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December 19, 2017

Dear Task Force Members:

Atypical circumstances prompt me to write this letter concerning the Task Force on Life and the Law's surrogacy report.

I recognize that, as members of the Task Force, you have spent considerable time reviewing the ethical and legal issues surrounding the availability of traditional and gestational surrogacy. As a result of your deliberations, you have reached unanimous consent in recommending that the existing State policy of declaring traditional surrogacy contracts void and unenforceable continue. A majority of you also agree, however, that gestational surrogacy contracts should be legally permitted.

I am not concerned about the discord among members pertaining to gestational surrogacy contracts. This is a difficult issue. Everyone on the Task Force is entitled and encouraged to express their point of view; freedom of expression sits as one of the most important foundations of our democratic principles. As recognized by Governor Mario Cuomo when he established the Task Force in 1984, members of the Task Force were likely to face issues that might elude simple answers and on which agreement could not be reached.

Yet, I am concerned that the minority position infuses into the surrogacy report divisive rhetoric regarding non-traditional families, the LGBT community and women's reproductive rights by presenting beliefs or opinions as facts. Whether intentional or not, the presentation of the ideas and principles articulated in the minority position lead to biased statements that are inconsistent with the Governor's message of tolerance and unity. As the Commissioner of Health, as the Chairperson of the Task Force, and as an individual, I cannot condone or accept the minority's use of such inflammatory and discriminatory statements.

The Task Force has been an invaluable resource over the years, and I remain committed to continuing to work with all of you to give this and other important issues deliberate and thoughtful consideration.

Very truly yours,

Howard A. Zucker, MD, JD

Howard A. Zucker, M.D., J.D.
Commissioner

**Revisiting Surrogate Parenting:
Analysis and Recommendations for Public Policy
on Gestational Surrogacy**

December 19, 2017

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Task Force reports should not be regarded as reflecting the views of the organizations with which
Task Force members are associated.

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Introduction

In 1987, at the request of Governor Mario Cuomo, the Task Force on Life and the Law (Task Force) examined the issues surrounding surrogacy and proposed recommendations for state action. One year later, the Task Force released *Surrogate Parenting: Analysis and Recommendations for Public Policy*, which urged the legislature to declare surrogacy agreements void as against public policy.¹ The report also advised legislation that would prohibit commercial compensation to surrogates and ban surrogacy brokers from operating in the state.² In 1992, the New York State Legislature enacted legislation based on the Task Force's recommendations.³

There have been significant changes in the practice of surrogacy since the Task Force's last report. Most significant has been the shift away from traditional surrogacy and the growing practice of gestational surrogacy. In the past, a surrogate became pregnant via artificial insemination using her own oocyte, and she was therefore genetically related to the resulting child. Today, artificial insemination is rarely used. With gestational surrogacy, a pregnancy results from the transfer of an embryo created by *in vitro* fertilization (IVF) in a manner in which the surrogate and child are not genetically related.

The United States Supreme Court (Supreme Court) has not addressed the question of whether surrogacy is a constitutionally protected practice. Therefore, states can decide whether and how to regulate this practice in the best interest of its people. Accordingly, the goal of the Task Force has been to reexamine the issues in the current context and determine, after careful analysis, what the appropriate policy is for New York today.

Since the Task Force issued the 1988 surrogacy report, medical, scientific, cultural, and social changes, as well as a growing body of research on surrogacy, have encouraged the Task Force to revisit ethical and legal issues regarding surrogacy. The Task Force has undertaken this task with the understanding that all families, however constituted, should have the opportunity to welcome children into their lives, regardless of their biological ability to procreate in the conventional manner. The desire for children remains strong among New Yorkers. This desire is evident in the robust interest in adoption, in the broader societal acceptance and prevalence of assisted reproductive technologies (ART), and in the willingness of New Yorkers to travel outside the state to enter surrogacy agreements.

The terms "gestational surrogacy" and "surrogacy" as used in this report refer to surrogacy arrangements in which the surrogates and resulting children have no genetic relationship. Under the current New York law, surrogacy agreements are unenforceable. Therefore, a child of such an agreement may be left without parental certainty as a surrogate, with no genetic relationship with the child, may change her mind and keep the intended parent(s) child or the intended parent(s) may decide to reject the child leaving the surrogate with a child she never intended to raise.

The passage of the 2011 Marriage Equality Act in New York State and the decision of the Supreme Court in *Obergefell v. Hodges* in 2015 requires the reexamination of the state's policies regarding surrogacy. Equity must be a driving principle if all families are to enjoy the opportunity to welcome children into their family. Gestational surrogacy affords lesbian, gay,

bisexual, and transgender (LGBT) families an important opportunity to have children. LGBT families should have options similar to those of other families facing infertility, and equal access to adoption and ART.

Surrogacy remains a controversial topic. The Task Force itself is sharply divided and therefore did not reach a unanimous decision; yet a majority of the members support changing New York law so as to permit and regulate *gestational* surrogacy. Specifically, the Task Force recommends that: (1) compensated gestational surrogacy, subject to specific regulations should be permitted in New York; (2) protections be implemented to safeguard the well-being of all parties; and (3) surrogacy agreements not in compliance with the recommended protections should remain unenforceable. The Task Force concludes that this course of action will best protect surrogates, intended parents, and children born through surrogacy, and is in the best interest of New Yorkers.

PART I

The Medical, Legal, Social, and Religious Context

I. Overview

The New York State Task Force on Life and the Law (Task Force),⁴ has spent several years examining the ethical, legal, and scientific dimensions of gestational surrogacy. The Task Force reviewed medical and policy literature detailing the risks and effects of surrogacy on surrogates, intended parents, and children born through surrogacy, of the surrogacy process, and of surrogacy agreements. The Task Force conducted extensive legal research on state and international laws on surrogacy, reviewed model laws and guidelines from professional organizations, and reviewed case studies pertaining to surrogacy conflicts. Many experts were consulted, including psychologists and physicians who have counseled, screened or treated individuals involved in gestational surrogacy, surrogacy agents who match intended parents with surrogates, attorneys who draft surrogacy agreements and who have had experience with surrogacy disputes, religious leaders of various faiths, and both advocates and opponents of legal surrogacy. The Task Force heard from women who had been surrogates, and parents of children born through surrogacy. Most importantly, the Task Force engaged in extensive deliberations about the practice of surrogacy, its moral and ethical dimensions, and the implications of regulating the practice.

Most Task Force members conclude that with appropriate regulations to protect the parties involved in place, gestational surrogacy can be an acceptable and safe means for intended parents to have children in New York State. Most members of the Task Force conclude that New York would be best served by a comprehensive law that provides clear guidelines to safeguard the parties involved in surrogacy agreements. While there remain concerns about the well-being of children born through surrogacy, the surrogate and her family, and intended parents and their family, most Task Force members conclude that, based on the transition from traditional to gestational surrogacy, the growing body of research on surrogacy, and the more inclusive legal definition of family, overrides historic concerns which informed the Task Force's 1988 surrogacy report. Furthermore, the Task Force recommends that all surrogacy agreements not in compliance with the recommended protections should remain unenforceable.

While most members conclude that permitting and regulating gestational surrogacy is the best option for the state, several members do not agree. These members are not persuaded and expressed concerns about the potential risks and negative effects of surrogacy on both individuals and society. These Task Force members conclude that the most serious risks of surrogacy cannot be eliminated with regulation and that no form of surrogacy can be acceptable (see attached minority report). Despite the disagreement, discussions among Task Force










“Gestational surrogate” or **“surrogate”** is the woman who gives birth to the child born through surrogacy but does not have a genetic connection to the child. The term **“traditional surrogacy”** is used if the surrogate is genetically related to the child. **“Intended parents”** is used to represent either a single individual or two individuals, regardless of marital status or sexual orientation, who commission the use of a surrogate and will raise the child. One or both intended parents may be genetically related to the child. A **“surrogacy agreement”** (also known as a surrogacy contract) is a document that details the parameters and responsibilities of the surrogate and the intended parents and if properly executed is enforceable. A **“surrogacy arrangement”** describes the entire gestational surrogacy process and includes the surrogacy agreement.

members were robust and collegial, and all members appreciated and respected the meaningful dialogue and agreed that both the majority and minority perspectives should be presented.

The Task Force intends for this report to inform the public dialogue on surrogacy. The 1988 surrogacy report stated, "... surrogate parenting would be addressed within the context of the medical technologies that are an integral part of the practice. At the least, society must remain sensitive to the broader scope of the issues as it grapples with surrogate parenting and settles on a path for government action."⁵ As such, this report examines several aspects of surrogacy. It first provides a legal history of family law and surrogacy in New York State. The report then examines constitutional claims to an individual right to engage in surrogacy agreements. It next reviews the various medical advances, as well as social and cultural changes, that persuaded the Task Force to examine gestational surrogacy. It then provides an overview of professional, medical, and legal guidance on gestational surrogacy. A discussion of the risks and benefits to surrogates, intended parents, and the children born through surrogacy, with particular emphasis on formal longitudinal research studies on these stakeholders, is provided. The report then examines the ethical issues surrounding surrogacy and its impact on women, children, and society. The report concludes with a review of the Task Force's deliberations and presents policy recommendations.

II. A Changing Landscape

In 2014, the Task Force decided to reexamine surrogacy for several reasons. First, significant advances in ART and IVF make it possible for a surrogate to be genetically unrelated to the fetus. In the past, a surrogate would become pregnant via artificial insemination, using the intended father's sperm and her own oocyte. Because the surrogate's oocyte was utilized, and conception occurred within the surrogate's uterus, the surrogate was genetically related to any resulting child. This form of surrogacy is known as "traditional surrogacy." Significant improvements in ART and IVF have eliminated the need for a surrogate to use her own oocyte. With most surrogacy arrangements today, an embryo is created in a laboratory, many using gametes from one or both the intended parents,⁶ and resulting embryo(s) is/are transferred to a surrogate's uterus. Because this form of surrogacy does not use the surrogate's oocyte, thereby eliminating the genetic connection between the surrogate and the child born through surrogacy, it is known as "gestational surrogacy." See illustration below.

Types of Surrogacy				
Traditional Surrogacy				
Intended Father's Sperm 	+	Surrogate's Egg 	Artificial Insemination	Fetus Carried by Surrogate 
-Or-				
Donor Sperm 				
Gestational Surrogacy				
Intended Father's Sperm 	+	Intended Mother's Egg 	In Vitro Fertilization	Fetus Carried by Surrogate 
-Or-		-Or-		No Genetic Connection to Child
Donor Sperm 		Donor Egg 		
There can be anywhere between three and five potential parties to a surrogacy arrangement. These include the surrogate, the intended parent one, the intended parent two, the sperm donor, and oocyte donor. ⁷ In addition, there may be other individuals not a party to the surrogacy agreement, such as the surrogate's spouse and other children, who may also be affected by the arrangement.				

In addition to medical advances, several social and cultural changes further indicated a need for a reexamination by the Task Force of its earlier report. Over the past decade, numerous states have enacted laws regulating the practice of gestational surrogacy.⁸ While commercial

surrogacy is not permitted in New York, easy and widespread access to the internet has eased the process by which intended parents connect with surrogates, allowing surrogacy agreements to exist between parties living in different states. In addition, over the past several years, legislation has been introduced in the New York State Legislature that would, if enacted, permit commercial (compensated) gestational surrogacy. Furthermore, changing social and cultural perceptions on parenthood and family have led to increased desires to have children and families that do not conform to the rigid different-sex (heterosexual) nuclear family model. Media coverage of births via surrogacy is more positive than ever before;⁹ this changing perspective on gestational surrogacy births follows the swiftly changing social and cultural perceptions on parenthood and family that have allowed many non-traditional models to be more socially acceptable. Finally, a revolution in marriage equality has enabled LGBT couples (and individuals) to consider having a child through surrogacy.

III. Legal History of Family Law and Surrogacy in New York State

The first surrogacy agreement in the United States was executed in Michigan in 1976.¹⁰ Over the following ten years, surrogacy agreements became more widespread and controversial.¹¹ The country's most infamous surrogacy arrangement, *In. Re Baby M*,¹² made public many of the complex ethical questions posed by surrogacy agreements. *Baby M* was a 1988 New Jersey case concerning a custody dispute arising out of a traditional surrogacy agreement between the surrogate mother, Mrs. Mary Beth Whitehead, and the intended parents, Mr. William and Mrs. Elizabeth Stern. Under the terms of the agreement, Mrs. Whitehead agreed to first be artificially inseminated with Mr. William Stern's sperm, and after becoming pregnant and giving birth to the resulting child, Mrs. Whitehead, who would also be the child's genetic mother, agreed that she would relinquish her parental rights to Mr. Stern. The intended mother, Mrs. Stern, would then adopt the child. Under the agreement, Mrs. Whitehead would receive financial compensation for her services as a gamete donor and gestational surrogate.

