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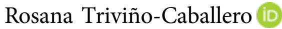
ARTICLE

Caring for Delivery: Healthcare Professionals' Ethical Conflicts in Surrogate Pregnancy



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Abstract

From the beginning of the practice of surrogate pregnancy, ethical approaches to it have included several dimensions. Central issues such as surrogates' genuine autonomy, the risk of exploitation of people in vulnerable situations, or the legitimacy of the commercialization of the body have kept this debate alive for more than three decades. Among all the conflicts, those related to healthcare professionals involved in the surrogacy process have been less frequently addressed. Which patient(s) should they protect? Whose interests should they preserve, the surrogate mother's or the intended parents'? Are there differences in healthcare provision between *regular* pregnant women and those who are going to relinquish their babies? Is adequate compliance with the ethical standards of the caregiver–patient relationship possible? In this article, I will address these questions to identify interests and practices at stake in the healthcare context, where an important part of the surrogacy process occurs.

From the beginning of the practice of surrogate pregnancy, ethical approaches to it have included several dimensions, which have kept the debate alive for more than three decades (Dickenson and van Beers 2020). Among the central issues discussed are surrogates' genuine autonomy, with counterviews between those who defend women's rights over their bodies (Robertson 1983; Shalev 1989) and those claiming that women's decisions are conditioned by financial reasons (Anderson 1990; Wilkinson 2003), by the "mystique of giving life" (Lindemann Nelson and Lindemann Nelson 1989; Raymond 1990; Pande 2010), or by an "adaptive preference"[1] (Nussbaum 2001; Donchin 2010; Khader 2011). Other widely debated questions are the legitimacy of women's and children's bodies' commodification (Phillips 2013; Satz 2017), as well as the risk of exploitation of people in vulnerable situations, especially in the case of transnational surrogacy. Under these circumstances, there are deep wealth and power differences between intended parents and surrogates (Anderson 1990; Wilkinson 2003; Bailey 2011). At the same time, some authors consider that there is potential empowerment

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of those vulnerable women through fair surrogacy (Purdy 1989; Panitch 2013; van Zyl and Walker 2013). Regarding family bonds, there have been controversial issues such as the relationship between genetic, gestational, and social motherhood/parenthood (Golombok et al. 2006; Jadva et al. 2012; Imrie and Jadva 2014); the right of nonheteronormative families to have children (Garwood 2016; Russell 2018); or the right of surrogate children to know their biological origins (Bernstein 2013).

However, ethical conflicts related to healthcare professionals involved in the surrogacy process have been less frequently addressed. To this date, only one survey on attitudes toward surrogacy among primary health professionals has been found, carried out in Sweden; its focus is on the experience of the children and the families following surrogacy abroad (Armuand et al. 2018). The main conclusion was that although 60% of the health professionals supported legalized surrogacy, many expressed concerns about the children's health and highlighted the need for greater knowledge about the medical and psychosocial consequences of surrogacy.

In other cases, the focus is on what should be the appropriate behavior and professional obligations of the gyn-obstetrician (Bhatia et al. 2009; Chervenak and McCullough 2009), not considering the ethical issues that the practice of surrogacy itself raises with regard to professional ethics. A common solution has been that the healthcare professional in charge of the surrogate should be different from the one who is conducting the surrogacy procedure (Bhatia et al. 2009). However, even considering this alternative, interests and practices that could imply ethical dilemmas for healthcare professionals are still at stake, such as unnecessary or controversial interventions established by contract between intended parents and surrogates that affect decision-making processes, surrogates' control over their bodies and lives, method of giving birth, maternal detachment, or perinatal care. This is the field I would like to explore in this article.

My thesis is that surrogacy is a potentially harmful practice for the surrogate woman, fetus, and baby, and thus healthcare professionals should avoid participating in those procedures that could be damaging for them. In order to achieve this goal, the first step will be to clarify the framework of the different types of surrogacy and justify which ones will be addressed in the article. Second, I will develop some questions about the agents, methods, and practices involved in the decision-making process. Finally, I will establish some caregivers' responsibilities toward surrogates and babies, as well as the ethical challenges they face.

Surrogate Pregnancy: A Conceptual Review

Surrogate pregnancy is a reproductive practice in which a woman agrees to carry a pregnancy to term and to relinquish the baby to other people, usually called intended mother/father/parents or commissioning mother/father/couple. This practice is far from new. There are well-known examples since Antiquity of servant women who conceive children for heterosexual couples to avoid the wife's repudiation by the husband and to guarantee the continuity of male lineage (Cantarella 1997).[2] Over the course of history, these reproductive services have been provided for free. These characteristics—altruism and centrality of the (male) genetic descendants—have highlighted the idea of women's sacrifice and abnegation as well as their social compromise with their biological function, making this practice, especially in its altruistic version, increasingly accepted (Rodríguez-Jaume, González-Río, and Jareño-Ruiz 2019, 308). Since the 1980s, surrogacy demand has intensified because of the biomedical advances in reproductive techniques, together with increasing rates in biological and social infertility,

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patterns in gay parenting, and the globalization of the reproductive industry (Lindheim et al. 2014, 229–30; Berk 2015).

