Considerations."
6. For convenience, this paper will refer to the case where the mental health professional is a psychiatrist. However, he or she may be a psychologist, marriage counselor, social worker, or other qualified employee of a child placement agency, etc.
7. Beauchamp TL, Childress JF: *Principles of Biomedical Ethics*. New York, Oxford University Press, 1983 (second edition)
8. The spouse of the surrogate mother applicant and of the biological father are generally involved at some point in the legal proceedings. They can be expected to protect their own rights.
9. Bayles, Harm to the Unconceived. 5 Phil and Pub Aff 292, 302 (1976)
10. Somerville MA: Birth technology, parenting and "deviance." 5 Int'l J of Law and Psychiatry 131, (1982)
11. See Roth, Meisel, Lidz, Tests of Competency to Consent to Treatment. 134 Am J of Psychiatry 279 (1977) for a discussion of various competency tests that might be used in the surrogate mother process.
12. This is also the view of Michael Bayles in his book *Reproductive Ethics*, New York, Prentice-Hall (in press). In the "Policy Analysis" section of the discussion on surrogate motherhood in Chapter 1 (p. 41) of the typed manuscript he states:

Moreover, a significant difference exists between deciding to reproduce and adoption. In adoption, a child exists and placement should be based on its best interests. We do not require that decisions to reproduce be based on the best interests of the potential child. At most, we require (usually ethically rather than legally) that reproduction not be harmful to the child, for example, not lead to a defect or parental neglect or abuse.
13. These views clarify and supplement the discussion at 352-53 in Parker-Surrogate Motherhood, *supra* note 2. In that paper, the role of the psychiatrist described should have been specified to apply after

the applicants have passed above the low minimum threshold. On the basis of unpublished data of the author from over 300 surrogate mother applicants and many parental applications, none has yet fallen beneath the low threshold of acceptance. *See also* *infra* text pages 25-28, for a further discussion of the psychiatrist's role after admission to the surrogate mother process.

14. Childress J: Who Should Decide? Paternalism in Health Care. New York, Oxford University Press, p 13
15. *See supra*, note 7, at 168-79 and *supra* note 14, at 16-21
16. *See supra*, note 14, at 102-26

One can regard such an intervention in "weak" paternalism as justified when the competent, voluntary, informed consent is below the degree required to content with a given degree of dangerousness. Dangerousness here is defined as being a function of the type of harm (including the degree of reversability) and the probability of harm. The following graph will serve to illustrate the area of justified interference as a function of dangerousness and competency or net voluntary informed consent (NVIC). Interference is justified in the area above and to the left of the line.



17. *See supra* note 11
18. The role of the psychiatrist after artificial insemination, during the pregnancy, and after the delivery has been briefly mentioned by the author in two other papers—Parker-Surrogate Motherhood, *supra* note 2, and Parker, The Psychology of Surrogate Motherhood: An Updated Report of a Longitudinal Pilot Study (unpublished paper presented at the Interdisciplinary Surrogate Mother Conference at Wayne State University on November 20, 1982 in Detroit that was reported, in part, in an earlier version in Govt. Regulation of Surrogate Motherhood Advised, OB-GYN News, July 15-31, 1981, at 10, and in Wylie, No Psychological Harm to Surrogate Moms, Medical Post (Toronto), Aug 24, 1982, at 19.) [hereinafter cited as Parker-Psychology of SM]
19. Meisel, Roth, Lidz, Toward a Model of the Legal Doctrine of Informed Consent, 134 Am J of Psychiatry 286 (1977) [hereinafter cited as Meisel Roth]
20. Meisel, The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking, 1979 Wis L Rev 422
21. Meisel, Roth, *supra* note 19, at 286. *See also* Murphy, Therapy and the Problem of Autonomous Consent, 2 Int'l J of Law and Psychiatry 415 (1979)
22. *See supra*, note 19, and Parker-Surrogate Motherhood, *supra* note 2
23. *See* Parker, Motivation of Surrogate Mothers: Initial Findings. 140 Am J of Psychiatry 117-18 (1983) [hereinafter cited as Parker-Motivation of SM]
24. Parker-Psychology of SM, *supra*, note 18, at 8
25. For a further discussion of the issue of a waiver for informed consent, *see* Meisel, *supra* note 20, at 453-60 and Childress, *supra*, note 14, at 149-50. *See also* Somerville, Consent to Medical Care, 1980 Ottawa, Canada, Law Reform Commission of Canada, 39-43. The issue of forcing information on the participants *during* the pregnancy will be described in a future paper.
The issue of interference with a person's autonomy as part of the informed consent function, should be distinguished from that which is part of the accumulation of data by the psychiatrist in his screening role.
26. Eisenstadt v. Baird, 405 U.S. 438, 453 (1971)
27. Robertson, Surrogate mothers: Not so novel after all. 13 Hastings Center Rep, No. 5, 32 (Oct 1983). For a detailed discussion of these constitutional issues *see* Robertson, Procreative Liberty and the Control of Conception, Pregnancy and Childbirth. 69 Va Law Rev 405 (1983)
28. *See, e.g.* Roe v Wade, 410 U.S. 113, 155 (1973), Carey v. Population Serv Int'l, 431 U.S. 678, 686 (1977), Griswold v. Connecticut, 381 U.S. 479 (1965)
29. *See supra* text, pp 22-25
30. *See* Roe v. Wade, 410 U.S. 113, 154 (1973)
31. For a list of articles dealing with legal issues in surrogate motherhood, *see* Parker-Surrogate Motherhood, *supra*, note 2, at 351, n. 41. The use of the term and concept "baby selling" has been

