Bioethical Inquiry (2015) 12:491–501
DOI 10.1007/s11673-015-9642-8

ORIGINAL RESEARCH

Reproductive Ethics in Commercial Surrogacy: Decision-Making in IVF Clinics in New Delhi, India

Malene Tanderup · Sunita Reddy · Tulsi Patel · Birgitte Bruun Nielsen

Received: 6 March 2014 / Accepted: 10 December 2014 / Published online: 2 July 2015

Abstract As a neo-liberal economy, India has become one of the new health tourism destinations, with commercial gestational surrogacy as an expanding market. Yet the Indian Assisted Reproductive Technology (ART) Bill has been pending for five years, and the guidelines issued by the Indian Council of Medical Research are somewhat vague and contradictory, resulting in self-regulated practices of fertility clinics. This paper broadly looks at clinical ethics in reproduction in the practice of surrogacy and decision-making in various procedures. Through empirical research in New Delhi, the capital of India, from December 2011 to November 2012, issues of decision-making on embryo transfer, fetal reduction, and mode of delivery were identified. Interviews were carried out with doctors in eighteen ART clinics, agents from four agencies, and fourteen surrogates. In aiming to fulfil the commissioning parents' demands, doctors were willing to go to the greatest extent possible in their medical practice. Autonomy and decision-making regarding choice of the number of embryos to transfer and the mode of delivery lay neither with commissioning parents nor surrogate mothers but mostly with doctors. In order to ensure higher success rates, surrogates faced the risk of multiple pregnancy and fetal reduction with little information regarding the risks involved. In the globalized market of commercial surrogacy in India, and with clinics compromising on ethics, there is an urgent need for formulation of regulative law for the clinical practice and maintenance of principles of reproductive ethics in order to ensure that the interests of surrogate mothers are safeguarded.

Keywords Reproductive ethics · Surrogate mothers · Informed consent · Decision-making · Embryo transfer · Fetal reduction · Delivery

M. Tanderup (✉)
Institute of Clinical Medicine, Faculty of Health Sciences, Aarhus University, Brendstrupgaardsvej 100, 8200 Aarhus N, Denmark
e-mail: mts@clin.au.dk

S. Reddy
Centre of Social Medicine and Community health, Jawaharlal Nehru University, 110067 New Delhi, India
e-mail: sunitareddyjnu@gmail.com

T. Patel
Department of Sociology, Delhi School of Economics, Delhi University, Delhi 110007, India
e-mail: pateltulsidse@gmail.com

B. B. Nielsen
Department of Obstetrics and Gynaecology, Aarhus University Hospital, Skejby, Brendstrupgaardsvej 100, 8200 Aarhus N, Denmark
e-mail: bbn@dadlnet.dk

Introduction

Reproductive medicine continuously confronts itself with ever more complex ethical considerations. Technological and scientific advancements have opened up immense possibilities in this field of medicine. There appear to be no limits to the advances being made in science and medicine, and there is a range of path-breaking technologies available to assist human

reproduction. But does this mean that we can push the limits of reproductive ethics in practice? Physicians use professional judgements in decision-making for most procedures in clinical practice. In the case of surrogacy, as in other fields, reproductive medicine is governed by medical ethics that call for certain principles to be followed. This includes principles such as informed consent—involving information giving, counselling, and consent from all participants in all procedures and with no conflicts of interest present. The present paper analyses clinical decision-making in the context of commercial surrogacy in India, where no law yet exists to regulate assisted reproductive technology (ART) clinics. The Indian Assisted Reproductive Technology (ART) Bill has been pending for five years, and only Indian Council of Medical Research (ICMR) guidelines are available for direction, resulting in self-regulated practices of fertility clinics (ICMR 2005; ART Bill 2010). The paper is based on a study of reproductive ethics as enacted in fertility centres providing surrogacy services in the city of Delhi, the capital of India. The focus here is on decision-making regarding three elements within surrogacy procedures: multiple embryo transplant, fetal reduction, and mode of delivery.

India has attained a reputation as the new destination for global medical tourism with commercial gestational surrogacy as an expanding market (Reddy and Qadeer 2010). It provides competitive prices, professional medical expertise, and women willing to be surrogates for an "affordable" price. Metro cities such as Mumbai, Delhi, Hyderabad, Chennai, and Bangalore have a reputation for providing surrogacy services, and even smaller cities like Anand in Gujarat have been pioneering in this field. However, the lack of ART laws, leading to self-regulated clinics, lends itself to several ethical considerations of which commercialization and exploitation are major themes (Sarojini, Marwah, and Shenoi 2011; Smerdon 2008).

Debates around the ethics of surrogacy are preceded by those relating to organ donation and transplantation (Scheper-Hughes and Wacquant 2002; Cohen 1999). Reproductive medicine, like organ transplantation, has been debated in the context of neo-liberal capitalistic medical enterprise and complicity in the commodification of body parts with market demands. However, unlike organ donation, which is a one-time process, reproductive medicine involves the use of eggs and sperm, which are regenerative. Furthermore, because women are capable of several pregnancies, this allows repeated surrogacy, thereby posing newer ethical challenges in the context of increasing the commercialization and commodification of women and their reproductive capacities. Many studies have described and discussed the dilemmas within the practice of surrogacy. Yet little attention has been paid to reproductive ethics such as medical decision-making within the various procedures of surrogacy in fertility clinics.