Nevertheless, evidence about the true rate and nature of surrogacy is limited. Where it is allowed, surrogacy is a social arrangement established by a private agreement, so there is no obligation for data to be gathered (Bhatia et al. 2009, 50). This difficulty is aggravated by the internationalization of the practice, which is frequently performed in a different country from that of the intended parents (Salama et al. 2018). Some evidence shows that Ukraine[3] and the Russian Federation are popular sources of surrogates for an international clientele, and Greece, Poland, and Georgia are quickly gaining a similar reputation (Deonandan 2015; Salama et al. 2018). By contrast, concerns about neocolonial exploitation have contributed to some countries such as Mexico, India, Thailand, or Cambodia restricting surrogacy to nationally intended parents (Salama et al. 2018; Frati et al. 2021).

Depending on the reproductive process, surrogacy can be genetic or gestational. In genetic surrogacy (also called "traditional," "straight," "natural," "partial"), the sperm—usually from an intended father or both fathers, in the case of gay couples—is used to inseminate the surrogate. This procedure can be done either in a clinic, using intrauterine insemination, or performed at home. As a result, the baby is genetically related to the surrogate mother and one of the commissioning parents.

Although genetic conception is less complicated, it has been said that this type of surrogacy may be more difficult to accept from a social and psychological point of view (Trowse 2011; Bernstein 2013). The surrogate mother must renounce a child she knows is genetically and physiologically related to her, and the potential mother must accept a child who comes from the direct or indirect interaction of her husband or partner with another woman (Bhatia et al. 2009, 50). This is a common intuition, even though there is a lack of evidence to support it (Imrie and Jadva 2014). Furthermore, some studies have suggested that intended parents are more likely to show gratitude and kindness to traditional surrogates (Teman 2010, 198).

From a legal point of view, the genetic connections between the surrogate and the child might complicate the arrangement, especially in those cases in which the surrogate wants to keep the child (ASRM 2012; Bernstein 2013). These assumptions have led to the international agreement that gestational surrogacy should be the only type of surrogacy accepted (FIGO 2008).

In gestational surrogacy, also known as "host," "full," or "IVF" surrogacy, the surrogate has no genetic connection to the child she carries, and *in vitro* fertilization (IVF) is required. It is typically performed using embryos generated from the commissioning couple's sperm and eggs, which are transferred to the surrogate mother, though a donor's egg and/or donor sperm may also be used. As has been established previously, this type of surrogacy is often perceived as less problematic than the traditional one, especially from a legal point of view. However, there are some conflicts to note. On the one hand, success rates are usually lower, implying more time and greater expense (Bhatia et al. 2009, 50). On the other hand, it involves more invasive procedures, medication, and surveillance, which should not be underestimated. Because of this, preference for gestational over traditional surrogacy has been criticized due to being seen as favoring the interests of intended parents and clinics at the expense of surrogates (Pande 2014, 78).

Depending on their economic terms, both traditional and gestational surrogacy usually are classified as either commercial or altruistic, although it is important to keep in mind that in both modalities of surrogacy, fertilization, pregnancy, and birth occur mostly in a clinical setting where economic interests come into play.

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In commercial surrogacy, the surrogate offers her services in exchange for economic benefits or some other form of payment. The surrogate is usually recruited through an agency. This type of surrogacy is allowed in countries such as the Russian Federation, Ukraine, Belarus, Georgia, Armenia, Cyprus, Israel, South Africa, United States (Arkansas, California, Florida, Illinois, Texas, Massachusetts, Vermont), but it remains illegal in most other countries (Salama et al. 2018; Frati et al. 2021). To some extent, this legal view of commercial surrogacy, when there is a monetary transaction for the gestational process, is rooted in the moral perception that women are subject to exploitation and children are treated as purchasable commodities (Anderson 1990; Wilkinson 2003; Jacobson 2016). It can also be argued that, by becoming commercial surrogates, women may have the opportunity to improve their own lives and those of their relatives (Scala, Montpetit, and Fortier 2005; Panitch 2013). Especially in cases of underprivileged women, payments for surrogacy can enable them and/or their families to achieve better housing, food, education, sanitization, and so on, which would be difficult to get through regular jobs.

Alternatively, in altruistic surrogacy the surrogate is usually either found among family, friends, and acquaintances, or by advertisement (Milliez 2008, Söderström-Anttila et al. 2016). The surrogate chooses to carry the child for reasons other than financial profit, which makes this model of surrogacy more morally acceptable than the commercial one (Rodríguez-Jaume, González-Río, and Jareño-Ruiz 2019). However, it is important to note that the surrogate usually receives compensation for medical expenses, diet, loss of earnings (*lucrum cessans*), and so on. This situation of nonperfect altruism, which has even been considered false altruism, has been criticized in countries like Canada, where altruistic surrogacy is the only legal choice (Lozanski 2015). There are several reasons for the debate. The first is related to the constraints placed on women's reproductive autonomy, noting the benefits that markets can bring to women (Scala, Montpetit, and Fortier 2005, 581–92; Panitch 2013); the second is linked to the difficulty of controlling under-the-table payments and, therefore, avoiding potentially abusive situations (Lozanski 2015). The third denounces the high standard of guarantees for surrogates, as well as the low monetary offers of the altruistic system, which could have a special impact on same-sex couples, provoking citizens of richer countries to go to poorer ones to source gestational surrogates (Deckha 2015). In doing so, they are contributing to the enlargement of an industry based strongly on wealth and intersectional disparities.