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- given wide media coverage in connection with surrogate motherhood. However, it is beyond the scope of this article to deal with this important aspect of the public perception of surrogate motherhood.
32. Commonwealth v. Surrogate Parenting Ass'n, No. 81-0429, complaint, at 4 (Franklin, KY Cir Ct), 7 Fam L Rep (BNA) 2246 (Feb 17, 1981)
 33. *Id.*, complaint, at 3, 7 Fam L Rep (BNA) at 2246
 34. *Id.*, 7 Fam L Rep (BNA) at 2246
 35. Op Att'y Gen Ky 81-18 at 7 (1981), 7 Fam L Rep (BNA) 2247 and 8 Fam L Rep (BNA) 4068 (Sept 28, 1982)
 36. *Id.*, at 3-4, 7 Fam L Rep (BNA) at 2247, col 1
 37. Ky Rev Stat § 199.590 (1969)
 38. Op Att'y Gen KY 81-18 at 4 (1981), 7 Fam L Rep (BNA) at 2247, col 1
 39. *Id.* The Attorney General also quotes the same statutes that prohibit consent for adoption or termination of parental rights prior to five days after the birth of the child. He uses these to justify his conclusion that surrogate parenting is illegal in Kentucky. Obviously, these statutes were not meant originally to apply to the surrogate mother procedure, since they were passed before this procedure became well known, but are being used here to justify such a conclusion that has been made for other reasons.
 40. Doe v Kelley, 6 Fam L Rep (BNA) 3011 (Feb 19, 1980), 8 Fam L Rep (BNA) 4068 (Sept 28, 1982), aff'd 106 Mich App 169, 307 NW 2d 438 (1981); *appeal denied* 414 Mich 875 (1982); *cert denied*, ____ U.S. ____, 103 S Ct 834 (1983), 9 Fam L Rep (BNA) 2188 (1983)
 41. Mich Comp Laws Ann § 710.54 (West)
 42. Doe v Kelley, 6 Fam L Rep (BNA) at 3013, col 1. The court's opinion also refers to the defendant prosecuting attorney who "concedes that the plaintiff, natural mother (Roe) and the plaintiff couple (Doe) are free to 'conceive a child, bear it, and raise it' as they agree among themselves because these acts are guaranteed by the right to privacy." The court does not disagree with this statement and, thus, by inference appears to agree.
 43. *Id.* at 3013, col 2
 44. *Id.*
 45. *Id.* at 3014, col 1
 46. *Id.* at 3013, col 2
 47. Doe v Kelley 106 Mich App 173-74, 307 NW2d 438 (1981), *appeal denied*, 414 Mich 875 (1981), *cert denied* ____ U.S. ____, 103 S Ct 834 (1983). In contrast to this Michigan ruling, the courts of at least two states, Florida and Oklahoma, consider adoption to be a fundamental right. *See* In re Delmoral Rodriguez, 552 P 2d. 397 (Okla 1976) and Grissom v. Dade County, 293 So 2d 59 (Fl 1974) Since all adoptions in a state must go through its court system, it can be considered a monopoly. The effects of this ruling will vary depending on how many states take such a stand. One possible result is to have the relinquishment of parental rights by the surrogate mother who received a fee and the adoption by the infertile wife take place in another state or country, for example, another state that allows step-parent adoption without prohibiting or inquiring about a fee. If all states prohibited a fee, then the process might take place in a foreign country that would not prohibit the fee. In any case, the result would be more time, financial costs, and emotional stress for all the participants. If no fee were paid at all, then perhaps 1/10 the number of women would apply to be surrogates (*See* Parker-Motivation of SM, *supra* note 23). The author believes that requiring the participants to go to other states or countries for the adoption or the total prohibition of a fee would unduly burden the fundamental reproductive rights of the infertile couple.
 48. Doe v Kelley, 106 Mich App 169, 307 NW 2d 438 (1981), *appeal denied*, 414 Mich. 875 (1982); *cert den.*, ____ US ____, 103 S Ct 834 (1983)
 49. Open letters from Michigan State Senator Connie Binsfeld (Feb 18 and March 1, 1983) (regarding Michigan Senate Bill #63 of 1983). Substitute (S-1) for SB #63 was passed by the Mich. Senate on Nov. 15, 1983 and was referred to the Mich. House of Reps.
 50. For a discussion of several decisions that deal with compensation in adoption agreements within the family, *see* Keane, Legal Problems of Surrogate Motherhood, 1980 So Ill Univ L J 147, 159 and Coleman, Surrogate Motherhood: Analysis of the Problems and Suggestions for Solutions, So Tenn L Rev 107 (1982). For a detailed discussion regarding opening up parental rights ("baby") markets, *see* Alexander & O'Driscoll, Stork Markets: An Analysis of "Babyselling," 4 J of Libertarian Stud 173 (1980) and *see also* Landes & Posner, The Economics of the Baby Shortage, 7 J of Legal Stud 323 (1978). An in-depth description of the possible psychological factors involved with the feelings and fantasies associated with the issues of money, profit, and baby selling is beyond the scope of this paper. These issues will be dealt with in a forthcoming paper by the author, tentatively titled "Surrogate Motherhood and Baby Bringing, Stealing and Selling: Some Psychodynamic Considerations," *supra* note 5
 51. All these possibilities need to be studied within the surrogate mother process. It is also possible, for