Methodology

This is a qualitative study carried out in Delhi, the national capital of India, between December 2011 and November 2012. Of the thirty-one clinics and hospitals contacted, twenty-three were involved in surrogacy, of which eighteen gave their permission for this study. Twenty doctors from eighteen clinics were interviewed with the help of an interview guide. Five agents from four surrogacy agencies and fourteen surrogate mothers (SMs) were also interviewed. In eleven of the cases, interviews with surrogates were done in the presence of other surrogates, agents, or lawyers. An interview guide was used, and an interpreter assisted the first author in interviewing SMs and one of the agents in their native language. Two SMs were met for interviews independently in a park for two hours and interviewed by the first author and the Hindi-speaking third author; the rest of the SMs were interviewed in the clinic or agency. Five agents and four of the eighteen doctors were interviewed twice, and the remaining doctors and all the surrogates were interviewed once.

Verbal consent was obtained from all the participants after informing them about the purpose of the study (in India, no formal requirement of written consent is required, and thus verbal consent is predominantly used when conducting social science research). Participants have been given pseudonyms to maintain confidentiality. All the interviews were summarized with detailed notes and verbatim quotations. Additionally, eleven interviews were transcribed after obtaining verbal consent to record.

A number of challenges and limitations arose during the interviews. Use of an interpreter may have limited the flow of the interviews, and some finer linguistic nuances may have been lost in translation. It was also a challenge to find agents and surrogate mothers and to obtain appointments with extremely busy doctors. Furthermore, during the interview sessions with the

SMs, the agents often interrupted and gave their opinion instead of letting the surrogates speak.

Profile of the Respondents

The doctors in this study had between three and twenty-five years' experience in in vitro fertilization (IVF) and surrogacy. Eight were owners of private clinics and twelve were employees. Out of the eighteen clinics, all of which were private, nine were smaller independent IVF clinics and nine were part of larger hospitals.

The agents in this study belonged to a range of IVF agencies. One agency worked in cooperation with an IVF clinic. Three agencies were independent companies offering services to the IVF clinics such as recruiting women for surrogacy, corresponding with international clients, and escorting surrogates to and from the clinic for treatment and scans. The agencies had social networks in poorer enclaves, which were potential sources of surrogate women for clinics and agencies. The agents had different professional and academic backgrounds, including a former singer, a master's degree in humanities and development, and a microbiologist. Their experience in surrogacy ranged from zero to six years.

Twelve of the surrogate mothers were married and two were widows; they were aged between twenty-one and thirty years. Twelve had one or two children, one had five children, and another had six children. All the surrogates were pregnant at the time of the interview, with the exception of one who had not yet conceived. Two of the participants were surrogates for the second time. Five reported the monthly income of their household as ranging from 5000 to 13,000 rupees (approximately US$80–US$208). Examples of their husbands' types of work included drivers, junior staff in offices, and fish salesmen. Five of the surrogates said that they also intermittently worked as tailors or engaged in domestic work or goods-checking for companies. The surrogate mothers' level of education varied from none at all to ten years of school.

Decision-Making in Surrogacy: Issue and Context

At various stages in surrogacy procedures, not only are physicians and surrogates involved in decision-making, but the important influence of the commissioning parents (CPs) as the primary stakeholder cannot be underestimated. Thus, conflicts of interest may arise between the parties involved. The clinics advertise high success rates at lower costs and thus raise expectations of early successful pregnancy amongst patients. Self-financed fertility treatment heightens the desire of CPs for a successful pregnancy in the first attempt (Dickens and Cook 2008). Therefore, CPs might see multiple pregnancies in a positive light and opt for those clinics that advertise higher success rates (Price 1999). This frequently results in multiple embryo transfers. Furthermore, surrogate mothers are often awarded a bonus for carrying a multiple pregnancy, and as such, if information regarding associated complications is underplayed or not provided, they may also opt for multiple pregnancies.

However, the number of embryos that should be transferred in IVF has been widely debated by fertility practitioners and researchers (SOGC-CFAS 2008; Cohen 2006; Armour and Callister 2005). While a higher number of transferred embryos might increase success rates, it also increases the risk of multiple pregnancies. Multi-fetal gestations are associated with significantly higher incidence of complications due to prematurity when compared with singleton pregnancies. Fifty per cent of twins and 90 per cent of triplets are born prematurely (SOGC-CFAS 2008).

The second major decision that must be made during the surrogacy procedure relates to the possibility of fetal reduction. Once multiple embryos have been transferred and a multi-fetal ongoing pregnancy established, physicians, well aware of the risks of multiple pregnancy, may opt for fetal reduction in order to increase survival of the remaining fetuses and decrease long-term morbidity for the delivered infants. One of risks of fetal reduction is that it can end in a total abortion. Furthermore, if the reduction is successful in leaving one or two fetuses alive, the CPs risk long-term psychological trauma arising from the loss of the unborn, reduced fetuses (Dodd and Crowther 2003; Boivin et al. 2001), not to mention if the CPs (or SM) have religious or culture persuasions opposed to abortion. It also implicates an extra intervention on the SM.