Upon the birth of the child, however, Mrs. Whitehead refused to relinquish custody of the child to the Sterns.¹³ The trial court used the "best interests of the child" analysis, and applied contract law, not family law principles.¹⁴ The trial court found that it was in the best interest of the child to be raised by Mr. Stern and his wife and upheld the surrogacy agreement.¹⁵ Mrs. Whitehead's parental rights were terminated and custody was awarded to the Sterns.¹⁶ The Supreme Court of New Jersey reversed the order of the trial court, holding that the surrogacy agreement conflicted with the law and the public policy of the state.¹⁷ The court found the use of money for the purpose of adoption "illegal and perhaps criminal" and found the genetic mother's pre-birth and pre-conception contractual commitments to surrender the baby coercive.¹⁸ The court declared the surrogacy agreement invalid as a matter of public policy of allowing "children to remain with and be brought up by both of their natural parents" but affirmed the lower court's decision that custody of Baby M should remain with the Sterns.¹⁹ The case was sent back to the trial court on the issue of visitation and Mrs. Whitehead was awarded visitation rights by the lower court.²⁰

The *Baby M* case quickly caught the public's attention. The public's concern with surrogacy was raised through dramatic media coverage of the story, which included images of the moment Baby M was forcibly removed from Mrs. Whitehead's arms. *Baby M* significantly

shaped early discussions and analyses of surrogacy arrangements, as both proponents and opponents of surrogacy recognized that the events precipitating *Baby M* and the following custody dispute were disruptive for both of the families involved and, most importantly, for Baby M.

A. Family Law

Under common law, a woman who gives birth to a child is recognized as the child's natural and legal mother. New York Public Health Law §4130, last amended in 1972, defines "birth" for the purpose of creating a birth certificate, as "as the complete expulsion or extraction from its mother of a product of conception."²¹ It therefore follows that a child's "mother" is the woman who gives birth to that child. Parental status may only change if the mother consents to the child's adoption or her parental rights are terminated based on a determination by a court that the mother was an unfit parent.

Family Law in New York regarding parentage has not changed significantly since the Task Force first examined surrogacy. The law still presumes that the birth mother of the child is the child's legal mother, and if the mother is married, the man to whom she is married is presumptively recognized as the father of the child,²² with equal powers, rights and duties. Since 1988, the Supreme Court has confirmed this strong paternal presumption, even in cases where a dispute exists over paternity.²³

Determinations of parentage, however, are not always the same as determinations of custody. When a dispute exists over custody, the court relies on the "best interest of the child" standard to determine the child's guardian. Domestic Relations Law (DRL) §70 notes that "In all cases there shall be no prima facie right to the custody of the child in either parent, but the court shall determine solely what is for the best interest of the child, and what will best promote its welfare and happiness, and make award accordingly."²⁴ In custody disagreements, legal parentage is a matter not of constitutional rights, but rather, of "pure public policy."²⁵ Legal scholars have noted that "parentage, then, as opposed to procreative or parental autonomy, is not some type of fundamental right that flows automatically from biological connections but is a policy decision based on a desire to privatize support for society's most vulnerable citizens, to designate the responsibility early, and to keep it in place."²⁶

In situations where a parent remarries, a new spouse has an opportunity to gain recognition as the child's legal parent through step-parent adoption. DRL §115-d waives many of the adoption requirements for adopting by a step-parent. Such a process has been used by couples in situations where one spouse is not automatically recognized as the legal parent under the existing law. This legal mechanism is especially useful when one of member of the couple has no genetic link to the child, such as certain surrogacy arrangements. In these cases, the non-genetic parent can seek parental recognition through step-parent adoption, which is streamlined and faster than traditional adoption.

One major shift in family law in New York over the past twenty years is the recognition of same-sex marriage. On June 24, 2011, the New York State Legislature approved the Marriage Equality Act, which was subsequently signed into law by Governor Cuomo. This Act legalized

same-sex marriage in New York State, and both parents of a child born to a same-sex married couple could be named on the child's birth certificate under the marital presumption, regardless of whether parental status was confirmed through an adoption proceeding. Names on a birth certificate, however, provide presumptive evidence of parentage, and do not alone confer parental rights. Even if a child's parents are married, a non-genetic parent may not be able to rely on the presumption to guarantee parental rights outside of New York.²⁷ Should this family leave New York and travel to, move to, or divorce in a state which does not recognize their parental rights by virtue of their marriage (i.e., marital presumption), the non-genetic parent's parental relationship with the child would be vulnerable to legal challenge.

Furthermore, in certain circumstances in New York, should a LGBT couple divorce or the genetic parent die, the "presumption" may be challenged. Until recently, in determining parentage New York courts only recognized individuals as parents if they were the genetic parents or the adoptive parent of the child.²⁸ While DRL §70 does not define "parent" the courts have begun to recognize individuals who are not genetically related to the child, not married to the genetic parent of the child, or not the adoptive parent of the child. In the *Matter of Brooke S.B. v Elizabeth A. C.C.*, the Court of Appeals may have created a precedent for family courts to recognize non-biological/non-adoptive individuals as parents if they can provide clear and convincing evidence that both parties entered into a pre-conception agreement and agreed to raise the child together. However, the determination of whether parental rights are granted is still determined by courts through the best interests of the child standard.²⁹

While the courts' view of who has standing to seek parental rights has expanded, parents who are not genetically related to the child, have not legally adopted the child, or are not married to the genetic parent are better positioned if they obtain an Order of Adoption or Order of Parentage. In cases where parents receive an order of adoption or order of parentage, they fall under well-established definitions of parentage and would not need to rely on parental presumption flowing from marriage or on courts to determine whether these individuals have standing to seek parental rights in order to address various gaps in the law and case law.³⁰

These recent changes in family law regarding the recognition of same-sex marriage have not affected the permissibility of surrogacy in New York, but they have created a new group of individuals seeking legal recognition of their parentage to a child from the State with little clear legislative or judicial guidance.

B. Surrogacy Before the Prohibition of Compensated Surrogacy Agreements

Surrogacy arrangements further present a challenge to the common law definition of "mother" because such agreements separate the act of birth from the act of motherhood, i.e., being a mother to a child. As a result of this division, surrogacy arrangements made their way to the New York courts on several occasions before the legislature passed the 1992 laws to regulate them.

In 1986, a court in Nassau County heard *Matter of Adoption of Baby Girl L.J.*, in which a surrogate was inseminated by the genetic father's sperm and relinquished all parental rights to the genetic father and his wife upon the child's birth in exchange for \$10,000.³¹ The court

permitted the enforcement of the surrogacy agreement because it was in the best interests of the child and current legislation did not forbid such enforcement, but expressed great reservation about surrogacy agreements in general.³² The court in its decision also requested that the legislature review the issue and determine whether statutory provisions should be put in place to address it.³³ The judge emphasized that the court's decision was rooted in his opinion that the child "needs a home."³⁴

In 1987, the Task Force first examined whether both traditional and gestational surrogacy should be permissible in New York. The report, *Surrogate Parenting: Analysis and Recommendations for Public Policy*, was published in May of 1988, three months after the ruling in *Baby M*. At the time of the report's publication, the legal status of surrogacy agreements in New York was uncertain. Determinations of parentage had until then been governed by family law principles and doctrines. Under those principles, the woman who gave birth to a child was recognized as its legal mother. The influence of the *Baby M* case was pivotal in the Task Force's 1988 analysis, and in the introduction of the Task Force's report, the decision by the New Jersey Supreme Court was cited as providing important constitutional guidance.

In the report, the Task Force examined the constitutionality of surrogacy to determine whether it was a protected liberty under the 14th Amendment Due Process clause, thus requiring a compelling state interest for the state to regulate or prohibit it. The Task Force concluded that:

"...the right to enter into and enforce surrogate parenting arrangements is not constitutionally protected. Surrogate parenting involves commercial and contractual—rather than individual—decisions and arrangements that place the rights and interests of several individuals in direct conflict."³⁵

In the 1988 report, the Task Force found that the fundamental right to privacy includes certain reproductive freedoms, and those freedoms vest with the person having a child. Surrogacy agreements, which are contracts to utilize another person's body, do not extend procreative liberty to intended parents. The prior cases the Task Force examined that established reproductive freedom involved the rights of plaintiffs to control their own bodies, not the right of a person to contract for or control the bodily integrity of another. Furthermore, the Task Force found that the right to raise one's own child is likely a right that may not be irrevocably waived.

The 1988 report identified five central themes of issues posed by surrogacy:³⁶

- (i) Individual access and societal responsibility in the face of new technological possibilities;
- (ii) The interests of children;
- (iii) Surrogacy's impact on family life and relationships;
- (iv) Individual liberty in human reproduction and attitudes about reproduction and women; and the
- (v) Application of the informed consent doctrine.

The Task Force addressed the harms and benefits to individuals affected by the practice as well as the impact of the practice on societal norms, and examined these five issues from the both “proponent of” and “opponent to” surrogacy perspectives.

At the time of the Task Force’s 1988 report, proponents viewed surrogacy as a reproductive technology people had a right to access.³⁷ Proponents argued there was no evidence indicating surrogacy harmed children.³⁸ Proponents believed regulated surrogacy could ensure a protected environment for all involved parties, including children, and that restricting or banning surrogacy would drive it underground.³⁹ Proponents believed that surrogacy would promote families, and provide many people with an option to have genetically related children.⁴⁰ Surrogacy was not viewed as exploitative, but rather as a process that women could freely enter into.⁴¹ It was argued that surrogacy provided financial and emotional benefits to a surrogate.⁴² Proponents saw a system that did not permit women to enter into surrogacy agreements as paternalistic and generally believed that women, as competent adults, could make informed decisions to enter into such agreements.⁴³

Opponents to surrogacy had a variety of concerns about the practice. Some did not believe a new technology created a right to access that technology. Others felt that any right to surrogacy that did exist needed to be balanced with the “interest of the child, the integrity of the family, and the dignity of women and human reproduction.”⁴⁴ Opponents characterized surrogacy as “baby selling,” noting that a surrogate’s contractual obligation was typically fulfilled when: (1) the resulting child was delivered to the intended parents, and (2) the surrogate surrendered her parental rights.⁴⁵ Opponents rejected surrogacy on moral grounds, and felt it was a moral transgression, which would contribute to the disintegration of the family unit.⁴⁶ Opponents also emphasized that the right to raise a child could not be revoked prior to the birth of that child, nor could informed consent cover relinquishing that right prior to birth.⁴⁷

One of the biggest concerns raised by opponents was the commercial aspect of surrogacy. Allowing surrogacy as a compensable service, they felt, reduced women to mere incubators for children to serve couples who desired children who would be genetically related to them.⁴⁸ The Task Force report stated that for some parties, it was not compensation that was of greatest concern, but rather the depersonalization of reproduction.⁴⁹ For others, compensation was the line between morally acceptable surrogacy and morally impermissible surrogacy.⁵⁰

After considering supporting and opposing arguments, the Task Force concluded that surrogate parenting was not a fundamental constitutional right, and therefore, was not entitled to protection by the court. While there was no evidence of the harm surrogacy could create, the risks of potential harms were significant enough to restrict the practice since it was not legally protected as a fundamental right. The Task Force concluded that surrogate parenting created “unacceptable risks to children” in that the practice was tantamount to baby selling, and that, by its nature, surrogate parenting fractured families.

The Task Force recommended that society discourage the practice of surrogate parenting and called for legislation declaring surrogacy agreements void. The Task Force concluded that laws barring payments for surrogacy were necessary. However, the Task Force concluded the law should permit payments for expenses that were acceptable in adoptions, including medical

fees. The Task Force recommended laws banning surrogate agencies in New York, yet did state that non-commercial surrogate parenting was permissible, and felt that existing law permitted the practice.

In concluding its recommendations, the Task Force returned to the problems faced by infertile couples. While the harms were considered too great to permit surrogacy as a means of alleviating these individuals' suffering, the Task Force felt that more measures to reduce infertility should be pursued, including increased education and research.

Two years after the publication of the Task Force report, a New York court invalidated a surrogacy agreement in *In re Adoption of Paul*.⁵¹ The court in *Paul* looked to adoption laws for guidance and held that the compensated surrogacy agreement was in violation of New York State adoption law. The court, like the court in *Baby M*,⁵² also found that the agreement was in violation of the policy of the State, enumerated by case law, barring the sale of children. The court held that compensated surrogacy agreements were void under New York law.⁵³

In 1992, the New York State Department of Health issued a report entitled *The Business of Surrogate Parenting*, which examined commercial surrogacy in New York.⁵⁴ The report gave examples of surrogacy agencies in the state and discussed disputes that had arisen over the parentage of children born through surrogacy. This report provided demographic information about surrogates, the compensation surrogates were paid, and the terms of surrogacy agreements.

C. Prohibition of Compensated Surrogacy Agreements

Subsequent legislation was passed in New York restricting commercial surrogacy.⁵⁵⁻⁵⁶ Chapter 308 of the Laws of 1992 added a new Article 8 (§§121-124) to the DRL that prohibited surrogacy agreements. DRL §122 states that surrogacy agreements are contrary to the public policy of the state, and are void and unenforceable.⁵⁷

DRL §121(4) defines a surrogacy agreement in which:

- (a) a woman agrees either to be inseminated with the sperm of a man who is not her husband or to be impregnated with an embryo that is the product of an ovum fertilized with the sperm of a man who is not her husband; and
- (b) a woman agrees to, or intends to, surrender or consent to the adoption of the child born as a result of such insemination or impregnation.⁵⁸

DRL §123 penalizes individuals who engage in surrogacy agreements for any remuneration. The law states that “a birth mother or her husband, a genetic father and his wife, and, if the genetic mother is not the birth mother, the genetic mother and her husband” are all subject to a civil penalty of up to \$500 for attempting to enter into a surrogacy agreement. Any individual who helps arrange a surrogacy agreement for a fee, such as a broker, is subject to a civil penalty of up to \$10,000 for a first time offense. However, in practice, an individual is permitted to pay for medical costs, which are considered reimbursement rather than compensation.⁵⁹ If an individual is penalized under DRL §123 for arranging a surrogacy agreement, and violates the provision again, that individual is guilty of a felony.⁶⁰

Under DRL §124, a “court shall not consider the birth mother's participation in a surrogate parenting contract as adverse to her parental rights, status, or obligations” when there is a dispute over parental rights between a surrogate mother and the genetic mother, the genetic father, or the parents of the genetic mother or father.⁶¹

D. Surrogacy After the Prohibition of Compensated Surrogacy Agreements

The enactment of a law prohibiting commercial surrogacy inhibited, but did not prevent, New Yorkers from pursuing surrogacy through one of two alternate arrangements:

- (1) A surrogacy agreement under a jurisdiction where such agreements were recognized, or,
- (2) Altruistic surrogacy in New York State.