example, that surrogate motherhood for a fee will tend to solidify the "traditional" family relationship.

52. Comment: Black-market Adoptions. 22 Cath Law 40 (1976). For a detailed discussion of the abuses found in the black market *see* McTaggart, *The Baby Brokers—The Marketing of White Babies in America* (1980)
53. Alexander & O'Driscoll, *supra* note 50, at 177
54. In the Michigan surrogate mother case, *Doe v. Kelley*, 6 Fam L Rep (BNA) 3014, Col 1 (Jan 28, 1980), the court referred to this possibility when it stated "[t]he defendant prosecuting attorney argues perceptively when he asks: How much money will it take for a particular mother's will to be overborne, and when does the decision turn from 'voluntary' to 'involuntary.'"
55. Parker-Motivation of SM, *supra* note 23, and unpublished data of the author.
56. Some surrogates felt uneasiness accepting the \$10,000 lump sum fee after relinquishment. This issue will be discussed further in a coming paper tentatively entitled, "Surrogate Motherhood and Baby Bringing, Stealing and Selling: Some Psychodynamic Considerations," *supra*, notes 5 and 50. The Michigan Circuit Court in *Doe v Kelley*, 6 Fam L Rep (BNA) 3011, 3014, col 1 (Jan 28, 1980), *aff'd* 106 Mich App 169, 307 NW 2d 438 (1981), appeal *denied*, 414 Mich App 875 (1982), cert *denied*, ___ US ___, 103 S Ct 834 (1983) inaccurately attributed feelings and motivations to the surrogate mother when it discussed baby bartering and the prohibition of surrogate motherhood for a fee by quoting the prosecuting attorney:

in all but the rarest of situations, the money plaintiffs seek to pay the 'surrogate' mother, is intended as an inducement for her to conceive a child she would not normally want to conceive, carry for nine months a baby that she would not normally want to carry, give birth to a child she would not normally want to give birth to and then, *because of this monetary reward*, relinquish her parental rights to a child that she bore [emphasis added].