Other arguments against altruistic surrogacy are related to the authenticity of the surrogates' repeated claim they are offering the "gift of life" (Raymond 1990); the quality of the information provided to the surrogates (Dodds and Jones 1989); and the impact of false expectations about surrogate motherhood (van Zyl and Walker 2013).

Altruistic surrogacy is allowed in countries such as India, Australia, Canada (except Quebec), the United Kingdom, Greece, Netherlands, Denmark, Hungary, Israel, the United States (New York, New Jersey, New Mexico, Nebraska, Virginia, Oregon, Washington) (Salama et al. 2018; Frati et al. 2021).

In this article, I intend to include traditional and gestational surrogacy, as well as altruistic and commercial modalities, if they have been established through statutory schemes that include a contract. Although specific harms befall one version but not the others, all of them are subject to the family of arguments claiming that surrogacy could be harmful (Agnafors 2014) and, therefore, ethically problematic for healthcare professionals. The only cases excluded from this discussion will be those performed in a more "informal" way, without contracts, agents, or brokers, in which the

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relationship between surrogate and intended parents could allow constructing a collective upbringing of the child.

This type of situation is not necessarily conflict-free (Raymond 1990; Roach Anleu 1990), but I have considered it as morally less problematic for healthcare professionals than the previous ones, since it is based on mutual trust, not on a contractual arrangement (Beier 2015). Agents involved do not need any guarantee other than their mutual compromise, so the threat of sanctions is not at play and trust is the most relevant feature of the agreement (Lahno 2001; Möllering 2006). Under these circumstances, when all of those involved share a common life project or are emotionally linked, conflicts of interest among biological mother, baby, and surrogate parents are less likely to occur (van Zyl 2002; Beier 2015). Significant relationships appeal to a sense of moral responsibility that includes attention and care for others (Kirkman and Kirkman 1988). Additionally, regular contact between biological mother and child would provide bonds between them, which is considered beneficial for their well-being (Brandon et al. 2009; Olza 2018).

From an ethical point of view, there could be two principal issues related to surrogacy that practitioners must face. The first is related to reproductive techniques and their potential harms, which would need to be counterbalanced by the desire for this type of motherhood (Stern et al. 2015; ACOG 2016; Dayan et al. 2019); the other is linked to the potential consequences of multiple motherhood/parenthood, children's identity, and the legal status of each of the people implicated in the process (Turner and Coyle 2000; O'Neill 2002). Despite its interest, debate on these last questions exceeds the goal of this article.

Who is the Patient? Maternal–Fetal Relationship in Surrogate Pregnancy

Surrogacy breaks with taken-for-granted beliefs about the nature of motherhood (Burrell and O'Connor 2014). Where once people trusted the Latin adage *Mater semper certa est*, based on the assumption that giving birth to a (new) human being turns a woman into a mother, with surrogacy, opportunities to have more than one biological mother are spread. This disruption between genetic, physiological, and social motherhood, on the one hand, and the establishment of contractual conditions on the process of fertilization, gestation, birth, and delivery on the other, strengthen the idea of two different recipients of care, the surrogate mother and the fetus/baby.

This kind of disconnection has also been established for nonsurrogate pregnancies, especially in relation to abortion. For example, in its 1987 report "Patient Choice: Maternal–Fetal Conflict," the Ethics Committee of the American College of Obstetricians and Gynecologists (ACOG) put forth the idea that mothers and their babies are antagonists (ACOG 1987). This "conflict" is based on women's potential decisions or behaviors that could affect fetal well-being or fetal life. Women may refuse medical treatment, C-section, forceps delivery, or other therapies that are deemed beneficial to the fetus. This also applies to some habits of their daily lives considered detrimental to unborn children (exposure to toxic substances, unhealthy diet, lack of exercise, and so on).

More than ten years later, the Committee changed the concept of maternal–fetal conflict to "maternal–fetal relationship" (ACOG 1999). This perspective is based on two intertwined premises. In most of the cases, pregnant women make their decisions considering the best interests of their future children. Even when this is not the case, basic rights related to women's autonomy cannot be erased on the assumption that there is a right to be born and born healthy. Therefore, there is no asymmetrical

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position between a pregnant woman and her unborn child that could be considered the basis for a "conflict" to be debated.