The third important decision made during the surrogacy process is the mode of delivery. Discussion is still ongoing as to whether caesarean section (C-section) without medical indication is ethical defensible (ACOG Committee on Ethics 2004; Schenker and Cain 1999), weighing autonomy versus the medical (dis)advantages between choosing vaginal delivery compared to C-section (SOGC-CFAS 2008). In India,

in the case of twin pregnancies in surrogacy, C-sections are carried out routinely (Pande 2010; Sarojini, Marwah, and Shenoi 2011), leaving the SM with risk of infection, a longer recovery period, risk of future C-sections, and a scar.

Informed Consent

Informed consent for medical procedures is a central concept in medical ethics and involves taking consent only after information sharing and counselling. This holds true for surrogacy as well. The ICMR guidelines, section 3.2.4, state:

> Before starting treatment, information should be given to the patient on the limitations and results of the proposed treatment, possible side-effects, the techniques involved, comparison with other available treatments, the availability of counselling, the cost of the treatment, the rights of the child born through ART, and the need for the clinic to keep a register of the outcome of a treatment (ICMR 2005, 58).

This spirit of ethical practice in the ICMR guidelines is reiterated in the ART Bill (2010) as well, which has been pending for five years. Section 4.20.6. of the Bill, which deals with informed consent, says:

> ART clinics shall provide professional counselling to patients or individuals about all the implications and chances of success of ART procedures, in the clinic and in India and internationally, and shall also inform patients and individuals of the advantages, disadvantages and cost of the procedures, their medical side effects, risks including the risk of multiple pregnancy etc. (ART Bill 2010, 15–16).

Both clauses have the patient in mind but, in essence, the stress is on the IVF seeker as patient. In the case of surrogacy, the involvement of the third party, the surrogate mother, makes the need for informed consent in decision-making even more compelling. The signing of a surrogacy contract provides an initial point at which information sharing may take place; this includes explanation of the medical procedures involved, complications, risks, counselling, and taking consent. Given the importance of informed consent in this context, our study sought to examine to what extent these guidelines are followed by clinics and physicians.

For example, Shamita, a surrogate mother, described how she signed the surrogacy contract:

> I don't know what will happen, what will not happen. … They just told that like you have a drop of water, we will keep that and grow it by means of injection. You will have to keep it in your womb for nine months and then deliver the child. … No benefit, no risk was told.

She further explained that the reason she had not asked the agent or the doctor for details about the procedures and risks was that she got the feeling that they were too busy with other patients and that it would therefore be inappropriate to ask—a common experience reflected among the other interviewed SMs in the study. Indeed, obtaining fully informed consent with quality and clarity of communication between parties is particularly challenging given that doctors are perceived as authority figures and surrogate mothers usually come from low economic and educational backgrounds (Deonandan, Green, and van Beinum 2012). Further, it appeared in the study that the agents having the initial talk with the SMs and CPs had a greater part of the responsibility to explain the surrogacy process than the doctors. Strikingly, none of the fourteen surrogates was able to explain what had been done to them—it seemed they had not been a part of most medical decisions relating to them. These findings are consistent with a common failure in India to provide detailed information about medical procedures to patients (Nandraj 1994).

Number of Embryos to Transfer

The ART Bill 2010 does not address the issue of multiple embryo transfer, while the ICMR guidelines (2005) remain vague on the matter. In the ICMR guidelines, section 3.2.7 (2005, 59) suggests that a maximum of three embryos be transferred in one cycle but makes exceptions for women who are older than thirty-seven years of age, have poor implantation or advanced endometriosis, and in cases of poor embryo quality. While the ICMR guidelines make this exception for the commissioning mother as a recipient of embryos, it does not attribute the same importance to embryos being transferred into a

healthy surrogate under thirty-five years of age with a fit uterus (the ART Bill prescribes that SMs must be under thirty-five years of age).

Surrogates' Experiences: Some Ask, "Am I Carrying One, Two, or Three Children?"

Two women in our study, Rumi and Radha, both six months pregnant, were introduced to the researchers by the agent as carrying a singleton and twins, respectively. Later, when the agent left, Radha whispered that she was, in fact, carrying triplets and Rumi was carrying twins. Neither Radha nor Rumi was able to explain anything about the risks of multiple pregnancies and was not even aware of procedures involving multiple embryo transfer or fetal reduction. They both hoped for a vaginal delivery and had not been informed about the high possibility of a C-section due to their multiple pregnancies.

Physicians on Embryo Transfer

Many of the physicians we spoke to were aware of the ICMR guidelines and clearly expressed the need for legal restrictions on the number of embryos that may be transferred. The doctors described basing their decisions regarding the number of embryos to transfer mainly on the quality, size, and number of embryos available. Nevertheless, the range of how many embryos the clinics decided to implant was significant. As Dr. Madhu reported:

> There are no restrictions in India on [the] number of embryos to implant. But in our clinic, if it is good quality blastocysts, we only implant two. Otherwise, if the embryos don't develop into blastocysts, the highest implant is five.

Dr. Madhu clearly did not perceive the ICMR guidelines as imposing any restrictions or being mandatory for maintaining good clinical practice.