57. It is also needed to assist the psychiatrist in his screening function and in assisting the participants in a CVIC.
58. Although on legislation exists anywhere dealing explicitly with surrogate motherhood, about 15 states have considered or are considering such legislation. Michigan has perhaps the most extensive experience with various drafts and revisions of both proposed regulatory and prohibitory legislation. (See Parker-Surrogate Motherhood, *supra* note 2, for a discussion of the early legislative history of the regulatory legislation in Michigan.) The latest revision (Substitute H-3 Draft I of HB4114 of 1983) of the proposed Michigan regulatory legislation was voted out of the House Judiciary Committee on June 21, 1983 to the House floor with the recommendation that it pass, however, it was subsequently sent back to that committee on Oct. 18, 1983 due to insufficient support. The bill provides for some screening by mental health professionals, assistance with CVIC, and regulates the payment of money to the surrogate. All this is within the context of a bill that would declare the artificially inseminating feather and his wife to be the legal parents without the need for adoption.

The proposed screening and CVIC with the parental couples is to be performed by

[a] person who has a certificate of registration as a marriage counselor, a licensed psychologist, a licensed physician who is a psychiatrist, or a qualified employee of a licensed child placement agency [who] signs a written acknowledgement that the person or the agency has counseled the natural father and his spouse on the consequences and responsibilities of surrogate parenthood and believes that the natural father and his spouse both fully understand these consequences and responsibilities, and are prepared, in the professional judgment of the person or agency, to assume these responsibilities. (Sec 4(c))

Thus, these screening criteria imply competency (capacity and ability) to give CVIC and to carry out some unspecified degree of adequate parenting ("are prepared . . . to assume these responsibilities"). This section also provides for the CVIC of the couple and not only specifies that the mental health professional must have "counseled" the parents but also requires that they "understand."

The surrogate mother applicant is seen by

[a] licensed psychologist, a licensed physician who is a psychiatrist, or a qualified employee of a licensed child placement agency [who] signs a written statement that the surrogate is capable of consenting to the termination of her parental rights and responsibilities . . . and that the psychologist, physician, or qualified employee of the agency has discussed with the surrogate the potential psychological consequences of her consent. (Sec. 4(e))

Here, again, competency ("capable of consenting") is required prior to the CVIC. However, in contrast to the parental CVIC, no explicit mention is made of the surrogate's "understanding." Rather, all that is required is that the issues be "discussed."

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The bill also requires

that, before entering into the written surrogate parenthood agreement, the natural father and his spouse [have] reviewed the results of medical and psychiatric or psychological examinations which have been performed on the surrogate and have decided the surrogate to be suitable. (5)(1)(c)

The bill does not require in a reciprocal manner that the surrogate find the parental couple psychologically "suitable."

Substitute H-3 Draft I of HB4114 of 1983 also specifies the factors for which the surrogate may accept payment.

A written surrogate parenthood agreement may contain agreements to provide to the surrogate, money or other consideration for the surrogate's reasonable and documented medical expenses, related psychiatric or psychologic expenses, or both, including expenses incurred for screening and counseling during pregnancy and after delivery, attorney fees, living expenses, and for the surrogate's loss of work time. (Sec 7(2))

A written surrogate agreement shall not contain an agreement to exchange money or other consideration for the child born to the surrogate. A written surrogate parenthood agreement shall not contain any agreement to reduce the amount paid to the surrogate for the expenses described in subsection (2) if the child is stillborn or is born alive but impaired. (Sec 7(3))

Here the surrogate is prohibited from accepting money for her parental rights to the child. Her *related* out-of-pocket expenses, including "loss of work time" would be covered. "Living expenses" also would be covered and since this does not specify "extraordinary living expenses" payment for ordinary living expenses is, in effect, a fee for her services. □