1. Out-of-State Compensated Surrogacy Arrangements

A feasible and common pathway to parenthood for a significant number of New Yorkers has been the pursuit of an out-of-state surrogacy agreement.⁶² Since New York recognizes any custody determination made in another state, parents arrange to have the child born in a state with laws that would grant them custody. For the intended parents, engaging in a surrogacy arrangement outside of New York State may often entail enormous psychological, physical, and financial burdens. It may also restrict their access to resources based in New York.

The granting of parental rights to the intended parents after the birth of a child varies by state. In some jurisdictions, the intended parents can obtain a court order designating them the legal parents prior to the birth of the child. However, such an order is not effective until after the birth of the child. In those jurisdiction, when presented with a court order, the hospital registrar will directly list the intended parents (not the surrogate) on the child's original birth certificate. In other states, an Order of Parentage, which requires a modification of the original birth certificate to list the intended parents, is issued by the court only after the child's birth.

A serious issue may arise in states with unclear laws or regulations for granting parental rights is determining the appropriate party to make medical decisions for a child in the hospital and ensuring that the child is covered by a health insurance plan. If a child is born with serious medical issues that require immediate attention, there may be confusion regarding who should provide consent to treatment decisions, i.e., surrogate or intended parents, which may delay necessary medical procedures. Second, although a child born from surrogacy may be covered by an intended parent's health insurance policy, the insurance company may refuse to cover the child until official documentation (e.g., an amended birth certificate naming the intended parent as a legal parent) is received. Some states have avoided these problems by passing statutes that effectuate parental rights at the moment the child is born. In these jurisdictions a legal instrument, such as a court order, may be presented to the hospital and insurer to show proof of parentage.

In some states, the surrogate may be designated as the “mother” on the child's initial birth certificate, but the birth certificate is amended once the parentage order is issued, typically shortly after the child's birth. In states where only genetically related intended parents may obtain an order of parentage, the non-genetic parent must petition for adoption (often in the

intended parents' state of residence). In states where surrogacy agreements are not legally enforceable, such as in New York, genetically related intended parents may be able to obtain either an Order of Filiation (men) or, provided the surrogate does not challenge maternity, an Order of Maternity (women). In these states, the only option for the non-genetically related intended parents is for them to petition for adoption.

Although legal recognition of same-sex marriage provides many legal and financial protections to same-sex spouses, it does not automatically protect the parental rights of both spouses to a child born into that marriage. Prior to the 2015 Supreme Court ruling in *Obergefell v. Hodges*, many states would not permit a LGBT parent to adopt his or her spouse's child because the state did not recognize the second parent as the married spouse. The *Obergefell v. Hodges* ruling should establish better footing for children in LGBT households to be adopted by the "step parent."⁶³ However, adoption laws vary by state, and some state-licensed child welfare agencies are permitted to refuse placement and services to children and families, including LGBT individuals and couples, if it conflicts with their religious beliefs.⁶⁴ Because laws governing the gestational surrogacy process vary from state to state, many New York intended parents work with a surrogate who resides in a state in which surrogacy agreements are clearly enforceable by law. When intended parents enter into a surrogacy agreement in states that recognize and enforce them, the intended parents typically return to New York after the child is born with an out-of-state court order declaring them to be the legal parents of the child and with a birth certificate naming them as the child's parents. While a birth certificate alone does not legally establish parentage the intended parents, the out-of-state court order, in effect, does exactly that. The out-of-state court order is given full faith and credit in New York despite New York's public policy against enforcing surrogacy agreements.

2. Altruistic Surrogacy Arrangements in New York

The other option for intended parents in New York is altruistic surrogacy, where a surrogate is not compensated. New York's law does not differentiate between traditional or gestational surrogacy arrangements. Commercial arrangements of both types are prohibited and altruistic arrangements, while not subject to civil or criminal penalties, are unenforceable and discouraged. Although altruistic surrogacy is legally permitted, there are no laws to declare or accelerate the granting of parental rights or resolve disputes when they occur. Thus, there continues to be legal challenges with surrogacy cases.

In 1994, the New York Second Department Appellate Court addressed the issue of maternity in *McDonald v. McDonald*,⁶⁵ a divorce proceeding wherein the husband claimed sole custody of a child born to his wife using his sperm and a donor egg. The court relied on a surrogacy case from California, *Johnson v. Calvert*,⁶⁶ where the court established an "intent test" for determining the "natural mother" of a child born through surrogacy where two women (the surrogate who gives birth and the intended mother who is genetically related to the child) both presented legally acceptable proof of maternity. The "intent test" determined custody by establishing which party initiated processes that led to the birth of the child. The *Johnson* court stated, "under our analysis, in a true 'egg donation' situation, where a woman gestates and gives birth to a child formed from the egg of another woman with the intent to raise the child as her own, the birth mother is the natural mother."⁶⁷ The *Johnson* court speculated that if the intended

mother used a donor egg to create the embryo and gestated the pregnancy, and gave birth to a child with the intent to raise the child as her own, then the birth mother would be the “natural mother” under California law.⁶⁸ Similarly, the Appellate court in the *McDonald* case upheld the Queens County Supreme Court decision that the wife, who gestated the pregnancy with the intent to raise the children, was the “natural mother” and entitled to temporary custody.⁶⁹

Also decided in 1994 was *Arredondo v. Nodelman*,⁷⁰ wherein the Queens County Supreme Court permitted the name of a genetic mother, whose husband was, and had already been declared, the genetic father, to be listed on the amended birth certificates of twin children born through surrogacy. The court relied on DNA tests which supported the maternity and paternity of the genetic parents.⁷¹ Neither the New York City Department of Health and Mental Hygiene (NYC DOHMH) nor the surrogate opposed.⁷²

In 1998, the Task Force considered the issue of parental rights in the complex world created by developments in ART in its publication, *Assisted Reproductive Technologies: Analysis and Recommendations for Public Policy*.⁷³ Advances in ART, including IVF, enabled a child to have up to three genetic parents, those who provide the gametes and the surrogate.⁷⁴ The Task Force affirmed its position that a birth mother may not relinquish her parental rights prior to the birth of the child.⁷⁵ The Task Force also affirmed in 1998 its previous recommendation that surrogacy agreements should remain unenforceable because such arrangements pose significant risks for women, children and society.⁷⁶

In the report, the Task Force identified four distinct scenarios arising under ART that could not be addressed under current State law. All of these situations apply to intended parents who are genetically related to the child born through surrogacy.

- 1) Where a surrogate and genetic intended mother “agree, after the child is born, that the genetic mother should be recognized as the child’s sole legal mother, the law should provide a mechanism for achieving [this] result...without...a formal adoption proceeding.”⁷⁷
- 2) Where both the surrogate and genetic intended mother assert parental rights, both should have standing as a genetic parent to seek custody, and the courts should resolve the dispute using the best interest of the child standard. Generally, only the genetic mother should be awarded custody and maternal rights, but the surrogate mother’s status as genetic parent (as a result of giving birth to the child) should not be terminated.⁷⁸
- 3) Where the intended parents change their minds and refuse the child born through surrogacy, the surrogate should have the right to obtain a declaration that the intended genetic parents are legally obligated to support the child, and the law should provide standing to the surrogate to establish the genetic mother’s legal relationship to the child. Where neither the surrogate nor the intended mother is willing to assume responsibility for the child, the court should be able to hold them jointly liable.⁷⁹
- 4) Where the surrogate and genetic intended mother desire joint custody, it is in the child’s best interest to permit this arrangement.⁸⁰

In the 2004 case *Doe v. New York City Bd. of Health et al.*, genetic-intended parents of triplets to be born through surrogacy joined with the surrogate to seek a pre-birth judgment that

the genetic-intended parents were the children's legal parents and should appear on triplets' birth certificates.⁸¹ The NYC DOHMH opposed the granting of a pre-birth order because surrogacy agreements are void and unenforceable in the State and the identity of the woman giving birth to a child must remain true to ensure that "medical records remain accurate and to prevent fraud or mistake in the determination of such matters as identity, [etc.]."⁸² The New York Supreme Court denied the request for a pre-birth order.⁸³

Furthermore, NYC DOHMH asserted it would not oppose a post-birth amendment to the birth certificates if the genetic parents were established as such via DNA testing, or if they formally adopted the children.⁸⁴ However, the court explained that DRL §124 "specifically leaves open the type of legal proceeding that may be instituted following the birth of a child born pursuant to a surrogate parenting contract, and does not limit the parties to a formal adoption proceeding."⁸⁵ With regards to DNA testing to prove filiation, the court explained that orders of paternity and maternity may be issued by a court and both intended parents without such evidence.⁸⁶ Instead, medical proof of filiation, based on a confidential medical report, could be used. Thus, upon receipt of the confidential medical report and report of birth from the hospital, the court ordered NYC DOHMH to issue two sets of birth certificates sequentially: (1) the first naming the surrogate as mother, which was to be sealed, and (2) the second naming the genetic mother as mother, not indicating on the certificate that it is amended, corrected or supplemental.⁸⁷

In the 2009 *Matter of Sebastian*, the Surrogate Court of New York addressed the question of adoption of a child who was born to a same-sex female couple married in another country, one of whom had provided an oocyte for fertilization by an anonymous sperm donor, the other having been the surrogate of the child.⁸⁸ The court determined there was "no clear law in New York determining the relationship between a child and various women who may lay claim to parentage through a genetic or gestational relationship."⁸⁹ The court noted that adoption is intended to create a parent-child relationship where none previously existed and is not intended to affirm an already existing parent-child relationship.⁹⁰ New York's adoption statute should be strictly construed since it is "in derogation of the common law."⁹¹ Thus, the question became whether it was appropriate to permit adoption "where the party petitioning for adoption was legally married to the child's mother at the time of the child's conception and birth, and where she is also the child's genetic mother."⁹²

The court examined the guarantee of equal protection and asked why "an unmarried man who is genetically related to, and who has established a parental relationship with, a child be permitted to establish legally protected and recognized rights of parentage through statutory acknowledgment or filiation proceedings when a similarly situated woman cannot?"⁹³ Essentially, the court questioned why a lesbian genetic mother of a child born to her wife be unable to utilize existing statutory procedures to establish her parentage status and rights and instead be limited to the more expensive and time-consuming adoption mechanism.⁹⁴ The court determined there was no reason for the State to "discriminate between male and female genetic parents who seek to use New York's statutory paternity laws to grant parental rights, as well as corresponding responsibilities, to their children."⁹⁵

The court noted that while a judicial order of filiation or even an acknowledgement of paternity should provide the same protections as adoption for full faith and credit purposes, any “extension of New York’s paternity acknowledgment to the genetic mother would depend on construction of the statute by courts of this state, [and] other states would be free to take a contrary view, such that reliance on the federal statutory guarantee offers no absolute guarantee of recognition” to the child’s parents.⁹⁶ The court concluded that the only authority it had to confer legal parentage was through an adoption proceeding.⁹⁷ Although such a proceeding should be unnecessary in New York, where same-sex marriages were recognized, the best interests of the child required that an adoption be used to ensure recognition of both of the child’s parents as legal parents in the eyes of other states.⁹⁸

Similarly, in 2010, the genetic parents and surrogate joined in *Feigenbaum v. NYS Dept. of Health* to seek a declaration under New York law that genetic parents’ names be listed on the child’s birth certificate as the legal parents of a child born via surrogate.⁹⁹ Marc and Elaine Feigenbaum, genetic parents of the child, also sought relief on the grounds that New York State’s DRL Article 8 and Family Court Act §§517 and 542 violate their rights under the Equal Protection and Due Process clauses of the United States and New York State Constitutions.¹⁰⁰ The court dismissed the genetic mother’s complaint and noted that a declaration of maternity proceeding does not exist, and such a declaration would go against the state’s policy prohibiting surrogacy arrangements.¹⁰¹ The court stated that the “designation and determination of the genetic mother as the legal mother of a child born to a surrogate . . . is a matter that must be addressed by the Legislature [and not the courts].”¹⁰² Further, the court found that in an order of paternity, there is only one father to a child while with an order of maternity, there may be two mothers – the birth mother (surrogate) and genetic mother (intended parent) and such orders have different legal responsibilities.¹⁰³ An order of paternity is to establish the legal father and his legal obligations concerning the welfare and support of the child. An order of maternity would have a different effect, which would permit the legal mother to obtain custody of the child.¹⁰⁴ Thus, the genetic mother and genetic father are not similarly situated and the equal protection clause is not violated.¹⁰⁵ The court also stated that due process rights for the surrogate and genetic mother were not violated because adoption proceedings were available to account for the complexities of a surrogacy arrangement.¹⁰⁶