However, the previous way of considering mothers and children as separate patients keeps influencing the healthcare context (Premkumar and Gates 2016; de Vries 2017). In this fictional battle between mother and infant, practitioners frequently are allies of the child (Brown et al. 2006; Brown et al. 2012). Having a healthy baby is the only outcome that seems to matter, as bioethicist Raymond de Vries has suggested (de Vries 2017). When the mother's preferences and interests are balanced with the perceived needs of the baby, her autonomy and role in decision-making are put aside to benefit the best interests of the child, as the following testimony reflects:

> Healthy, safe deliveries are the goal, and I thank God and the medical personnel that my son made it into the world safely. However, the dehumanizing aspects of this labor are a permanent part of our story. We had the right outcome, yes, but at what cost personally and medically? . . . as I openly tried to process the C–section, a passing nurse told me, "at least you have a healthy baby." I will never forget how bad that nurse made me feel in that moment. I was no longer in control even of my own emotions. The hospital staff knew better. Our eventually healthy baby didn't erase our ordeal. Eventually, my opinion evolved from gratitude—thank goodness we were in the hospital so that my baby could get help for five hours —to resentment—maybe they had helped my baby for five hours because we were in the hospital. My son needed medical attention, but equally important were . . . my needs to be kept informed of the condition of my child. (de Vries 2017, 219)

This way of proceeding is usual in regular pregnancies, under the deep-rooted belief that "good mothers are those who subordinate their own needs (and bodies) in service of their children and families" (Joslin 2020, 383). In the case of surrogacy, this kind of pressure is also present, since getting a healthy baby for others is openly the main goal. In addition to the common situations faced by pregnant women, surrogacy implies a potential conflict between the surrogate mother's preferences, needs, and interests and those of the intended parents. To a lower or higher degree, contracts and laws allow prospective parents a say regarding their baby's gestational development (Joslin 2020). These circumstances concern decision-making at any point of the process, from surrogate mothers' lifestyle to perinatal care. Practitioners may be involved in a complex framework in which it could be difficult to determine who the legitimate decision-maker is, not only from a legal perspective, but also from an ethical point of view. At the same time, healthcare professionals must manage those potential conflicts of interest between surrogate woman and baby during the whole process.

Who Decides and How? Some Concerns about Surrogates' Autonomy and the Informed Consent Process

Regarding who makes the decisions during pregnancy and labor, ethical guidelines generally accept that the surrogate mother should be the one deciding when her health is affected (Bhatia et al. 2009, 51). Consequently, she should have the right to agree to or reject any clinical procedure during her pregnancy. When only the child's health is concerned, there is a common agreement according to which the prospective parents "should decide" (51). Under these guidelines, there is a strict division between mother

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and fetus/baby, whose development depends on the intended parents. In fact, specialists widely agree in seeing them as different patients (Brown et al. 2012). However, such a division is not that easy to establish from an ethical point of view, since woman and fetus are anatomically and physiologically connected. This is crucial where surrogacy may imply a restriction on women's reproductive autonomy, since those decisions considered as *exclusively* linked to the fetus do not fall on pregnant women, but on intended parents, dismissing the biological dimension of reproduction and the importance of the interaction between woman and fetus/newborn (Olza 2018).

To what extent can a woman be free to decide about any healthcare procedure before beginning a gestational process that may vary with the progression of pregnancy? At what point is it possible for her not to accomplish the wishes of the intended parents? She is willing to have a baby for them under contractual conditions that may imply the assumption of some measures she may agree to *a priori*, but that she has not established or experienced yet. It is also possible that even if the surrogate had agreed to some conditions, she could change her mind during the process, and this change could have consequences for her that she cannot predict. Therefore, it is unclear whether the surrogate's genuine autonomy is guaranteed.

The autonomy of women in general, and pregnant women in particular, continues to be a controversial issue (Kruske et al. 2013; Villarmea 2021). As Stella Villarmea has colorfully put it, "when a uterus enters the room, reason goes out the window" (Villarmea 2020, 63). Pregnancy, labor, and birth have frequently been considered nonrational processes. This common belief has contributed to—and still does contribute to—the lack of recognition of women as accountable agents in decision-making, due in part to the lack of recognition of their epistemic agency (Freeman 2015). Consequently, violations of fundamental rights to mental and physical integrity and informed consent have been committed and widely denounced (Pickles and Herring 2020).

In surrogate pregnancies, it seems clear that the greater the intended parents' margin of decision, the lower the surrogate's will be. If a conflict of interest were to arise between the pregnant woman and the fetus, it is unclear what decisions would be made to preserve the best interests of each of the parties implicated. Prospective parents would likely decide in favor of the best interests of their future child, not of the surrogate; but what about healthcare professionals? How will they manage the surrogate's and fetus's physical and mental health risks? In an under-contract pregnancy, performed in a clinical context frequently imbued by economic interests, it could be difficult to make decisions more advantageous for the surrogate mother than for the fetus/baby. When clients' satisfaction comes first, the surrogate's physical and mental integrity could be compromised.

To avoid undesirable situations, professional associations have established strategies to manage the physical and emotional risks of surrogate pregnancy. These strategies are related mostly to restrictions on lifestyle, activities, diet, emotions, contact between the surrogate mother and the newborn, including breastfeeding, handling, or even viewing the baby prior to separation (Bhatia et al. 2009; ASRM 2012). Implementing each one of these measures requires surrogate women to accept them, showing their agreement by signing an informed-consent document.

To accomplish surrogate pregnancy, healthcare professionals must inform their patients and discuss with them the potential side effects of the procedures they will undergo. Reaching informed consent among healthcare professionals and patients is still challenging on multiple levels (Grady 2015), especially if that patient is pregnant (Villarmea 2021), and even more so if she is a surrogate mother (Deonandan et al.