Dr. Devyani offered an alternative perspective, arguing for the transfer of fewer embryos. She said:

> I don't like to transfer a lot of embryos and then put the surrogate through fetal reduction. … I took my specialization in Europe, and when they can keep the success rates high and standards high even though they transfer a maximum of three, then why can't we?

Apparently, the training and work experience abroad made this physician follow higher standards of clinical and ethical practice.

Only three of the eighteen clinics included in the study described limiting embryo transfer to a maximum of two per surrogate—seven clinics would transfer up to three embryos, four clinics up to four, one clinic greater than four, two clinics a maximum of five, and finally one clinic a maximum of seven. Thus, eight clinics appear to transfer high numbers of embryos per transfer (from four to seven), in contravention of the recommendations of the ICMR guidelines. The transfer of multiple embryos resulted in high reported rates of multiple pregnancies among participating clinics. Dr. Bharati reported 50 per cent singletons, 30 per cent twins, and 20 per cent triplets in her clinic; Dr. Aditi also reported 50 per cent multiple pregnancies and reducing all triplets to twins.

Transfer of multiple embryos was carried out both due to vague guidelines and non-existent laws but also, the doctors argued, because IVF is self-paid in India and thereby a financial hardship for the CPs, so the doctors cannot opt for elective single embryo transfer (eSET), unlike their European counterparts. According to one of the doctors, "The CPs cannot afford any decrease in the success rates though the risk of medical complications is higher." This argument is consistent with reports of doctors in Taiwan practicing multiple embryo transfers (Wu 2012). In standard IVF treatment, the doctor together with the couple would weigh the advantages of multiple implantations, such as higher success rates and fewer costs, against the risks involved in a multiple pregnancy, such as higher maternal and neonatal morbidity and mortality (Wimalasundera, Trew, and Fisk 2003). It is clear that clinics project rather high success rates on their websites and many do not distinguish whether they refer to chemical pregnancy, clinical pregnancy, or take-home baby rates, which may confuse and misinform. The difference between decision-making in normal IVF and in surrogacy is that in surrogacy it is the health of the SM that will be compromised. Internationally, healthcare providers are requested to reduce the risk of multiple pregnancies to protect the surrogate and future babies (International Federation of Gynecology and Obstetrics Committee for Ethical Aspects of Human Reproduction and Women's Health 2008),

and clearly ten of the doctors who did follow the ICMR recommendation were conscious of the higher risk for multiple embryo transfer. However, the range from a maximum of two to seven embryo transfers across the participating clinics shows the wide variation and compromise on reproductive ethics.

Decision-Making Regarding the Number of Embryos Transferred

In a majority of the clinics, doctors alone made decisions about the number of embryos to transfer. Some of the clinics chose to involve the commissioning parents but not the surrogate mothers. Only in one clinic were the wishes of both the CPs and the surrogate acknowledged. As Dr. Vahini said:

> Some CPs only want singletons, and in that case the clinic only transfers one embryo. Some of the SMs also don't want to carry twins, because there are more complications and many of them are doing physical labour.

In this case, the CPs' wishes regarding how many children they wanted through IVF was respected, and at the same time the surrogate had the right to take part in the decision.

Having More Than One Surrogate

The ICMR guidelines indicate that commissioning parents should not hire more than one surrogate simultaneously. However, of a smaller subset of clinics that were questioned regarding how many surrogates they offer a CP, only three said they follow the ICMR guidelines and only recruit one surrogate. In one clinic, there were clear violations of these guidelines. Dr. Devyani said that in her clinic:

> Thirty to 40 per cent of our CPs have two surrogates at a time … but the risk with two surrogates is that the chances of getting multiple children is high. Recently we had one couple who had four children; two children from each surrogate. But if the CPs don't want to have more than one or two children, they might only let one surrogate continue the pregnancy and the other has to go for an abortion.

Even though the doctor disapproved of CPs having two surrogates, she agreed to it because, as she explained, "When you have international CPs, you have to give them the best service; otherwise, they will go to another clinic and have it. The CPs believe that ART is like 100 per cent success." According to one of the agents cooperating with the previous mentioned clinic, one international CP from this clinic took this to the extreme by hiring four surrogates at one time. This gives some indication of the power that CPs have over the decision-making process. Commissioning parents have the power to choose the clinic they believe will give them 100 per cent success, instead of a mere chance or hope of receiving a child.

Despite ICMR guidelines prescribing that only one surrogate may be commissioned at a time by prospective parents, the above narrative indicates that these guidelines are violated at times. Furthermore, the number of simultaneous surrogates is difficult to track, as CPs may themselves register in several different clinics without revealing this to clinic staff. However, in the case described above the doctors *were* aware that the CPs with whom they were working had engaged multiple surrogates, and it seems commercial interests prevailed over ethical principles. Thus, throughout the surrogacy process it is very clear that the surrogate mother, in addition to being excluded from most clinical decision-making, is also highly vulnerable in other ways. In order to ensure higher chances of successful pregnancy, clinics at times transfer embryos to more than one surrogate. If multiple pregnancies result and the CP does not want more than one or two children, then the clinic may decide to terminate one of the pregnancies and this surrogate will not be paid the full amount.