In 2011, in *T.V. v. New York State Dept. of Health*, the Nassau County Supreme Court was asked to declare the maternity of a child born from an embryo created from the intended mother’s egg, but gestated and birthed by a surrogate.¹⁰⁷ The court declined to do so, holding that the court was unable to declare the genetic mother the legal mother of the subject child absent legislation permitting it, and that the proper vehicle to do so would be the adoption process.¹⁰⁸ The decision was appealed to the Second Department Appellate Court of New York.¹⁰⁹

In the case, the plaintiffs challenged the constitutionality of DRL Article 8 and Family Court Act §§517 and 542 which allow a genetic father, but not a genetic mother, to obtain an order of filiation. The New York State Department of Health asserted that Public Health Law §4130 was clear that the “woman who actually gives birth to the child is the mother”¹¹⁰ with no reference to genetics and, neither the Family Court Act nor any other statutory provision provided for an order of maternity. The Department of Health also denied that the statutory scheme violated the Equal Protection or Due Process Clauses of either the state or federal

constitutions, since “the challenged classification served an important governmental objective of having an accurate identification of the birth parents on the child’s birth certificate.”¹¹¹

The plaintiffs argued that the statutory framework was adopted when the identity of an infant’s mother was clear, but now that there is uncertainty, the courts have inherent authority to make such a clarifying declaration.¹¹² Plaintiffs also argued that the statutes as applied were unconstitutional since the individual right to privacy includes the right to bear and raise children, which includes the use of ART to conceive and raise a genetically related child, and that no compelling state interest justified interference with this right.¹¹³ Because technology now enabled a non-related individual to gestate and give birth to a child, the presumption that the woman who gave birth to the child was the mother was rendered rebuttable, leaving men and women similarly situated in a gestational surrogacy arrangement.¹¹⁴

The appellate court reversed the holding of the lower court and found that the Supreme Courts of New York does have the authority to declare the maternity of a child.¹¹⁵ In its holding, the court cited the 1998 Executive Summary of the Task Force’s ART Report, which stated that “the determination of maternal rights and responsibilities in gestational surrogacy arrangements should reflect both the genetic and gestational contributions to motherhood [and] if both the genetic mother and the birth mother agree, after the child is born, that the genetic mother should be recognized as the child’s sole legal mother, the law should provide a mechanism for achieving that result efficiently, without the need for a formal adoption proceeding.”¹¹⁶

In 2016, in *Frank G. v. Renee P.-F.*, the New York Second Department Appellate Court addressed the issue of parental rights involving unmarried male domestic partners, Frank G. and Joseph P., and a surrogate, Renee P.-F..¹¹⁷ Frank G. provided the sperm and Renee P.-F., Joseph’s sister, provided the egg and was the surrogate (i.e., traditional surrogacy arrangement) for twins.¹¹⁸ While Joseph never adopted the twins, he and Frank shared parental responsibilities and Renee P.-F. was a frequent visitor.¹¹⁹ The domestic partners separated and Frank denied both Joseph P. and Renee P.-F. access to the children and moved with the children to Florida without the court’s permission.¹²⁰ Joseph P. petitioned to seek custody of the children and Renee P.-F. separately petitioned for custody of the children.¹²¹

The appellate court ruled that Joseph P. had standing to seek parental rights. The court stated, in reference to *Matter of Brooke S.B. v Elizabeth A. C.C.*,¹²² that Joseph P. had “sufficiently demonstrated by clear and convincing evidence that he and Frank G. entered into a preconception agreement to conceive the children and raise them together as their parents.”¹²³ The appellate court found that the surrogacy agreement, while unenforceable, could be used as evidence of Joseph and Franks’ intention to become parents, and that this intention to become parents could be introduced as evidence to establish standing to seek custody and/or visitation (DRL §124(1)).¹²⁴

E. The Legal Status of Surrogacy in New York Today

Although New York’s prohibition has deterred some individuals from entering into surrogacy agreements, serious problems and uncertainties have been created by the state’s ban

that remain unresolved. Individuals seeking to have a child in New York through altruistic surrogacy agreements are subject to a process created in response to the decision in *T.V. v. New York State Dept. of Health*. Currently, after a child is born through surrogacy, the intended male parent of the child may be listed as the father on the child's birth certificate, but the surrogate, not the genetic intended mother, is listed as the mother. The surrogate, who did not intend to be recognized as the legal mother and therefore legally and financially responsible for the intended child, is listed as the mother because she physically gave birth to the child. In the event of an intra-family surrogacy, this is especially problematic because a birth certificate could suggest incestuous parentage. Even where the female intended parent is genetically related to the child, she must formally adopt the child. The process for amending a birth certificate, which includes obtaining a court order, is difficult. Because local courts' levels of experience and understanding of gestational surrogacy determines how quickly parentage proceedings are scheduled and the documentation required, in many regions of New York State, the process may not be timely. Delays in determinations of parentage may cause complications relating to health insurance coverage and inheritance for the child.

Further, because surrogacy agreements are unenforceable in New York, a child born through surrogacy may be left without parental certainty and a surrogate, with no genetic relationship to the child, may change her mind and attempt to claim custody of the child or the genetic intended parents may attempt to reject the child potentially leaving the surrogate with a child she never intended to raise.

Finally, in New York, the courts have advanced the discussion regarding surrogates and parental rights. In *Frank G. v. Renee P.-F.* the Appellate Division found that the unenforceable surrogacy agreement cannot be used to challenge the surrogates standing under DRL 70 and 124(1) to seek visitation and custody of the children. However, the court ruled that the surrogacy agreement can be used as clear and convincing evidence that it was the intention of all the parties that the intended parents would become the parents of the children born through surrogacy.¹²⁵ The case could potentially affect the significance of surrogacy agreements. In the future, parties in New York may use a surrogacy agreement as evidence of their intent to become a parent, although it is not clear that a surrogacy agreement alone would be sufficient to establish standing as a "parent" under DRL §70.¹²⁶

The laws governing surrogacy and the options for intended parents in New York have changed significantly since the Task Force first recommended the State prohibit compensated surrogacy agreements. These changes reveal three main points. First, New York parents can still have children through surrogacy, although many may choose to have children in a jurisdiction that permits gestational surrogacy agreements to ensure any surrogacy agreements are locally enforced. Second, for those who choose to have a child in New York State through altruistic surrogacy, the process of determining legal parentage is confusing and unclear. Third, surrogacy arrangements, both in-state and out-of-state, have not created the myriad of problems the Task Force in its 1988 report predicted would occur if surrogacy arrangements continued to occur.

IV. Constitutional Status of Claims to an Individual Right to Surrogacy

In 1988, when the Task Force examined court rulings regarding surrogacy, the Task Force found little support for the contention that gestational surrogacy agreements are protected from state interference under a constitutional right to privacy.¹²⁷ The Task Force reasoned that once rights enter into the field of commerce, they no longer qualify for the same protections. A number of court cases support this conclusion.¹²⁸

While the Supreme Court has yet to hear a case examining whether surrogacy is a constitutionally protected practice,¹²⁹ there have been a number of constitutional challenges to state laws which restrict or prohibit gestational surrogacy agreements. These cases, heard by state courts, have been decided on grounds of filiation (the relationship between parent and child), equal protection, the right to parent, and the right to procreate. Even in cases where people have raised claims that laws banning surrogacy violate reproductive freedom, the courts have relied on family law standards of custody. Given that the Supreme Court has not yet definitively spoken on the issue, each state must decide, as a matter of its own law and policy, and in light of evolving legal doctrines, whether and how to regulate this practice. Thus, the Task Force affirms its previous conclusion that it is legally permissible for the state to regulate this practice.

V. Examining Gestational Surrogacy Arrangements

Significant medical advances and social and cultural shifts on a variety of issues related to families and marriage, including the recognition of same-sex marriage, have compelled the Task Force to reexamine surrogacy. The ethical and legal recommendations from nearly 30 years ago may not be as compelling and applicable to our society today.

A. Advances in Assisted Reproductive Technologies

When the Task Force first issued recommendations on surrogacy, there was scant research regarding the effects of the process on the children born through surrogacy, the surrogate and her family, and the intended parents, and little formal guidance, or experience, addressing appropriate safeguards and protections. While the 1988 surrogacy report addressed the possible use of gestational surrogacy, the deliberations focused on traditional surrogacy because this type of surrogacy was the dominant form practiced. However, today, with medical advances in ART and IVF, traditional surrogacy has been replaced with gestational surrogacy. IVF has made it possible for most surrogacy arrangements today to only involve gestational surrogacy.¹³⁰

Today many intended parents, who are both able to provide gametes, will do so to create the embryo for implantation via IVF and the resulting child is genetically related to both intended parents.¹³¹ In some instances, only one of the intended parents will provide gametes and donor gametes are used and the resulting child is genetically related to one intended parent. This is often the case with same-sex intended parents, single parents, or different-sex couples in which one parent's gametes are unviable. While the Task Force takes no position on the moral value of the desire for a child to be genetically related to one or both parents, it recognizes that some

individuals have a strong preference for a genetic connection. Often these individuals have exhausted all other ART options and gestational surrogacy is the last or only opportunity to have a child genetically related to both intended parents.

B. Social and Cultural Changes regarding Motherhood and Parenthood

Intended parents may seek gestational surrogacy for social, cultural, or medical reasons. Economic realities of today and changes in society's views on motherhood, parenthood, employment, and women's rights have led many women to postpone childbearing.¹³² For women, the risk of infertility increases with age.¹³³ For some women, an inability to become pregnant or sustain a pregnancy to term may not be related to the viability of their oocytes, but rather to physical or medical conditions.¹³⁴ Furthermore, women with chronic health conditions who must take medications to maintain their health may be unable to have children because of the effects the medications may have on fetal development (i.e., birth defects).¹³⁵ These women have viable eggs, and gestational surrogacy offers an opportunity for a genetic connection to a child born using these eggs, despite infertility.¹³⁶

C. Limited Availability of Infants for Adoption

Adoption greatly benefits children in need of homes and individuals who desire to be parents. For many who want to bring children into their families, adoption may be the best option. The Task Force strongly supports adoption as a historically important pathway to family formation. Society benefits in innumerable ways from matching children with loving parents. By placing some of the most vulnerable children into caring environments, adopted children are able to live healthy and enriching lives.¹³⁷

However, the number of children, especially infants, who meet parental preferences regarding race and health status, available for adoption has been decreasing over the past three decades.¹³⁸ The reduction in infants available for adoption is problematic for prospective parents because many will only consider adopting an infant, not an older child. While the Task Force does not opine on intended parents' preference for an infant, it does acknowledge that the parenting experience can be different depending on the age of the adopted child. Many individuals and couples prefer to adopt an infant; thus, there is intense competition for these children. Gestational surrogacy provides an alternate pathway to have a child.

D. Fewer Opportunities for LGBT Individuals to Adopt

LGBT individuals in New York have limited opportunities to adopt children through adoption agencies. The number of adoption agencies in New York is limited because state law requires all adoption agencies be licensed by the State; currently, there only 102 licensed adoption agencies.¹³⁹ Although adoption agencies are not permitted to discriminate against applicants based on many factors, including sexual orientation,¹⁴⁰ many private and religious agencies in New York are reluctant to work with LGBT individuals. Of the 102 licensed adoption agencies in New York, only 28 (27%) will work with LGBT individuals to adopt infants.¹⁴¹ According to representatives from the remaining agencies, birth parents the agencies

work with would like their babies adopted by different-sex parents. Thus, it is unlikely that these agencies would match LGBT applicants with birth parents.¹⁴²

Similarly, opportunities for LGBT individuals to adopt internationally through an agency are limited because their sexual orientation bars them from adopting in most countries. Only three jurisdictions, Brazil, Mexico City, and South Africa, permit adoption by LGBT couples,¹⁴³ and these programs are small and have weak track records.¹⁴⁴ While some LGBT couples choose to bifurcate the adoption process, i.e., one parent will adopt the child via the international adoption process and the second parent will adopt the child at a later date in New York, this process may be difficult to execute in practice.

Due to these limitations, many LGBT individuals turn to private placement domestic adoptions in lieu of adoption agencies. However, as previously discussed, the number of infants available for adoption is extremely limited and many LGBT individuals, especially male couples, turn to gestational surrogacy to have a child.

E. Changing Demographics of Intended Parents

Another significant change since the Task Force's 1988 surrogacy report involves the demographics of intended parents using surrogacy arrangements as a reproductive option. In the past, infertile different-sex couples were the primary users of surrogacy. These intended parents consisted of a married man and woman. In addition to different-sex couples, more same-sex couples, particularly male couples are turning to surrogacy to have children.¹⁴⁵ Gestational surrogacy permits one male parent to be genetically related to the child and some male couples are choosing to have twins so that both men may be genetically related to a child.¹⁴⁶ Furthermore, the legalization of same-sex marriage¹⁴⁷ has also encouraged same-sex couples to pursue surrogacy because LGBT parents can raise a newborn and both be legally recognized as the parents to the child.