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2012; Laufer-Ukeles 2018). In liberal and developed countries, to become a surrogate mother may be considered a symbol of women's autonomy (Robertson 1983; Shalev 1989). However, the exercise of this autonomy is conditioned by restrictive measures regarding the imposition of specific lifestyles, the disclosure of information about the process, prenatal tests, or compulsory C-section. Even in cases where these agreements are accepted as a proof of autonomy, under the premise that an autonomous decision can also be potentially harmful (Cave 2017), we still have an ethical problem for practitioners, since they are involved in the accomplishment of damaging measures. Contractual clauses obliging pregnant women to undergo invasive procedures and control over their daily lives could imply medical treatment even before getting pregnant. In addition, they may include unwanted interventions even when the viability of the fetus is not at stake (Joslin 2020). I will develop this conflict below.

In underdeveloped countries (India, Nepal, Cambodia), unregulated destinations (Nigeria, Kenya), or states with more relaxed legal frameworks (Ukraine), where many surrogacy procedures happen, informed consent becomes more challenging to get in an ethical way. For uneducated surrogates from lower socioeconomic backgrounds, medical terms are especially complicated to understand. This limitation may be due not only to language barriers, but also to practitioners' shortcomings, such as paternalistic habits and lack of time and/or unwillingness to dedicate time to make the terminology understandable by the surrogate (Tanderup et al. 2015). Besides, in an authoritative, paternalistic, and patriarchal environment, getting informed consent from a surrogate woman may not be an important achievement as she is considered a "demure mother worker" (Fochsen, Deshpande, and Thorson 2006; Pande 2010; Tanderup et al. 2015).

Deciding on What? Some Concerns about Fertilization Procedures, Counseling and Maternal Detachment, Delivery and Perinatal Care

Sometimes, caregivers must deal with thorny ethical questions in a traditional pregnancy; for example, how should the needs of mother and fetus be weighed against each other? This kind of conflict becomes messier when the wishes and anxieties of another set of parents are at stake. As Tafari Mbadiwe has ironically noted, "Three's company, but 5 is definitely a crowd" (Mbadiwe 2018). After all, they have a vested interested in the baby's health and have paid a high price for the privilege. All the procedures, decisions, and care of surrogate and fetus aim to achieve a successful end, which may imply a risk for the pregnant woman's physical and psychological integrity.

Healthcare professionals are involved in problematic interventions. In the following paragraphs, I will expose some of the conflicts that could emerge.

Fertilization Procedures

Good practice recommends that practitioners reduce the risk of multiple pregnancies to protect the surrogate and babies born from surrogacy (FIGO 2008). However, the number of embryos to be transferred is greatly dependent on laws, guidelines, and ethics concerns regarding hazards and demands of success rates in infertility treatment. A high number of embryos transferred might enhance the success rate of pregnancy but might also raise the risks of multiple pregnancy and, therefore, the risk of prematurity (Tanderup et al. 2015). In these cases, it is necessary to face the ethical and medical balance between risks and benefits of fetal reduction, whose main goal is to sacrifice some fetuses to get better chances for the remaining ones (Tanderup et al. 2015).

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Usually, fertility doctors oversee making decisions about how many embryos to transfer and whether embryo-reduction surgery will be performed (Ryman and Fulfer 2018). Even if practitioners discuss such decisions with surrogates, they tend to rely on experts' opinions (Tanderup et al 2015; Ryman and Fulfer 2018).

Up until this point, the risks described are like those of an ordinary fertility treatment. The difference is that in surrogacy, medical decisions may be linked to contractual arrangements that do not grant the pregnant woman the choice of how many children to have, for example, but grant the choice to other individuals (the intended parents). Thereby, decisions are made to maximize the results for the intended parents—for instance, having twins and not just one child—something that may put the pregnant woman's well-being at risk.

Counseling and Maternal Detachment

Part of the counseling in surrogacy aims to construct a distance between the surrogate mother and the fetus, a goal essential for the success of the whole procedure (Agnafors 2014). Paradoxically, encouraging the creation of bonds between pregnant woman and baby is also the central goal for fertility professionals when they assist women who want to have a child and carry fetuses not genetically linked to them (Brandon et al. 2009; Olza 2018). They consider the attachment between physiological mother and child a factor in their mutual well-being and good upbringing later. However, the importance of the boundaries between mother and child has not always been so appreciated. Furthermore, empirical data shows that the detachment process that occurs in surrogacy does not imply a harm for children or surrogate (Golombok et al. 2006; Jadva et al. 2012; Agnafors 2014).

Despite the undeniable value of these studies, it is important to consider that most of them have serious methodological limitations (Söderström-Anttila et al. 2016; Patel, Kumar, and Sharma 2020) and therefore their conclusions should be interpreted with caution. It is important to note, for example, the lack of studies of children born after cross-border surrogacy or of children growing up with gay parents (Söderström-Anttila et al. 2016). Among other pioneering works, the one conducted by Nishta Lamba and colleagues on the psychological well-being and prenatal bonding of gestational surrogates in India is particularly worth mentioning for its detection of higher levels of depression among Indian surrogates during pregnancy and post-birth than in the comparison group of mothers (Lamba et al. 2018).