And the ethical issues do not end there. Because the success rate for clinical pregnancy is highest with a good endometrium, some of the clinics in our study also prepared more than one surrogate for embryo transfer and selected the surrogate with the best endometrium for transfer while hormonal treatment was withdrawn from others until the following month's cycle. Some of the clinics also had experienced surrogates falling sick, meeting with accidents, or having a weak endometrium when the embryos were ready. Accordingly, some clinics have adopted a practice of preparing more surrogates and keeping some as standbys.

Our results suggest that doctors and agents are aware of the demands from foreign couples and are willing to meet their expectations in violation of ethical guidelines and without considering the adverse health consequences for the surrogates. Clearly there is a commercial interest in this transaction, and a number of doctors in our study justified their actions on the basis that if they did not do it CPs would simply go to other clinics to get what they want.

Decision-Making on Fetal Reduction

One of the risks in ART of transferring a greater number of embryos is, as mentioned above, the possibility of a multiple pregnancy. When such a pregnancy occurs, the commissioning parents have to make a decision about whether they want a singleton, twins, or triplets. Depending on the decision of the CPs, the doctors then have to decide whether to continue the pregnancy, terminate the pregnancy, or reduce the number of fetuses. If they decide to continue with multiple pregnancies, there is an increased risk of maternal and neonatal morbidity and mortality; if, however, they choose fetal reduction, they risk a total abortion, thus taking them back to square one. Furthermore, as mentioned previously the CPs risk long-term psychological trauma arising from the loss of the unborn, reduced fetuses (Dodd and Crowther 2003; Boivin et al. 2001).

The decision-making process becomes even more complicated when a surrogate is involved. It is not the commissioning mother's body that has to go through the intervention of fetal reduction but rather the surrogate's. The Indian ART Bill and the ICMR guidelines do not provide a clear picture of how the doctor should include both the CPs and SMs in decision-making concerning fetal reduction. The Bill's clause 4.23.5 suggests that clinics inform the patients of a multiple pregnancy and the medical implications of it, not specifying whether this is the CP or SM. After counselling patients, a reduction of the fetuses may be carried out (ART Bill 2010, 18). Clause 3.4.3 of the ICMR guidelines provides for fetal reduction whenever the pregnancy involves more than two fetuses (ICMR 2005, 61). Yet the reports of the doctors in our study suggest that they differed even more greatly in their practice of fetal reduction than in their approach to embryo transfer.

In ten of the clinics in our study, the commissioning parents were included in the decision-making process. However, the role of the doctors varied, from acting as medical advisers to the CPs to taking an active part in the decision. Dr. Lipi explained the doctor's role in her clinic as follows: "We counsel the CPs in their decision about fetal reduction and make them understand the risk of multiple pregnancy. For example, the higher risk of spontaneous abortion when carrying triplets." In three of the participating clinics, the decision to reduce the number of fetuses was made by doctors and not by any of the CPs or SMs. As Dr. Alishi said, "We do fetal reduction down to twins. This decision is solely the doctors'—we inform the CPs in advance when they come initially that this will be done, if there are more than two fetuses." Although this conforms with the ICMR clause 3.4.3, it gives the doctor the power to decide on issues that will have a significant impact on the CPs and the SM. Only three clinics explained fetal reduction as a joint decision between the doctor, CPs, and surrogates. This was mainly in the case of triplets, which the surrogate could object to carrying on the basis of the increased risk to her health. Dr. Bharati explained decision-making in her clinic as:

> I think usually it is between the commissioning parents and us, but sometimes the surrogates are also apprehensive about the three pregnancies, and then it is of course her call; at the end of the day, she's the mother who is carrying the babies.

Not only does Dr. Bharati include the SM in the decision, she also considers her a mother—"the mother who is carrying the babies," unlike others who see the SM as just a carrier.

The surrogate mother's role in the decision-making regarding fetal reduction appeared to be more unclear than the commissioning parents'. Dr. Madhu said, "The SM knows that more than one embryo can be implanted. She doesn't have anything to say in the decision on fetal reduction—of course not, as she is not a parent." This suggests that for this particular doctor the parental role is connected to the genetically linked CPs and not the SM. Views such as these that frame the surrogate mother as a woman and her reproductive organs and thus merely a carrier invoke a birthing machine metaphor (Gupta and Richters 2008, 40)—the surrogate mother is used for producing a child for another couple who have "rented" her womb. Dr. Swati illustrated this approach in the context of the binding nature of the surrogacy contract:

> See, when they [the SMs] are signing on the contract paper, they are giving yes [*sic*] to all the

> complications and risks associated with it. … She cannot choose that I will be the mother of one child and I will not be carrying twins, I will not be carrying triplets. … [I]t doesn't happen that way. … She has hired out her womb for nine months and seven days of her life to another woman, and we can assure only one thing, nothing will go wrong with you.

Held in authority since colonial times (Prakash 1999), the biomedical doctor's assurance is assumed to be sufficient for the surrogate most of the time; but is it actually sufficient when speaking of a pregnancy and delivery with all its well-known, acknowledged implications? This perception of "renting" the womb of the surrogate mother implies a loss of rights over one's body and a relinquishing of control to the doctor. If the doctor promises the surrogate that "nothing will go wrong with her," when signing the contract one must ask whether the surrogate's consent can be called informed.