F. Increased Use of Gestational Surrogacy

Data indicate that the number of gestational surrogacy births continues to increase every year. The American Society for Reproductive Medicine (ASRM) has been collecting data on surrogacy from ASRM member clinics who have voluntarily provided data since 2004. In 2004, 738 babies were born through surrogacy; in 2015, 2,807 babies were born through surrogacy – a 280% increase in the span of eleven years.¹⁴⁸

As the number of children born through surrogacy increases, the media's portrayal of these families is increasingly positive overall. A large number of these families have shared their surrogacy stories in the media, illustrating that the shift from traditional to gestational surrogacy has made the process less contentious for many people. Many families, including celebrity families, have used gestational surrogacy to have children and media attention on these births, while not always positive, is rarely as negative or contentious as it was in the 1980s.¹⁴⁹ The predominant use of gestational surrogacy has led to mainstream articles supporting policy changes to "update" surrogacy laws.¹⁵⁰

G. Other States' Laws on Gestational Surrogacy

Laws regulating surrogacy are promulgated at the state level and laws vary significantly from state to state.¹⁵¹ The legal landscape throughout the country concerning surrogacy is also changing. Nineteen states and Washington, D.C. have laws permitting and regulating the practice of commercial gestational surrogacy, and other states, including New York, that currently ban surrogacy, have proposed legislation that would, if enacted, allow compensated gestational surrogacy. Six states have enacted legislation restricting or banning gestational surrogacy.¹⁵² Seven states have established governing guidelines (six states permitting surrogacy and one banning) via case law.¹⁵³ In the remaining 19 states, the status of gestational surrogacy is uncertain but arguably permissible because there are no laws or published case law banning the practice.¹⁵⁴

States vary with respect to the following factors in the context of gestational surrogacy agreements: (1) whether surrogacy agreements are legally enforceable; (2) whether compensation beyond costs associated with the surrogate pregnancy (e.g. legal, medical, and psychological screening fees) is permitted; (3) who may qualify to be intended parents in a surrogacy agreement (e.g., only a married different-sex couple); (4) how the parental rights to intended parents are granted; and (5) what requirements must be established for surrogates and intended parents to enter into an agreement. Even in those states with governing regulatory or judicial guidance, many gray areas exist with respect to specific issues surrounding gestational surrogacy agreements. When these issues are litigated, courts have relied on a number of different authorities and standards.

H. Problems with Altruistic Surrogacy Arrangements in New York

New York State law permits altruistic surrogacy and often a family member is asked to be a surrogate. These familial arrangements are complicated and subject the parties to uncertainties that renders them vulnerable. While the number of such arrangements is not available, estimates suggest that altruistic surrogacy remains fairly rare.¹⁵⁵

Because it is difficult to find an unrelated woman willing to be an altruistic surrogate, many intended parents enlist a sister or sister-in-law to be the surrogate. However, the reliance on intra-family surrogacy has created complex disputes for the families involved. Familial relationships may place undue pressure on female family members to be a surrogate. Furthermore, unlike formal surrogate-intended parent matching procedures where the match is based on shared values and interests that are expressly articulated, research has shown that familial surrogates tend not to have such discussions. A familial relationship in and of itself does not guarantee shared values and beliefs. Surrogates in these situations often had negative experiences as a result of intra-family disputes and there was often a risk of intra-family coercion in these arrangements.¹⁵⁶

VI. Professional Medical and Legal Guidance on Gestational Surrogacy

When professional organizations began to issue opinions on surrogacy, IVF was still new and surrogate pregnancies were limited to traditional surrogacy. However, as more people began

engaging in gestational surrogacy, professional medical and legal associations have issued specific opinions or guidance/best practices on the ethical, medical, psychological, and legal issues related specifically to gestational surrogacy. In addition, while these organizations may not advocate for surrogacy, their guidance – primarily targeted to medical professionals, lawyers, and judges – indicates a recognition that professionals may engage in assisting gestational surrogacy agreements, and if they do so, there are ethical standards of practice they should employ. A summary of the various organizations that have issued guidance is below.

A. Professional Medical Organizations

In 1994, the American Medical Association's (AMA) Ethics Group, issued a brief opinion in their Code of Medical Ethics that was supportive of gestational surrogacy.¹⁵⁷ The AMA recommended that a surrogate in a traditional surrogacy arrangement has the right to void a surrogacy agreement within a reasonable period of time after the birth of the child because she has a genetic relationship to the child. The AMA did not, however, recommend the same option for gestational surrogates. Because a gestational surrogate has no genetic connection with a fetus, the AMA concluded the "justification for allowing the surrogate mother to void the contract becomes less clear."¹⁵⁸ The AMA recommends that gestational surrogacy agreements should be strictly enforceable and not voidable by either the surrogate or the intended parents.¹⁵⁹

The American College of Obstetricians and Gynecologists (ACOG) first issued a committee opinion regarding surrogacy in 1983, at a time when the discussion was limited to traditional surrogacy. ACOG stated that individual physicians were free to determine whether they would participate in surrogacy arrangements, but the organization had "significant reservations about this approach to parenthood."¹⁶⁰ In 1990, ACOG issued a revised opinion, which included gestational surrogacy. In this opinion, it was concluded that surrogacy arrangements "can be morally justifiable, in cases of medical need" if safeguards were put in place.¹⁶¹ In 2008, ACOG released its opinion on surrogate motherhood.¹⁶² It affirmed that surrogacy should only be considered where there is infertility or serious health-related issues, not for convenience, and provided more detailed guidance on the ethical responsibilities of physicians choosing to participate in surrogacy arrangements.¹⁶³

In 2016, ACOG released its most recent and current opinion on surrogate motherhood, and does not address traditional surrogacy.¹⁶⁴ ACOG expanded the circumstances where gestational surrogacy could be used to include "situations in which carrying a pregnancy is biologically impossible or medically contraindicated."¹⁶⁵ This guidance provides an overview of the potential benefits, ethical considerations, medical risks, legal considerations, and psychosocial considerations. It also offers recommendations to obstetricians and gynecologists who are: (1) advising women who may potentially become a surrogate, (2) providing obstetric services for a pregnant surrogate, and (3) counseling intended parents considering surrogacy.¹⁶⁶

The opinion stresses that independent legal counsels for both the surrogate and intended parents, and even the physicians, is highly recommended.¹⁶⁷ It also recommends that physicians should not serve both the surrogate and the intended parent(s) because doing so would create a conflict of interest that could prevent the provider from attending to his/her patient properly.¹⁶⁸ ACOG recommends all physicians discuss the medical, ethical, legal and psychological issues

related to surrogacy with all parties involved in the agreement.¹⁶⁹ It also recommends separate and independent mental health counseling to the surrogate and the intended parents.¹⁷⁰ ACOG states that physicians should recognize that the pregnant woman is the “only one empowered and enabled to make independent decisions regarding any screening, testing or procedure that may be indicated during her pregnancy.”¹⁷¹ ACOG makes no statements about the particulars of a surrogacy agreement with respect to medical decision-making. Furthermore, although the nature of a surrogacy arrangement encourages the intended parents to be part of the discussion regarding a surrogate’s or the fetus’ health, ACOG states that physicians should only have these discussions with the intended parents after receiving explicit permission from the surrogate.¹⁷² ACOG states that obstetrician-gynecologists may work with an agency that is involved with surrogacy arrangements if the agency is “medically and ethically reputable and if the physician receives no more than standard compensation for the services.”¹⁷³ For the first time, ACOG addresses cross-border reproductive health care and advises physicians to advise their patients who are considering or engaging in ART outside of the United States. ACOG recommends that should a physician treat a pregnant surrogate from abroad, the physician has an obligation to provide the same level of care to any patient.¹⁷⁴

The Ethics Committee of the American Society for Reproductive Medicine (ASRM) issued an opinion on gestational surrogates in 2013.¹⁷⁵ Unlike ACOG’s opinion, which is limited to recommendations for physicians, ASRM presents a general statement supporting the ethical treatment of surrogates. It addresses the permissibility of reasonable economic compensation, informed consent by the surrogate, medical considerations of a gestational pregnancy, psychological screening and evaluation of the surrogate. ASRM states that in cases where these issues are properly addressed, gestational surrogacy is “ethically justifiable and ... the intended parents should become the legal parents of the child.”¹⁷⁶

In 2014, ASRM issued an opinion suggesting how physicians should respond to misconduct by surrogates, intended parents, and the agents/attorneys involved in third party ART arrangements.¹⁷⁷ ASRM recommends that physicians who become aware of surrogate misconduct may need to balance the duty to obtain informed consent with the duty to maintain patient confidentiality.¹⁷⁸ In addition, for surrogacy arrangements involving compensation, physicians should know about all financial arrangements between the surrogate and the intended parents, refuse to participate in any activity that involves wrongdoing, and advocate on behalf of a victimized patient.¹⁷⁹

In 2014, the National Perinatal Association (NPA) released recommendations on the ethical use of ART and articulated specific recommendations pertaining to surrogacy. The NPA states surrogates should receive independent legal counsel, and suggests all contractual arrangements be finalized before embryo transfer. The NPA recommends that the surrogate and intended parents reside in the same state and be therefore subject to the same legal due process because filiation is a legal proceeding. The NPA also recommends that commercial surrogacy agencies should be regulated by states, and that any financial transactions between the intended parents and the surrogate comply with both federal and state tax laws.¹⁸⁰ Finally, the NPA strongly discourages medical tourism for surrogacy, and perceives the hiring of surrogates in other countries by American intended parents as an exploitative practice.¹⁸¹

B. Professional Legal Organizations

In addition to medical organizations, professional legal organizations, including the American Bar Association (ABA) and the Uniform Law Commission (ULC),¹⁸² have issued model laws to address the complexities surrounding surrogate parentage, and outline clear legal rights, obligations, and protections for stakeholders, including children born through surrogacy. The primary difference between these models is the level of intervention by a court necessary to validate a surrogacy agreement and to grant parental rights to the intended parents.

ULC drafted the Uniform Parentage Act (UPA) in 1973; the document was most recently amended in 2002. The UPA “modernizes the law for determining the parents of children.”¹⁸³ The 2002 amendment includes an optional Article 8, which addresses gestational agreements.¹⁸⁴ Under this provision, a court must hold a hearing to validate the agreement before it is legally enforceable.¹⁸⁵ If the court finds that all requirements of a surrogacy agreement have been met, it will issue an order validating the agreement and recognizing the intended parents as the parents of the child.¹⁸⁶ Compensation is permitted, if it is reasonable and does not limit “the right of the gestational mother to make decisions to safeguard her health or that of the embryos or fetus.”¹⁸⁷ The UPA also requires that the surrogate or intended parents are residents of the state where validation is sought for at least 90 days.¹⁸⁸ Unless waived by the court, a home study of the intended parents’ must be performed.¹⁸⁹ Article 8 of the UPA also requires that the agreement provide for health care expenses related to the gestation and birth of the child, including coverage for those expenses in the event the agreement is terminated.¹⁹⁰ The court conducting the proceeding has “exclusive, continuing jurisdiction” until the child born through surrogacy is 180 days old.¹⁹¹

The UPA allows a surrogacy agreement to be terminated by the surrogate, her husband if married, or either of the intended parents “[a]fter issuance of an order under this article, but before the prospective gestational mother becomes pregnant by means of assisted reproduction.”¹⁹² In addition, the court may also terminate the gestational surrogacy agreement “for good cause.”¹⁹³ To gain recognition as the legal parents, the intended parents are required to file notice within 300 days of the child’s birth, at which point the court should issue an order confirming that the intended parents are the child’s legal parents and a birth certificate listing the intended parents as parents of the child.¹⁹⁴

The 2008 ABA’s Model Act Governing Assisted Reproductive Technology (ABA Model Act) was largely intended to track the corresponding provisions of the 2002 UPA.¹⁹⁵ Section 7 of the ABA Model Act covers surrogacy agreements and contains two alternative model laws recognizing a surrogacy agreement, Alternative A and B. In addition, Section 8 addresses surrogate compensations.¹⁹⁶ Compensation must be reasonable and negotiated in good faith between the parties and compensation may not be conditioned upon any particular characteristics of the child.¹⁹⁷

Alternative A mirrors the UPA¹⁹⁸ and requires “a judicially authorized gestational agreement for the determination of ART parentage” (for an overview of Alternative A, please review the discussion on UPA above). Alternative A and the UPA require a court order to both validate a surrogacy agreement and to confirm that parental rights are granted to the intended

parents. However, neither Alternative A nor the UPA impose a limit on how long a court may take to evaluate or approve a surrogacy agreement. These models provide courts with great discretion, “creating at least the possibility that similarly situated parties in front of two differently inclined judicial officers may receive different results in their approval process for apparently no substantive reason.”¹⁹⁹ Both Alternative A and the UPA require a second court order after the child’s birth to confirm that the intended parents are the parents of the child and to amend the birth records to name the intended parents as the parents of the child.²⁰⁰

Alternative B “provides an administrative model that does not require a judicial proceeding for parentage determination provided all of the parties are in compliance.”²⁰¹ Alternative B, in contrast to Alternative A, is “self-executing” and “automatically and administratively establishes parentage for the intended parents provided all of the parties meet the eligibility and procedural requirements of the [ABA Model Act] without any court intervention, approval, or orders.”²⁰² Immediately upon birth of the child, the intended parents are the legal parents for state law purposes and have parental rights and sole custody of the child.²⁰³ Attorneys representing both the surrogate and the intended parents must provide certifications that the surrogacy agreement’s requirements have been met and the parties must file the appropriate paperwork within 24 hours of the child’s birth.²⁰⁴ Upon completion of the attorney’s certification process, the birth records and original birth certificate will only list the intended parents as the parents of the child.²⁰⁵