At the same time, a shared opinion attributes a greater value to the genetic link than to the physiological and epigenetic one. However, genes do not procure the only stable connection between woman and baby. A gestational surrogate is not just an oven for the infant. She will develop a bond with the fetus, and vice versa, which will be beneficial for both, and destroying it constitutes a potential harm (Brandon et al. 2009; Agnafors 2014; Olza 2018).

It could be thought that avoiding the link and reinforcing the distancing process is adequate to reduce or eliminate psychological repercussions on the surrogate woman who must deliver the baby. Indeed, strategies related to keeping the surrogate's nonownership over the child in focus, preparing her for a smooth process when relinquishing the baby to the intended parents, are widely accepted as nonproblematic and beneficial for all parties involved (Agnafors 2014).

Even if this kind of practice minimizes the harm to surrogate and child, a healthcare professional who endorses the promotion of an intentional detachment between women

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and fetuses or babies comes into an ethical conflict that still needs to be addressed. As has been established earlier, in regular pregnancies, promoting the construction of boundaries between pregnant woman and child has proved highly beneficial. These improve the well-being of and avoid potential harm to both pregnant woman and child. Conversely, in a surrogacy process, it has been argued that if a caregiver allows or encourages the construction of attachment, she is potentially subjecting both the surrogate and the intended parents to great distress when the time comes to deliver the baby (Berk 2015).

Therefore, if a caregiver avoids through her interventions the construction of boundaries, is she prioritizing the surrogate's and child's immediate well-being, as she usually would do in a regular pregnancy, or is she prioritizing the success of the surrogacy process? Is she avoiding the attachment benefits, or creating the conditions for potential harm for the gestational mother and child, *just* to ease the transaction for intended parents?

Ethical conflicts affect the caregivers involved in the process to varying degrees. Specifically, psychologists, therapists, and psychiatrists address part of their work to producing an emotional detachment aimed toward a successful transaction, conditioned by the greatest absence of sadness, anguish, remorse, and guilt they can provide to women who have just given birth. Counselors are encouraged to minimize negative feelings that present risk and to normalize detachment, creating new emotion cultures, ironically constructing displays of bonding between the surrogate mother and child as "emotionally deviant" (Berk 2015, 151). As Hillary Berk has established: "Detachment is a central rule of the game in surrogacy, violation of which may lead to disputes, breach, and significant risk, especially where law is unsettled" (152).

There is evidence that surrogates do not seek an attachment with the child to the same extent as pregnant women who want to keep their babies (Tieu 2009; Berk 2015; Schurr and Militz 2018). This lack of connection could be caused by the inner motivation of surrogate women or to external pressure and encouragement not to bond with the fetus (Agnafors 2014; Berk 2015). On the one hand, knowing that the child is not intended to be raised by them, surrogate mothers view their pregnancy differently and are not willing to form the same bond to the infant. On the other hand, counseling before conception is aimed at reducing the psychological risk that may arise if a surrogate woman encourages her attachment with the baby (Bhatia et al. 2009; Berk 2015).

Beyond these ethical questions, linked to the use of their knowledge and experience in deconstructing boundaries, professionals must face an additional issue. Some of them may feel a conflict of conscience or moral distress due to the disconnection between one's own feelings and what they consider intimately correct, and their outward performance. If a) they know that constructing attachment between women and their fetuses is beneficial to both; and b) it is what they normally promote in other situations (regular or IVF pregnancies), they may fall into a contradiction when they discourage that attachment in the case of surrogate pregnancies, which may lead them to a morally distressing situation.

Despite this, the only reports of conflicts of conscience regarding surrogacy are not related to specific conflicts of professional practice. There is a case mentioning some healthcare professionals' claim for a clause of conscience to not support surrogacy itself (Armuand et al. 2018). In other work, conscientious objection is addressed in the framework of potential restrictions on single persons or same-sex couples by healthcare professionals, a possibility that the authors consider an act of "discrimination and prejudice" (Igreja and Ricou 2019, 69).

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Type of Delivery

Decisions about delivery in surrogacy also pose some ethical conflicts to caregivers. They have to advise the surrogate mother about the best way to give birth, but at the same time, they must preserve the fetus's well-being. In surrogacy, delivery by C-section is most common (Ryman and Fulfer 2018). It is considered a good option to guarantee that the baby will not be born in poor condition, as well as to establish a date for intended parents to be present at that moment.

Some surrogates can negotiate for vaginal deliveries, but they are an exception (Pande 2010). In the case that the surrogate strongly wishes to avoid the additional risks associated with a C-section or further complications when labor is prolonged at her request, practitioners are involved in the balance between the surrogate's consent and the potential harm to the baby if she decides against the professional's advice (Bhatia et al. 2009). Moreover, caregivers may be under pressure by the intended parents if their choice is a C-section.