Whether one views a surrogate as a parent or (only) a medium to produce a child for the CPs certainly changes the doctor's attitude towards the surrogate. As a parent, she has the right to decide for her own body and the child, but as a part of the treatment, she loses these rights (Gupta and Richters 2008). However, regardless of how a surrogate is viewed, a high number of embryos per transfer and subsequent fetal reduction is unethical and needs regulation (Dickens and Cook 2008).

Decision-Making in Mode of Delivery

The ethics of the decision on mode of delivery and the right of the pregnant woman to undergo elective caesarean without a medical indication remain debatable. The American College of Obstetricians and Gynecologists (now the American Congress of Obstetricians and Gynecologists) accepts elective caesarean based on the principles of patient autonomy and informed consent (ACOG Committee on Ethics 2004). On the other hand, the International Federation of Gynecology and Obstetrics' guidelines state that performing a caesarean delivery for non-medical reasons is not ethically justified when looking at the benefits compared to complications (Schenker and Cain 1999). As mentioned previously the advantages of choosing vaginal delivery compared to elective C-section without medical indication are well known (SOGC-CFAS 2008; Beckmann et al. 2010). However, the doctors in our study brought not only medical expertise but also moral and financial responsibilities to their decisions, thus making these decisions more complex and open to question.

The Precious Child

In eleven of the clinics participating in our study, the decision on mode of delivery was reportedly made solely by the doctors, based on medical indications. As Dr. Sejal said:

> We aim to perform normal deliveries; only if needed, we do a caesarean section. We don't want to give these women a scar. The intended parents cannot influence the mode of delivery. You cannot put your [CPs'] decision on someone else's life.

In three clinics, commissioning parents were reported to exert pressure on doctors for C-sections. In one of the clinics, the CPs could reportedly directly decide the mode and then pay the surrogate extra for the C-section. In this case, the clinic would ask the surrogate right at the start if she was willing to undergo a planned C-section, and if she was not willing, they would match the CPs with a more willing surrogate. In two clinics, doctors reported only carrying out C-sections and not providing surrogate mothers the opportunity to have a vaginal delivery, even if she is a multipara. They use arguments like, "No one wants to risk a vaginal delivery when it is such a wanted child. We also leave very little to chance," and

> These parents have been through so much, so we don't want to risk a stillbirth or other complications. … So, for them even that 1 per cent or 0.1 per cent chance of having, say a catastrophe during labour … is a risk no one would like to take.

In other words, because of the anxieties of the commissioning parents, the decision on mode of delivery tends to be made in their favour and not the surrogate mother's. These two doctors explained that before signing the contract the surrogate is counselled that a C-section will be done, and in this way it is assumed that she has consented to the decision effected later on. Dr. Devyani (based in a clinic that has yet to have any deliveries), in comparison, was of the opinion that the surrogate should have the opportunity to choose a vaginal delivery and should not be forced to undergo a C-

section. As she said, "Why should she go for caesarean section, when she has delivered normally before?" On the other hand, Dr. Swati said that she, as a doctor, makes the final decision. Being a "precious pregnancy," she wants to be sure that nothing would go wrong.

Surrogate Ojal expressed her wishes regarding the coming delivery. "I know that a caesarean may be needed, but I think I have the strength for a normal delivery." She had already given birth to her own children, one by C-section and the other vaginally. This view was consistent with views of the other surrogates in our study, who in general expressed a wish for vaginal delivery—although none of them had been included in the actual decision on mode of delivery.

The above narratives and interviews revealed that 40–45 per cent of the doctors in our study had a preference for C-sections and the rest for vaginal delivery. However, in India a high rate of C-sections is common in private facilities for the non-ART population (Mishra and Ramanathan 2002). In the absence of access to delivery records in these clinics, the C-section rates may actually be much higher than reported by participants. We would argue that as surrogates are recruited after already giving birth to their own children, they should be given the opportunity to choose a vaginal delivery. The two clinics that reported only performing C-sections are depriving the surrogates of vaginal delivery even if they are carrying a singleton. Exposing the surrogate to the unnecessary risk of an invasive C-section is an economic rather than medical trade-off to avoid any risk to what physicians termed a "precious child." The child is precious for the CPs, involving great financial (as well as emotional) investment, and a clinic's reputation for higher success is tied to carry-home baby rates.

The World Health Organization considers C-sections to be necessary in only 5–15 per cent of (non-ART) deliveries and describes a higher rate as indicative of over-utilization of the procedure for other than life-saving reasons. Such over-utilization is dangerous for women's lives because of the unnecessary risks associated with any major surgical operation (World Health Organization Division of Family Health 1994).

Discussion and Conclusion

It is important that clinical decision-making in reproductive medicine, and particularly in surrogacy, be both evidence-based and ethically sound. This implies informed consent for all procedures—number of embryos transferred, fetal reduction, and mode of delivery. However, our results suggest that, in the Indian context, in order to have higher success rates there are frequent violations and breaches of ethics. Ethically there should be open discussion and shared decision-making among all interest groups, especially when there is a potential conflict of interest, as in the case of surrogacy.