Because there is no judicial involvement for a surrogacy agreement to be valid, the requirements for surrogates and intended parents are more detailed in Alternative B than the requirements for these parties under Alternative A or the UPA. For example, the surrogate must be at least 21 years old, have given birth to at least one child; have completed a medical and mental health evaluation relevant to the surrogacy arrangement; and have undergone legal consultation with independent legal counsel regarding, and have health insurance that will cover the surrogacy pregnancy and eight-weeks post birth.²⁰⁶ For the intended parents, they must contribute at least one of the gametes that will be used to create the embryo to be implanted, and they must possess a medical need for the surrogacy arrangement. The intended parents must also undergo a mental health evaluation and consult with independent legal counsel.²⁰⁷ Finally, two disinterested adults must witness the agreement.²⁰⁸

Alternative B requires that a surrogacy agreement be executed prior to embryo implantation.²⁰⁹ A surrogate, and her spouse if she is married, must agree to undertake the obligations imposed on the surrogate via the agreement and to surrender custody of all resulting children to the intended parents upon their birth.²¹⁰ The surrogate has the right to choose the physician who will provide her care during pregnancy.²¹¹ Gestational surrogacy agreements may include provisions requiring the surrogate to undergo all physician recommended medical exams, treatments, fetal monitoring and to abstain from activities the intended parents or physician believe may harm the pregnancy or the child.²¹² The agreement may also provide for the payment of reasonable expenses and compensation to the gestational surrogate and these funds must be maintained in an independent escrow account.²¹³ For the intended parents, the agreement must state that they accept custody of the resulting child or children upon birth and are financially responsible for the child or children.²¹⁴ Furthermore, Alternative B states that an individual considered to be the legal parent under the surrogacy agreement is liable for child

support and a breach of a gestational surrogacy agreement by the intended parents will not relieve them of support obligations.²¹⁵

Alternative B also contains a provision addressing noncompliance of the surrogacy agreement. In the case of noncompliance by any party with any of the agreement's provisions, "a court of competent jurisdiction shall determine the respective rights and obligations of the parties to any gestational surrogacy agreement based solely on evidence of the parties' original intent."²¹⁶ Alternative B does not permit specific performance as a remedy for a breach of contract by a surrogate in the event she does not become pregnant.²¹⁷ Nevertheless, Alternative B permits intended parents and surrogates to seek all other remedies available at law or equity.²¹⁸

Alternative B would provide the relevant state regulatory agency with the authority to adopt rules pertaining to requisite medical and mental health assessments. Until such rules are adopted, such evaluations should be conducted in accordance with current American Society of Reproductive Medicine (ASRM), Society for Assisted Reproductive Technology (SART) and American College of Obstetricians and Gynecologists (ACOG) guidelines. Finally, Alternative B states that any action to invalidate a gestational surrogacy agreement must be commenced within 12 months of the child's birth.²¹⁹

VII. Evaluation of Potential Risks and Benefits of Gestational Surrogacy

In the 1988 Task Force report on surrogacy, as part of its recommendations to prohibit commercial surrogacy, the Task Force stated:

... that the risks to children or to the surrogates are unproven – no empirical data exists to confirm these predictions because the practice is so novel. Nonetheless, society can conclude that the potential or likely risks of a practice outweigh the benefits conferred without awaiting broad-scale social experimentation.²²⁰

In light of the absence of evidence of tangible harms, the Task Force in 1988 focused on the potential harm to societal norms and values by permitting surrogacy, which was the prudent course at the time. In addition, the Task Force relied on adoption studies (i.e., looking at the effects of giving up a child from the birth mother's perspective) and the few available studies on surrogacy, which were primarily focused on *potential* surrogates, not actual surrogates who had been party to a surrogacy arrangement. At the time of the report, because research was not available to indicate whether surrogacy would harm these children or the surrogate, the Task Force recommended that surrogacy should not be practiced or legally enforceable to avoid any potential and unknown risks.

In the nearly 30 years since the Task Force surrogacy report was released, there have been an increase in both the number of women who have been surrogates and children born through surrogacy. As a result, there is a growing body of research available to help examine whether surrogacy may be harmful to surrogates, to children born through surrogacy, and to the intended parents of such arrangements. Since the 1988 report was released, a broad-scale social experiment has occurred in the many states and nations that permit surrogacy agreements and the number of surrogacy arrangements has been increasing every year. Research on the topic of

surrogacy that has become available over the last 30 years has not identified peer-reviewed studies that found significant harms from surrogacy. Empirical data overall suggest that there are no significant harms that threaten the surrogate or the child born through surrogacy. While the studies may occasionally include a “negative” finding/result, these findings are limited in scope and number. In addition to the availability of empirical research, information resulting from internet sites in which surrogates connect with each other for support and advice has provided insight.²²¹ The internet has provided surrogates with an avenue to share detailed first-person accounts relating to the surrogate’s “journey.”²²²

The Task Force now has empirical evidence in the form of a growing body of research studies²²³ and first-person accounts to determine: (1) whether the potential risks discussed in 1988 have translated to harms, (2) if any of these potential harms can be mitigated with appropriate oversight, and (3) the benefits of surrogacy. The Task Force not only examined the potential risks and benefits for the surrogate and child born through surrogacy, but also examined the risks and benefits for the intended parents. Many of these studies on the children born through surrogacy and their intended parents have been longitudinal, tracking human subjects for more than 10 years with plans to follow-up with these individuals into the future. Long-term data on surrogates is also now available.

Below is an evaluation of the potential risks and harms to a surrogate and her family, the intended parents, and the children born through surrogacy.

A. Potential Risks and Benefits to the Surrogate and to Her Family

Some risks to surrogates, their partners, and families were identified and described in the 1988 surrogacy report, but several were not. In addition, several benefits to surrogates have been identified but were not discussed in the previous surrogacy report.

1. Physical Risks to the Surrogate

As described in the 1988 Task Force report, the physical risks to the surrogate include the medical risks associated with artificial insemination, IVF, pregnancy, and childbirth.²²⁴ Because gestational surrogacy arrangements do not use the surrogate’s oocyte, the risks associated with artificial insemination are not relevant.

Today, with gestational surrogacy arrangements, the physical risks to a surrogate include the potential side effects from taking medications to prepare her body to accept embryo implantation and to maintain the pregnancy during the first trimester. Although the “best” embryos are selected for implantation,²²⁵ a pregnancy may not be achieved with the first embryo implantation procedure, and the surrogate may be asked to take another cycle of medications for subsequent implantation(s). Hormones are needed to suspend the surrogate’s menstrual cycle and to support the pregnancy before the placenta has formed. The most common drugs used include gonadotropin releasing hormone agonist, estrogen, and progesterone. The risks associated with hormones vary depending on the dosage and duration of use.²²⁶ The repeated exposure to hormones and other medications may increase the surrogate’s risk of short-term side effects and long-term incidence of diseases such as breast and gynecologic cancers.²²⁷ Meta-analysis studies

on women who have utilized fertility-related hormones for IVF/ART have shown that there have been no evidence to suggest an increased risk of cancers, although most researchers suggest that further surveillance should be performed.²²⁸

After becoming pregnant, a surrogate faces the typical risks associated with pregnancy and birth.²²⁹ Many of these risks are directly related to the age and overall health of the surrogate. Women over 35 face greater risks for complications in pregnancy. As with any pregnancy, a woman may experience serious complications such as preeclampsia, gestational diabetes, preterm delivery, placenta previa, anemia, and maternal death.²³⁰ These women are at risk for miscarriage and prolonged hospitalization.²³¹ Pregnancy and childbirth complications may be mitigated if only women who are healthy and under a certain age are permitted to become surrogates.

Pregnancy- and birth-related risks also vary depending on the number of embryos implanted. Multiple gestations increase the likelihood of developing the serious medical and obstetric complications listed above. Compared with single pregnancies, multiple gestations have an increased risk of spontaneous abortion, excessive bleeding, caesarean delivery,²³² placental abnormalities and premature delivery.²³³ These complications may be avoided by implanting only the appropriate number of embryos into the surrogate's uterus.

In several published studies, obstetric outcomes for surrogate mothers indicate that the main complications of pregnancy for surrogates include hypertensive disorders (i.e., high blood pressure), placenta previa (placenta attaches close to the cervix), placenta abruption (placenta detaches from uterine wall too early). It is estimated that five to ten percent of pregnancies in the United States are complicated by hypertensive disorders.²³⁴ A meta-analysis study of obstetric complications of gestational surrogates stated that 3.2 to 10% of subjects reported a hypertensive disorder while pregnant with one fetus,²³⁵ which falls within the norms. It is estimated that placenta previa occurs in approximately 1 in 200 pregnancies with the incidence increasing each year, as a result of the increased number of caesarean deliveries and advanced maternal age with ART.²³⁶ In the same meta-analysis study of gestational surrogates, placenta complications occurred between 1.1 and 4.9% of singleton pregnancies.²³⁷ In addition, the study concluded that the rates of hypertensive disorders and placental complications were similar to those in women who undergo IVF.²³⁸

2. Psychological Risks to the Surrogate

When the surrogacy report was issued by the Task Force in 1988, little information regarding the psychological risks of surrogacy on surrogates was available. Today, a growing body of formal research and first-person accounts from surrogates inform this topic today.

a. Relinquishment of the Child Born Through Surrogacy

As described in the 1988 report, the greatest psychological risk faced by a surrogate is the harm from “relinquishing the infant at birth.”²³⁹ At the time, the only available research on relinquishment of a child was limited to adoption. The 1988 report described that women who give up their child for adoption experience “guilt, depression, marital problems and sexual

dysfunction” and this experience remains an “issue of conflict and intrapersonal difficulty for years after the adoption.”²⁴⁰ In addition, the report relied on a few available studies of *potential* surrogates²⁴¹ who had not yet given birth to a child born through surrogacy and on studies that examined the relinquishment of a first child for adoption by female psychiatric out-patients and parents who surrendered their children for adoption.²⁴²

Applying conclusions about relinquishing a child in the adoption context to the surrogacy context is problematic. There is an assumption that surrogates, like birth mothers in adoption cases, will experience feelings of regret and loss after relinquishing a child. However, a birth mother relinquishing a child in an adoption scenario may experience dramatically different circumstances and emotions from that of a surrogate who is relinquishing a child that was intentionally conceived for another couple, that is not genetically related to her, and that she never intended to raise. Surrogates enter into a “contractual agreement with the intent to become pregnant and relinquish the resulting child, while birth mothers [in an adoption scenario need to contemplate relinquishing a child] under the pressures of an existent confirmed pregnancy.”²⁴³ Furthermore, surrogates can exert “more control over their decision and its personal and social repercussions” than birth mothers contemplating adoption.²⁴⁴

Research specifically analyzing the emotional well-being of surrogates after childbirth and at the time they give the baby to the intended parents is now available. Fourteen (14) studies that examined the experiences of surrogates in the United States, United Kingdom, and France have been published.²⁴⁵ Many longitudinal studies on surrogates relinquishing the children born through surrogacy indicate that surrogates do not experience long-term psychological distress or trauma from relinquishing the child.²⁴⁶ For example, a study of 15 surrogates reported that they all relinquished the baby.²⁴⁷ In another study of 34 surrogates one year after childbirth, all the surrogates stated that they had “no doubts or difficulties” at the moment of relinquishing the child.²⁴⁸ Immediately following the relinquishment of the child to the intended parents, 22% of the surrogates expressed had no difficulties, 32% had some difficulty and 3% had moderate difficulties.²⁴⁹ With regard to the surrogates who expressed having some difficulties, the study stated that these feelings were “not severe, tended to be short-lived, and to dissipate with time.”²⁵⁰ Furthermore, one year after the child’s birth, none of the surrogates reported feeling “the child was like their own.”²⁵¹

The same researchers conducted a follow-up study with 20 of the same surrogates ten years later and the data reinforced their earlier findings that the majority of these surrogates did not experience psychological problems.²⁵² The surrogates self-reported as having a “positive well-being as demonstrated by their high self-esteem, their lack of signs of depression and their good or above average relationship quality with their husbands/partners.”²⁵³

There have also been several studies examining the surrogate’s emotional attachment to the fetus while pregnant that indicate surrogates are less attached to the fetus than women who are pregnant with a child they plan to raise.²⁵⁴ Surrogates report detachment from the fetus early in the pregnancy, and this detachment is maintained throughout the pregnancy. A study of 61 surrogates found that while pregnant, surrogates were emotionally detached toward the fetus.²⁵⁵ This detachment may be intentional so the surrogate avoids any emotional connection with the

fetus, avoids attachment to the baby following delivery, or minimizes any potential feelings of loss at the child's relinquishment.²⁵⁶

Many of the follow-up studies with surrogates inquire about the surrogate's relationship to the child born through surrogacy as a proxy for how she feels about the child and whether she has an emotional connection to the child even after relinquishment.²⁵⁷ For example, a follow-up study of 20 surrogates ten years after their surrogacy arrangements indicates that the surrogates' feelings toward the children born through surrogacy remained stable/similar to the feelings they expressed one year after the child's birth.²⁵⁸ The majority of surrogates who reported no special bond continued to assert that there was no special bond ten years later, and those who reported a special bond reiterated the same at ten years.²⁵⁹ However, the "special bond" was not the deep emotional connection typical between a mother and child.²⁶⁰