In many cases, surrogates accept caesareans as necessary because caregivers present them as such (Pande 2014, 114–20). This kind of situation can also arise in a typical pregnancy. However, in the case of surrogacy the interest in preserving the baby's well-being may be wider than usual, since the intended parents are expecting a healthy baby. In research driven by Amrita Pande, Dr. Desai describes surrogates' consent to medical procedures in this way: "There is a higher chance of caesarean since it's a precious baby. . . . So once a surrogate does reach her last trimester successfully, we don't take any chances at the delivery stage and at the first warning signal we go for a caesarean. The surrogates don't mind, they are willing to do this for the sake of the baby" (Pande 2014, 117).

Medical interventions related to giving birth are not limited to caesarean sections. They can include "labor induction, membrane stripping or breaking, vacuum-assisted or forceps-assisted delivery, or manual removal of the placenta" (Kukura 2018, 734). Sometimes, pregnant women are obliged by healthcare professionals to undergo this kind of procedure against their will (Kukura 2018), a practice that could be considered obstetric violence (Kukura 2018, 725; Joslin 2020). As in some regular pregnancies, obstetric violence has a negative impact on women's physical and mental health (Kukura 2018, 265), even if there is still an extended denial of this form of violation of body integrity and autonomy (Bahren et al. 2019).

Perinatal Care

The postpartum period is a time of great emotional changes in a surrogacy arrangement. Decisions on which the parents would normally be consulted may need to be taken immediately after delivery in certain cases, such as premature birth or the unexpected birth of a baby in poor condition (Bhatia et al. 2009). This kind of situation can be especially difficult to manage for clinicians, since intended parents and surrogate mother may disagree on which procedure should be applied, and it could be difficult to determine who can make a definitive decision. This is especially important when intended parents can reject the baby if she is not healthy enough, as a case reported in the media has shown (Allan 2014).

Apart from dramatic situations, it is common that surrogacy contracts contain rules against surrogates breastfeeding, since this unique form of intimate contact can intensify an emotional bonding between the surrogate and the newborn and construct a "mother–child relationship" (Berk 2015, 165). These contractual clauses from different

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states of the US that are considered legally safe places for surrogacy explicitly show prospective parents' and surrogacy agents' fears:

> Carrier acknowledges the importance of immediate bonding between the Child (ren) and the Commissioning Couple and agrees to assist in every way possible to strengthen that bonding including but not limited to Carrier agreeing not to breast feed the Child. (Contract FL)
>
> The Traditional Surrogate further agrees that because she is entering into this Agreement with the intention of providing a service to the Genetic Father and Intended Father, it is in the best interests of the Child . . . [t]he Traditional Surrogate will not nurse the Child. (Contract NJ)
>
> Carrier represents that she will not form nor attempt to form a parent–child relationship with any Child she bears pursuant to the provisions of this Agreement. All parties understand that under no circumstances may Carrier ever breast feed Child. (Contract MA). (162)

When the benefits of maternal milk are recognized, the clauses address the possibility of pumping it from the surrogate to be provided by the intended parents, establishing the price and method of payment for the service, shipping expenses, and potential burden:

> The parties recognize the benefits to the Child associated with the availability of breast milk. Carrier will use her best efforts to express breast milk after the Child is born and to provide such breast milk to Parents. Carrier, alone, will determine what is a reasonable amount of breast milk and a reasonable time frame for providing it. (Contract WI).
>
> For a reasonable time after delivery, to pump and deliver breast milk to Genetic Parents, with Genetic Parents' concurrence, at Gestational Carrier's sole discretion and Genetic Parents' sole expense, for the purpose of feeding the newborn Child. (Contract MN). (162)

Another intimacy restriction to manage attachment is preventing the surrogate from holding or even viewing the newborn following delivery, which extends into future contact with the family. The same trend that applies to breastfeeding —rules to minimize legal risk by inhibiting emotional bonding—applies here (167). Feeding rules related to degrees of contact may be implemented by healthcare professionals to establish intended parents' parentage and break the surrogate mother's, both crucial processes for a successful surrogacy. Another contractual piece exemplifies the terms of the relationship:

> Upon delivery of the Child, the Child shall be placed with the Intended Parents so that they can hold and care for the Child. Intended Parents shall be exclusively entitled to feed, change and take care of the Child. Gestational Carrier will be permitted to contact and view the Child as solely determined by Intended Parents. (Contract CO). (168–69)

Contact rules and intimacy restrictions with the newborn are intended to prevent surrogates' feelings emerging after the delivery. Caregivers try to minimize the risk by managing opportunities for attachment, especially after the surrogate's body has completed its task by giving birth.

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Despite these measures, there are still cases in which the detachment intervention, the "emotional work" (Hochschild 1983), has been unsuccessful. A surrogate from India relates her experience, which is similar to others'[4]:

> I want to know about the baby. I want to know where he or she is and what it is studying. For three months after giving birth, I spent sleepless nights, I would get headaches thinking about the baby and I had to take medicines to calm down. Every year, on 4 November, the day the baby was born, our family celebrates its birthday. I do all the rituals that I do for my other children. . . . I've always wondered if the baby is like any of my other children. I really do miss the baby and would give anything to see it once. I know it's not my baby after all, but I know that if I'd seen the baby, I wouldn't have given it away. I hope the baby is happy and fine wherever it is. (Pandey 2016)

This kind of experience shows the moral risk healthcare professionals assume when intervening in a surrogacy process. Feelings of abandonment, loss, anger, and alienation are consequences of the delivery that surrogate women go through (Berk 2015, 170). To avoid that, intended parents are sometimes encouraged to allow the carrier to see the baby afterwards, send her pictures and emails, at least during the postpartum period, where there is a higher risk of depression (170).