We found that in many cases the autonomy of both the surrogate mother and the commissioning parents was neglected or disrespected. The doctor's authority as a medical expert became the most important part of the decision-making process, reflecting the age-old paternalism of the medical establishment. Indirectly, CPs have power as paying clients of the clinic. They also have the power to choose the clinic with the best success rates or the one that will provide them the service they want. At the same time, many of the doctors in this study did not directly include the CPs in their decisions. Furthermore, CPs might not always be in a position to question complicated medical treatment, as the doctor is, after all, providing what they have so long desired—a baby. In our study of eighteen clinics, only one clinic engaged in joint decisions on the number of embryos to transfer and three clinics engaged in joint decisions regarding fetal reduction. Thus, it is the minority of clinics that prioritize both the CPs and the SMs in decisions, which should be the norm. The law should emphasize joint decision-making that involves all parties, especially the surrogate and the CPs. Implementing ethically correct procedures after obtaining informed consent from surrogates (not simply signing a contract) is even more imperative before women undergo invasive medical interventions.

It is certainly a challenge to maintain the autonomy and self-determination of both the commissioning parents and the surrogate mothers in medical decisions. The doctors in our study felt that they were in the best position to make decisions on the clinical aspects and procedures related to surrogacy. These decisions, however, tended to be in the best interests of the CPs and to have a healthy baby but frequently de-emphasized the interests of the SMs. The ART Bill and the ICMR guidelines are also mute on the interests of SMs. An apparently non-coercive medical authority is exercised upon CPs and SMs who trust the physicians to make decisions on their behalf. Although it does not look coercive, the clinical ambience underscores that the

doctor is an expert and his/her decisions are rarely countered or questioned. Medical practitioners are accustomed to being authoritative in the decision-making process, as Price (1999) reports in her U.K. study; they often do not look into the social complexities of multiple pregnancy but make decisions on pragmatic grounds. While a general contrast between Western and Indian values and medical ethics is well stated (Palattiyil et al. 2010), the empirical studies on ART by Price (1999) in the United Kingdom and by Gupta (2010) on prenatal testing in Delhi present a more complex play of values and power relations in decision-making. Additionally, Gupta's study illustrated how infertile couples were unable to understand medical terminology and statistical probability relating to outcomes and preferred geneticists to make decisions on their behalf. It is even more challenging for doctors to explain modern medical procedures to SMs who often have lower levels of education compared to the CPs (Minocha 2010). Further, coercive medical interventions, especially in the commercial gestational surrogacy service sector, tend to compromise reproductive ethics. Our paper supports earlier findings of this complex situation in the clinical setting, illustrating how nuanced political economy, commercialization, and commodification come into play.

The commercial aspect weighs heavy on surrogacy decision-making. Multiple embryo transfer, preparing more than one SM for one CP and then aborting, fetal reduction, and caesarean sections frequently contravene the ethics in reproductive medicine based on international guidelines (Wu 2012). We would argue that the good clinical practice reported in three of the clinics from our study, which did not transfer more than two embryos to the SM, should be made mandatory in the coming ART Act. At present, unregulated ART clinics form their own clinical standards, which, our study results suggest, may often go against the SMs, who have little, if any, say in the decision-making process. It is our view that the ART Bill needs to be strictly enacted, not only to guide but also to regulate the clinics to follow international ethical medical standards, to register the clinic, and to send the clinic's database to a centralized regulatory authority. Unregulated clinics endanger basic human rights; thus, a firm regulatory framework is crucial in making surrogacy a safe and respectable line of work (Ramskold and Posner 2013).

The context of informed consent in surrogacy practice in Delhi is complex, and improvements in processes of obtaining informed consent may not be the sole answer to the ethical issues raised here. The differences between medical and lay language restrict smooth communication, which is further exacerbated by social stratification. These differences should not be an excuse not to fully inform surrogate mothers, as they can be informed of the medical terms and procedures in locally understandable concepts. However, commercial gestational surrogacy, even in the presence of informed consent, is exploitative. Not only in relation to payments, which many other studies have pointed out, but also in clinical decision-making the balance of power and resources are inevitably weighed against the SMs. We would argue that the onus for adequate information on the risks involved in surrogacy practice should be on the physicians. Unlike IVF treatment for couples and single women, where the woman bears her own children, reproductive ethics in the case of surrogacy requires "informed" consent from the surrogate on all the three medical procedures, without glossing over the real risks involved. Clearly, the inherent risk of exploitation will not be solved through informed consent alone. However, receipt of adequate information and provision of consent is one level of clarity surrogates ought to be able to expect of doctors and agents.

Statement of Competing Interests The authors have stated explicitly that there are no conflicts of interests in connection with this article.

References

American College of Obstetricians and Gynecologists Committee on Ethics. 2004. Surgery and patient choice: The ethics of decision making. *International Journal of Gynecology and Obstetrics* 84(2): 188–193.

Armour, K.L., and L.C. Callister. 2005. Prevention of triplets and higher order multiples: Trends in reproductive medicine. *The Journal of Perinatal & Neonatal Nursing* 19(2): 103–111.

Beckmann, C.R.B., F.W. Ling, B.M. Barzansky, W.N.P. Herbert, D.W. Laube, and R.P. Smith. 2010. *Obstetrics and gynecology*, 6th ed. Baltimore and London: Wolters Kluwer and Lippincott Williams & Wilkins.