Furthermore, first-person accounts from online forums support the theory that the surrogates do not develop an emotional connection to the child, which facilitates their relinquishment of the child. One study on such a forum, Surrogate Mothers Online (SMO), revealed that surrogates "emphasize that the child is not theirs and they are not bonded with it."²⁶¹ In addition, surrogates on the forum "insist that the child always belongs to the IPs" (intended parents) and not to the surrogate.²⁶² A common theme in surrogates' comments is: "I cannot give up what was never intended to be mine in the first place."²⁶³

Finally, numerous best practice guidelines issued by medical, psychological, and legal professional associations recommend that one of the requirements a potential surrogate must meet is that she must previously have been pregnant and given birth.²⁶⁴ Because pregnancy and childbirth are unique experiences that must be experienced first-hand, women who have had children can manage a surrogacy pregnancy. This requirement provides an element of protection that safeguards against women who have never experienced pregnancy and childbirth from emotionally bonding with the fetus.

b. Relationship with the Intended Parents

Research on surrogates has indicated that surrogates most often do not bond with the fetus, but rather with the intended parents.²⁶⁵ In addition, surrogates' opinion of their surrogacy arrangement is significantly influenced by the relationship they have with the intended parents. The relationship between surrogates and intended parents is a delicate one, but one that can be mutually rewarding. Many surrogates describe their intended parents as "the perfect couple" or state that it was "love at first sight,"²⁶⁶ and "we bond more with the couples than [sic] the babies!!"²⁶⁷ Another surrogate stated, "Most people think you will have trouble giving up the baby ... but the baby isn't mine from the beginning so that was nothing. But my intended parents were mine ... and I was theirs also."²⁶⁸

Follow-up studies on surrogates often inquire about the surrogate's satisfaction with the level of contact/intimacy with the intended parents during and after the surrogacy arrangement. A study of 34 surrogates one year after the conclusion of the surrogacy arrangement, indicated most of the surrogates reported a harmonious relationship with the intended parents during the pregnancy.²⁶⁹ In addition, another study of 34 surrogates seven years after the conclusion of the

surrogacy arrangement indicated that surrogates had more frequent contact with the intended mothers than the children born through surrogacy. This finding suggests that a positive relationship between surrogates and intended mothers is essential to successful surrogacy experiences as surrogates bond with intended parents more rather than the children born through surrogacy.²⁷⁰

Furthermore, other long-term studies of surrogates provide additional data confirming that surrogates develop relationships with intended parents. In one such study involving twenty (20) surrogates that was conducted ten (10) years after their surrogacy experiences concluded, fifteen (15) were still in contact with the intended parents (mother or father), and fourteen (14) reported having a positive relationship; only one reported having no relationship with the intended parents.²⁷¹ Interestingly, many surrogates stated that their relationship with the intended parents changed over time, and the change was for the positive.²⁷²

Surrogates were accepting of their evolving relationship with the intended parents and indicated that the changes were beneficial for both parties. The researchers concluded that the frequency of contact between the intended parents and the surrogate after the surrogacy arrangement concluded did not affect the relationship between the two parties.²⁷³ Satisfaction with the quality of the surrogacy arrangement did, however, appear to be significantly influenced by the surrogate's experience and interaction with the intended parents during her surrogate pregnancy. Long-term contact between the surrogate and intended parents may simply reflect the previously established relationship. Thus, a surrogate's long-term satisfaction with intended parents was often contingent upon whether her expectations regarding her relationship with the intended parents and the child born through surrogacy were met.²⁷⁴

There is a risk that the emotional bond between the surrogate and intended parents can decline during the pregnancy and especially after the birth of the child born through surrogacy. A surrogate's dissatisfaction with the arrangement is often expressed when the expectations she had for the intended parents are not met. Often, when the surrogate and the intended parents have different expectations regarding the level of emotional intimacy and communication during – and after – the surrogacy arrangement, conflict and distress may occur. Surrogates perceive themselves as “doing a good thing for someone else,” and positive feedback from the intended parents is important to maintain this perspective.²⁷⁵ If the level and degree of contact from the intended parents do not meet the surrogate's expectations, negative feelings may develop.²⁷⁶ In a poor surrogate-intended parent relationship, there is a risk that communication between the parties breaks down, and the surrogate may perceive the intended parents as “bad” people.²⁷⁷

Typically, any decline in emotional intimacy between the surrogate and intended parents occurs soon after the birth of the child born through surrogacy. The reduction/absence of communication from the intended parents may be emotionally difficult for the surrogate, and she may feel an intense loss with the decline in communication and interaction with the intended parents. “I can feel our relationship changing. The calls are less often and shorter. The distance has begun,” one surrogate reported.²⁷⁸ Many surrogates experience a sense of loss, not for the baby but for the regular interaction with the intended parents. For example, statement such as: “I bonded more with my IPs [intended parents] ... I miss my IPs ... the baby ... is NOT the loss

that I grieved,” are common statements.²⁷⁹ Some surrogates hope their intended parents have an “honest desire to be close ‘friends forever.’”²⁸⁰

To ensure a successful surrogacy arrangement and for a satisfying surrogacy experience, there must be a positive relationship between the surrogate and intended parents. Expectations about any ongoing relationship after the birth of the child should be discussed prior to ensure a good match.

c. General Psychological Well-Being of Surrogates

Several follow-up studies of the psychological health of surrogates examine the general psychological well-being of surrogates.²⁸¹ One study of 11 surrogates found that these women surrogates did not have psychological disorders and fulfilled their own emotional needs by acting as a surrogate.²⁸² Furthermore, research with surrogates ten (10) years after the conclusion of their surrogacy arrangement indicates normal self-esteem and no signs of depression.²⁸³ Another study concluded that most surrogates showed no psychological health problems years after the completion of their surrogacy arrangement which adds additional support to the theory that surrogates are psychologically resilient.²⁸⁴

d. Additional Psychological Risks to the Surrogate

Additional psychological risks to the surrogate not covered in the 1988 report may include the following.

First, a surrogate may encounter social disapproval of her decision to be a surrogate. Surrogacy is controversial, and while some surrogates may receive support, others may encounter explicit or implicit disapproval from family, friends, co-workers and others. Only women who are confident in their decision to become a surrogate should pursue surrogacy.

Second, medical screening of the surrogate may uncover unknown or undiagnosed medical or genetic condition, causing stress for the surrogate. Although submitting to medical screenings may be stressful, the likelihood that something new about their health is discovered is unlikely because surrogates have already been screened during previous pregnancies and must be in good physical health prior to becoming a surrogate.

Third, the surrogate may experience undue pressure and discomfort from the intended parents about her lifestyle and behaviors while pregnant, including directives regarding food choices, exercise habits, traveling, and her work and home environments.²⁸⁵ The intended parents may make demands on the surrogate that appear or may be unreasonable or controlling as the intended parents want to ensure that their child is in the healthiest environment possible. Because surrogacy agreements often address lifestyle and behavior limitations, the surrogate should carefully negotiate this aspect of the agreement to ensure that the conditions are acceptable.

Fourth, if detailed discussions regarding the “what-if” scenarios are not conducted prior to the embryo implantation, there may be conflict over medical decisions involving the fetus if the surrogate and the intended parents do not agree on a course of action. Expectations regarding

genetic testing and screening, birth defects, fetal reduction, and abortion should be discussed and set forth in the surrogacy agreement to help ensure that all parties will have the same understanding and share the same beliefs so that medical decisions are unanimous.

Finally, like many women who give birth, a surrogate may experience post-partum depression, especially if she experienced post-partum depression with a previous birth.²⁸⁶ While no two pregnancies are alike, screening surrogates for post-partum depression and informing them of the increased risks of depression may help reduce these risks.²⁸⁷ In addition, surrogacy agreements that provide for appropriate mental health care can help mitigate harms.

3. Financial and Legal Risks

Surrogacy arrangements may entail financial and legal risks to the surrogate. These include the risk of economic exploitation and financial liability if there is a lack of clarity in the surrogacy agreement regarding a breach of the agreement. In addition, a surrogate may risk becoming the legal parent of the child born through surrogacy.

Surrogates are not likely to have the same socio-economic status as intended parents who are able to afford the costs of surrogacy. This economic inequality may give the intended parents an advantage in any dispute because the surrogate may not have the resources to challenge them. As a result, intended parents could exert undue pressure on a surrogate without consequence. Furthermore, a surrogate may face financial liability, depending on the penalties for breach of a surrogacy agreement. For example, she may risk a financial penalty for engaging in a lifestyle activity prohibited by the agreement. In addition, if the surrogate does not relinquish the child, the intended parents could sue the surrogate to recover expenses incurred by the intended parents. In all the above examples, the use of an independent counsel for the surrogate, whose fees would be paid for by the intended parents, may help protect the surrogate from exploitation. Her own independent counsel would represent her interests and review the terms regarding breach of the agreement to ensure they are fair to the surrogate.

Finally, a surrogate may be forced to assume custody of and financial liability for a child born through surrogacy if the intended parents reject an unhealthy or disabled child.²⁸⁸ However, recent court cases, such as *Baby S.*, have affirmed that the intended mother of a surrogacy agreement is the legal mother of a child born through surrogacy.²⁸⁹ It is the intended parents who have a purposeful intention to have and raise a child. A surrogate, however, enters into a surrogacy arrangement for other reasons such as to experience the joys of pregnancy and childbirth, not to have and raise a child born through surrogacy. To ensure that the surrogate is not legally or financially responsible for the child born through surrogacy, best practices recommendations mandate that the intended parents must assume the parental rights, custody and financial responsibilities for the child born through surrogacy without exception.

4. Risks to the Surrogate's Partner/Spouse and Children

A surrogacy pregnancy will impact a surrogate's relationship with her spouse/partner and make demands on her family. Ideally, the spouse/partner will provide emotional support and manage any practical day-to-day duties that the surrogate cannot perform because of her

pregnancy.²⁹⁰ Research indicates support by a partner is important for a surrogate to enter into a surrogacy arrangement.²⁹¹ As one surrogate stated, “The love of surrogacy is temporary, the love of a partner should be forever.”²⁹² Surrogates on SMO advise potential surrogates that they should not enter a surrogacy arrangement unless their spouse/partner is completely supportive and “completely on board.”²⁹³ Surrogates who had concluded their surrogacy arrangement 10 years earlier reported having “good or above average relationship quality with their husbands/partners.”²⁹⁴

Most surrogates are often raising their own children when they enter a surrogacy arrangement and the well-being of their children may be at risk. As stated in the Task Force’s 1988 surrogacy report, there are concerns that the surrogate’s children’s sense of stability and emotional well-being could be negatively affected when the child born through surrogacy is relinquished to the intended parents. A surrogate’s child may fear losing a sibling or of being given away him or herself.²⁹⁵ However, available research on children of surrogates shows these fears are unfounded. One study examining the impact of surrogacy on the surrogate’s own children revealed that these children did not “experience negative psychological health” and did not exhibit moderate or major difficulties regarding handing over the child born through surrogacy to the intended parents.²⁹⁶ The surrogate’s children were not psychologically or emotionally harmed by surrogacy, and that children have a great capacity for understanding the nature of the surrogacy relationship.²⁹⁷

Furthermore, research indicated s that surrogates’ children are psychologically well adjusted and maintained a positive relationship with their mothers. For example, one study of 36 children, ages 12 through 25, of women who had been surrogates five to 15 years earlier,²⁹⁸ assessed family function and psychological health, and concluded that these children of surrogates suffer no ill effects as a result of the surrogacy. Most children (86%) held a positive view of their mother’s involvement in surrogacy, and the remaining 14% reported neutral or ambivalent feelings.²⁹⁹ Those who expressed positive views noted that they were proud of their mothers for helping a couple in need. For example, one gestational surrogate’s child stated, “I think it’s a really like nice thing to do for someone, obviously if they can’t have children and they really want a child that’s a bad thing, so if someone else is able to do that for you and help you through it then it’s something that’s compassionate really.”³⁰⁰ Almost half (47%) of the surrogates’ children were in contact with the child born through surrogacy, and all reported a good relationship with the child.³⁰¹ Eighty-nine percent of surrogates’ children also reported a positive view of their own family life and all of the children reported enjoying spending time with their mother.³⁰²

Beyond the typical disruption to daily life that a pregnancy will cause, it is beneficial when all members of a surrogate’s family, i.e., her spouse/partner and her children, are involved (to the extent appropriate) in a surrogacy arrangement. Because a surrogacy arrangement may entail emotional and practical demands on the family, the involvement by the surrogate’s spouse/partner in the decision and consent to a surrogacy arrangement improves the surrogate’s experience.³⁰³ Furthermore, surrogates have reported that informing and educating their own children in an age-appropriate manner about the surrogacy arrangement, with special emphasis that the baby is for another couple, can help reduce their children’s confusion or fears about the surrogacy process.³⁰⁴

5. Benefits of Surrogacy to the Surrogate

Surrogates offer several reasons for their choice to participate in surrogacy arrangements. First, surrogates state they are primarily motivated by empathy and altruism.³⁰⁵ They are moved by the intended parents' desire for a child and sympathize with their fertility struggles. Surrogates emphasize the altruistic nature of surrogacy and their desire to "make people's dreams come true."³⁰⁶ Providing a child for intended parents who would be otherwise unable to have a genetically related child is cited as a significant accomplishment by surrogates, is a source of pride, and increases their feelings of self-worth and confidence.³⁰⁷