Ethical Challenges for Caregivers

As we have seen in this article, one of the substantive questions in surrogacy is the conflict of interests between implicated parties. The greater the surrogate's protection, the lower the guarantee of intended parents', clinics' and agencies' interests, and vice versa. Women are left vulnerable (in part) because their well-being may not be prioritized within the industry by fertility clinicians, counselors, and prospective parents (Ber 2000; Bailey 2011).

Therefore, it is possible that healthcare professionals become involved in morally problematic situations. For this reason, professional associations and boards have tried to establish ethical guidelines to help practitioners make decisions. However, is it possible to establish ethical guidelines for *a practice that cannot itself be ethical* in a number of cases? Is it possible for caregivers to respect the ethical principles of nonmaleficence, beneficence, justice, and genuine autonomy in gestational surrogacy? Conflicts between ethical principles are common in many healthcare interactions. Healthcare professionals frequently struggle to balance protection of the patient's autonomy and doing what one believes (knows) is medically best for the patient, or between doing what is medically best for the patient (*beneficence*) versus what is best for the patient's family or society at large (*justice*) (Ber 2000). In surrogate pregnancy, more than the usual conflicts arise because of the larger number of persons involved. Additionally, the status quo tends to privilege the convenience of prospective parents and the health interests of the fetus. Thus, the status quo entails that surrogates' autonomy is not prioritized (Ryman and Fulfer 2018).

Since professionals cannot exclude the possibility of harm to surrogates or children, they should avoid the risk of applying the precautionary principle to restrict their participation in surrogacy. Bodily risks that surrogates take reveal the degree to which their health interests are subject to caregivers' use, or abuse, of discretionary power. Although pregnancy is not an illness, surrogates are in a position of structural vulnerability

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relative to the caregivers overseeing their pregnancies (Ryman and Fulfer 2018). This structural vulnerability is underscored by the health-related vulnerabilities surrogates face in relation to broader social and economic inequalities (Tanderup et al. 2015; Ryman and Fulfer 2018).

Thereby, following Paul B. Miller and Charles Weijer, practitioners have a "duty of active care" based on their fiduciary obligation toward their patients (Miller and Weijer 2006). Patients are exposed to the risk that their caregivers will fail to make the judgments they have been trusted to make, or that they will exercise their discretionary powers without due diligence (Ryman and Fulfer 2018). Fiduciary duties are aimed at addressing this vulnerability. Thanks to them, practitioners' authority cannot overrule patients' health interests (Bailey 2011; Ryman and Fulfer 2018). As a consequence, healthcare professionals should not be exempted under contractual clauses from all responsibility for the medical risks a surrogate takes (Ryman and Fulfer 2018). However, the contractual agreement may establish that the surrogate must assume all the risks (medical, psychological, economical). Thus, intended parents, physicians, attorneys, and any other agents of the surrogacy arrangement are discharged from any legal accountability (Ryman and Fulfer 2018).

Advocates of surrogacy may say that all the procedures are part of a reconceptualization of motherhood, which implies putting the emphasis on child-raising (Tieu 2009). However, this commitment to a motherhood radically constructed and mediated by a contract denies obvious biological, physiological, psychological, and social events that cannot be dismissed, especially by those professionals who have a mandatory commitment to the physical, mental, and social well-being of those who are in their care.

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Notes

1 Adaptive preferences refer to those desires and decisions based on people's options or, more precisely, their beliefs about their options, which are shaped by unjust living conditions (Khader 2011). According to this notion, the adaptive preferences of surrogate women are incompatible with the flourishing of their lives. Pregnant women exercise their autonomy within very narrow limits, hence there is a legitimate duty on the part of the public powers to intervene politically and legally (prohibiting paid surrogacy, for example). In this way, these women, who are generally in a situation of greater vulnerability, could opt for a more rewarding life trajectory.

2 For example, Elly Teman refers to some biblical episodes from Genesis (Teman 2010, 273, note 2). At 16:1–2 Sarai says to Abram, "Look, the Lord has kept me from bearing. Consort with my maid; perhaps I shall have a son through her." At 30:3 Rachel says to Jacob, "Here is my maid Bilhah. Consort with her, that she will bear a child on my knees and through her I too may have children." Finally, at 30:9: "When Leah saw that she had stopped bearing, she took her maid Zilpah and gave her to Jacob as concubine."

3 During the publication process of this article, the war between Russia and Ukraine broke out. This conflict has implied serious problems for surrogate women who were pregnant and their newborns, who cannot be picked up by their intended parents. About this situation, see, for instance, König 2023.

4 Other narratives, from different contexts, can be found in Anonymous 2013; Lahl and Epinette 2014; Berk 2015.

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