Boivin, J., T.C. Appleton, P. Baetens, et al. 2001. Guidelines for counselling in infertility: Outline version. *Human Reproduction* 16(6): 1301–1304.

Cohen, L. 1999. Where it hurts: Indian material for an ethics of organ transplantation. *Daedalus* 128(4): 135–165.

Cohen, J. 2006. Embryo transfer: One or two? *Reproductive Biomedicine Online* 12(5): 644–645.

Deonandan, R., S. Green, and A. van Beinum. 2012. Ethical concerns for maternal surrogacy and reproductive tourism. *Journal of Medical Ethics* 38(12): 742–745.

Dickens, B.M., and R.J. Cook. 2008. Multiple pregnancy: Legal and ethical issues. *International Journal of Gynecology and Obstetrics* 103(3): 270–274.

Dodd, J.M., and C.A. Crowther. 2003. Reduction of the number of fetuses for women with triplet and higher order multiple pregnancies. *Cochrane Database of Systematic Reviews*, no. 2: CD003932.

Gupta, J.A. 2010. Exploring Indian women's reproductive decision-making regarding prenatal testing. *Culture, Health & Sexuality* 12(2): 191–204.

Gupta, J.A., and A. Richters. 2008. Embodied subjects and fragmented objects: Women's bodies, assisted reproduction technologies and the right to self-determination. *Journal of Bioethical Inquiry* 5(4): 239–249.

Indian Council of Medical Research (ICMR). 2005. National guidelines for accreditation, supervision and regulation of ART clinics in India. http://icmr.nic.in/art/art_clinics.htm. Accessed June 6, 2015.

International Federation of Gynecology and Obstetrics Committee for Ethical Aspects of Human Reproduction and Women's Health. 2008. FIGO committee report: Surrogacy. *International Journal of Gynecology and Obstetrics* 102(3): 312–313.

Ministry of Health and Family Welfare, Government of India, New Delhi. 2010. The assisted reproductive technologies (Regulation) Bill 2010 (ART Bill). http://icmr.nic.in/guide/ART%20REGULATION%20Draft%20Bill1.pdf. Accessed June 6, 2015.

Minocha, A.A. 2010. The socio-cultural context of informed consent in medical practice. In *Understanding Indian society: Past and present*, edited by B.S. Baviskar and T. Patel, 231–253. New Delhi: Orient Blackswan.

Mishra, U.S., and M. Ramanathan. 2002. Delivery-related complications and determinants of caesarean section rates in India. *Health Policy and Planning* 17(1): 90–98.

Nandraj, S. 1994. Beyond the law and the Lord: Quality of private health care. *Economic and Political Weekly* 29(27): 1680–1685.

Palattiyil, G., E. Blyth, D. Sidhva, and G. Balakrishnan. 2010. Globalization and cross-border reproductive services: Ethical implications of surrogacy in India for social work. *International Social Work* 53(5): 686–700.

Pande, A. 2010. Commercial surrogacy in India: Manufacturing a perfect mother worker. *Signs* 35(4): 969–992.

Prakash, G. 1999. *Another reason: Science and the imagination of modern India*. Princeton: Princeton University Press.

Price, F. 1999. Beyond expectation: Clinical practices and clinical concerns. In *Technologies of procreation: Kinship in the age of assisted conception*, edited by J. Edwards, S. Franklin, E. Hirsch, F. Price, and M. Strathern, 29–59. London: Routledge.

Ramskold, L.A., and M.P. Posner. 2013. Commercial surrogacy: How provisions of monetary remuneration and powers of international law can prevent exploitation of gestational surrogates. *Journal of Medical Ethics* 39(6): 397–402.

Reddy, S., and I. Qadeer. 2010. Medical tourism in India: Progress or predicament. *Economic and Political Weekly* 45(20): 69–75.

Sarojini, N., V. Marwah, and A. Shenoi. 2011. Globalisation of birth markets: A case study of assisted reproductive technologies in India. *Globalization and Health* 7(1): 1–9.

Schenker, J.G., and J.M. Cain. 1999. Report of the FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. *International Journal of Gynecology and Obstetrics* 64(3): 317–322.

Scheper-Hughes, N., and L. Wacquant. 2002. *Commodifying bodies*. London: Sage.

Smerdon, U.R. 2008. Crossing bodies, crossing borders: International surrogacy between the United States and India. *Cumberland Law Review* 39(1): 15–86.

Society of Obstetricians and Gynaecologists of Canada and the Canadian Fertility and Andrology Society (SOGC-CFAS). 2008. Guidelines for the number of embryos to transfer following in vitro fertilization: No. 182, September 2006. *International Journal of Gynecology and Obstetrics* 102(2): 203–216.

Wimalasundera, R.C., G. Trew, and N.M. Fisk. 2003. Reducing the incidence of twins and triplets. *Best Practice & Research Clinical Obstetrics & Gynaecology* 17(2): 309–329.

World Health Organization Division of Family Health. 1994. *Indicators to monitor maternal health goals. Report of a Technical Working Group, November 8–12, 1993*. Geneva: World Health Organization, publication no. WHO/FHE/MSM/94.14.

Wu, C.L. 2012. IVF policy and global/local politics: The making of multiple-embryo transfer regulation in Taiwan. *Social Science & Medicine* 75(4): 725–732.