Second, surrogates often perceived financial compensation as a supplemental benefit. Although women may be motivated to become surrogates for altruistic reasons, they consider financial remuneration as compensation for their work.³⁰⁸ Surrogates recognize that pregnancy and childbirth entail significant time, discomfort, and expense and that they should be compensated for their efforts. Interestingly, data indicate that some surrogates who bond with the intended parents often accept lower than average amounts, which indicates the financial remuneration is secondary to the altruistic motivation to help intended parents.³⁰⁹ For example, comments such as, "It is so hard for me to ask a person who I truly love and care about to pay me anything to carry her baby. It honestly breaks my heart. I have to charge the fee not for me but for my family ... if it were up to me I would say no fee, nothing" are common on online surrogacy forums.³¹⁰ Surrogates acknowledge that one does not become a surrogate to "get rich" or "make a few bucks" but instead surrogacy is "done with every ounce of your heart, soul and life."³¹¹ The compensation is valued because these additional funds are often used as a substitute for income no longer earned from outside employment. This income permits these women to stay at home and care for their own children.³¹² For others, funds are used for their own children or home improvement projects, which serve to provide opportunities and security for the surrogate's family.³¹³

Third, many surrogates enjoy being pregnant and wish to experience pregnancy without the responsibility of raising another child. Many surrogates have a history of easy pregnancies and childbirths and see surrogacy as a way to relive such positive experiences. Surrogates perceive their reproductive abilities as positive aspects of their identity and do not see themselves reduced to "wombs for rent" or machines, but as nurturing caretakers for a woman unable to have a child herself.³¹⁴

B. Potential Risks and Benefits to the Intended Parents

Although the Task Force's 1988 report did not discuss potential risks and benefits to intended parents who pursue surrogacy, there are physical, psychological, and other risks involved. The primary benefit of surrogacy to intended parents is having a genetically related infant.

1. Physical Risks to the Intended Parents

Physical risks of surrogacy are limited to intended/genetic mother who must take hormone enhancing medications and subsequently undergo a procedure to retrieve her eggs for IVF.³¹⁵ The hormone medications used to stimulate the ovaries and mature as many eggs as possible can cause a variety of minor short-term side effects.³¹⁶ Long-term side effects may include ovarian hyper-stimulation syndrome (OHSS), which can cause swelling of the ovaries, abdominal pain and nausea.³¹⁷ Hormonal stimulation may also pose long-term health risks, some of which are not fully known at this time.³¹⁸ In addition, the egg retrieval procedure entails some risks, such as internal bleeding if the retrieval process is not performed correctly, or complications with general anesthesia, if used.³¹⁹

2. Psychological Risks to the Intended Parents

Intended parents are vulnerable to several psychological risks when pursuing surrogacy.

a. Relationship with the Surrogate

Finding the right surrogate can be a stressful process for the intended parents. This is especially true in New York, where intended parents must find an altruistic surrogate or a surrogate outside of the state.³²⁰ The importance of ensuring that the surrogate and intended parents have the same expectations regarding the nature of their relationship and what is expected from each party is essential to a successful surrogacy arrangement. In a successful surrogacy arrangement, the intended parents and surrogate will share the same values, beliefs, and have the same understanding for the course of action for “what-if” scenarios. Many disputes that arise can be avoided by matching a surrogate with intended parents who hold the same views. For example, intended parents who are open to the possibility of selective reduction of multiples are best matched with a surrogate who would be willing to undergo this procedure if necessary.

Another source of potential stress for the intended parents is balancing the desire to have a genetically related child with the health of the surrogate. Intended parents may recognize the surrogate’s legal right to make medical decisions regarding her body and that of the fetus; however, once a surrogate becomes pregnant, it may be difficult for intended parents to adhere to this belief in practice. Ideally, the intended parents and surrogate will have the “what-if” discussions before the pregnancy has occurred and agree on courses of action. While surrogacy agreements often highlight this non-negotiable provision, the reality of prioritizing the health of the surrogate over the fetus may cause intense emotional conflict for the intended parents.

b. Uncertainty of Parental Rights

The intended parents may experience additional psychological risks if the surrogacy arrangement is conducted in a state in which surrogacy agreements are not enforceable (as in New York). There is always a possibility that the surrogate will refuse the terms of the surrogacy agreement and attempt to keep the child, a potentially devastating situation to the intended parents. Furthermore, in states where surrogacy agreements are unenforceable, the intended

parents have less recourse to seek custody of the child born through surrogacy. Finally, because there is not a consistent legal pathway to grant parental rights for the (genetic) intended mother in New York, granting parental rights can be stressful.

3. Financial Risks

Surrogacy involves considerable financial risks. Many intended parents turn to surrogacy after they have already spent considerable sums of money on IVF treatments, and the additional costs of surrogacy may be difficult to manage financially. The financial costs of gestational surrogacy may range from \$30,000 and \$120,000,³²¹ while the average costs are usually between \$60,000 and \$80,000, excluding the cost of IVF.^{322, 323} The cost of surrogacy may increase depending on the situation, such as whether a donor egg or sperm is needed, the number of embryo implantation attempts, the number of fetuses gestated, complications during the pregnancy, and whether the surrogate needs a separate health insurance policy to cover the surrogacy pregnancy.³²⁴ Some intended parents resort to loans and mortgages to finance surrogacy, which may strain the intended parents' finances and relationship.³²⁵

4. Benefits of Surrogacy to the Intended Parents

The most significant benefit of surrogacy for intended parents is that they will have a child and the child may be genetically related to one or both intended parents. For many intended parents, the desire to have a newborn outweighs any potential disadvantages associated with surrogacy.

C. Potential Risks and Benefits to the Child Born through Surrogacy

There are various psychological and other risks to children born through surrogacy. The primary benefit of surrogacy to these children is being welcomed into families with great joy and love.

1. Psychological Risks to a Child Born through Surrogacy

In the 1988 report, the Task Force expressed concern that surrogacy could be psychologically harmful to a child born through surrogacy. Because there were no data on children born through surrogacy at the time, it was prudent for the Task Force to conclude that a child would be harmed from knowing that his/her gestational mother relinquished the child at birth. In addition, the Task Force stated it was problematic to deliberately have a child born through surrogacy in a fractured family because, "Once parenthood is fragmented among persons who are strangers to one another, there is no basis to reconstruct the family unit" which would lead to instability in the child's life.³²⁶

Since the 1988 report, research is now available that examines the psychological well-being of children born through surrogacy. Research has focused on the quality of parent-child relationships, the psychological development and temperament of the children, and the parents' psychological well-being. These variables served as proxies for examining whether the children born through surrogacy experience psychological issues and whether they live in an unstable

environment. Importantly, there are no formal, peer-reviewed research publications that conclude that children born through surrogacy have adverse psychological harms.

The Centre for Family Research (CFR) in the United Kingdom examined 10 years of longitudinal data collected from a cohort of children born through surrogacy, their intended parents, and their surrogates, when the children reached one, two, three, seven, and ten years of age.

In the study when the children were one-year old, researchers were primarily interested in comparing families who had used surrogacy arrangements and “natural-conception” families.³²⁷ The researchers examined the parents’ psychological well-being, the quality of parent-child relationships, and the temperament of the children, and found that parents of children born through surrogacy fared better than the parents whose children were born without ART on nearly all measures tested. Parents of children born through surrogacy had lower levels of stress associated with parenting, and more warmth and attachment behavior toward their infant and greater enjoyment of parenthood. The study revealed that families who used surrogacy reported a more positive family experience than natural conception families. For the infants, there was no difference in temperament based on family type.³²⁸

Follow-up studies with these children at ages two³²⁹ and three³³⁰ reported positive outcomes for families with children born through surrogacy. The families were questioned about the parents’ psychological well-being, the quality of parent-child relationships, and the psychological development of the child at ages two and three. The results revealed that mothers of children born through surrogacy reported more positive parent-child relationships than other mothers and there were no differences in psychological well-being of mothers, fathers, or the children in any of the family types.³³¹

At ages seven³³² and ten,³³³ the research focused on the mother-child relationship/quality of parenting and the child’s psychological adjustment. At age seven, the researchers identified that the mother-child relationship experienced by parents of children born through surrogacy was similar to parents of children conceived without ART in terms of maternal positivity and maternal negativity.³³⁴ However, mother-child interaction of families who used surrogacy were lower than families who did not use ART, and it is suggested that one reason for this difference may be that for some families who had used surrogacy, there is an absence of a genetic link between the mother and the child (i.e., the gestational surrogate is also the genetic mother). This finding is similar to the experiences of families with adopted children, which implies that the absence of a genetic link may be associated with a less positive mother-child interaction.³³⁵ Finally, the psychological adjustments of children born through surrogacy were within the normal ranges for children from other family types.³³⁶

At age ten, there were no differences in the quality of parenting between families who engaged in surrogacy and other family types.³³⁷ However, although the psychological adjustment scores for children born through surrogacy were within the normal range for the United Kingdom’s population mean, the children born through surrogacy experienced higher levels of adjustment problems at age seven.³³⁸ Children born through surrogacy who were aware of the circumstances of their conception and birth and whose mothers had experienced emotional

difficulties when the child was three were more likely to have adjustment problems at age seven.³³⁹ The authors suggest that these adjustment issues mirror those faced by children who are adopted and that adopted children's behavior issues generally decrease by adolescence. Similarly, the children born through surrogacy by age ten also experienced a reduction in behavior problems, similar to that of children who were adopted by age ten.³⁴⁰

Additional research by CFR examined the experience of families who used surrogacy over a ten year period.³⁴¹ The study provided insight into how children born through surrogacy feel about the circumstances of their conception and birth based on interviews with these children at ages seven and ten. At ages seven and ten, most parents disclosed to the children information about their surrogacy arrangement, 88% and 91%, respectively.³⁴² By age seven, 77% of children who were aware of their surrogacy arrangement had at least some understanding of surrogacy; by age ten, 90% had at least some understanding of surrogacy. At age ten, 24% of the children felt positive and 67% felt neutral about being born through surrogacy.³⁴³ In addition, 93% of these children had positive feelings toward the surrogate; 7% were ambivalent; and none had negative feelings toward the surrogate.³⁴⁴

2. Other Risks to the Children Born through Surrogacy

In many surrogacy arrangements today, the embryo is created from the gametes of both the intended parents, but some intended parents may choose to use an anonymous donor to contribute the sperm, egg, or both, to create the embryo.³⁴⁵ Where a donor gamete is used, there are concerns that the children born from such an arrangement may suffer from psychological issues stemming from not knowing their genetic parent(s). Furthermore, use of donor gametes creates a small possibility that these children could engage in accidental consanguinity. However, intended parents will likely be acutely aware of the potential danger of accidental consanguinity and will take necessary precautions to prevent it from occurring. While New York does not have laws or regulations on how anonymous gamete and embryo donations should address consanguinity, the Task Force's 1998 ART report issued several recommendations on this issue.³⁴⁶

3. Benefits of Surrogacy to the Children Born through Surrogacy

It is difficult to assess the benefits of surrogacy to children born through surrogacy because without the process they would never have been born. The best, albeit imperfect, way to determine if there is a benefit for these children is to compare them to children born through other means. Children born through surrogacy are welcomed into families with great joy and love. For many of these parents, the great difficulties they encountered on their journeys to become parents, made them more thankful and appreciative of the children they ultimately had who were born through surrogacy.³⁴⁷ They are dedicated and committed to these children.³⁴⁸ Some parents of children born through surrogacy have indicated high levels of joy and pleasure with their children because of the hardships they endured to have them, as compared to parents who were able to conceive children without ART.³⁴⁹ Overall, children born through surrogacy feel secure about themselves³⁵⁰ and their families, and are in loving families because of their parents' devotion to them.³⁵¹

VIII. Religious Perspectives on Gestational Surrogacy

The Task Force reviewed religious perspectives on gestational surrogacy as part of its deliberations. Understanding the varied beliefs about gestational surrogacy from the many religious traditions of New York was integral for thoughtful debate and consideration. In addition, discussing the religious perspectives on challenging issues, such as gestational surrogacy, is an important defining aspect of reports by the Task Force. The most prevalent religions in New York State are Christianity, Judaism, Islam, Buddhism and Hinduism.³⁵² These religions have a wide range of perspectives on surrogacy, from prohibition to acceptance. As discussed in subsequent sections of the report, these different perspectives informed the Task Force's deliberations and reflected the lack of consensus among members.

The Roman Catholic Church explicitly opposes assisted reproductive technologies that “add a ‘third party’ into the act of conception, or which substitute a laboratory procedure for intercourse,”³⁵³ and therefore opposes both traditional and gestational surrogacy.³⁵⁴ Ideally, a child should be conceived by way of sexual intercourse between a married man and woman. The church states that a child born through surrogacy using laboratory techniques such as IVF is disrespectful to the integrity of the child. A child from surrogacy is the result of an act of technology rather than the “natural fruit of a human act in which there is a full and total giving of the [married] couple.”³⁵⁵

In its formal doctrines, the Catholic Church addresses surrogacy and states, “Surrogate motherhood represents an objective failure to meet the obligations of maternal love, of conjugal fidelity and of responsible motherhood; it offends the dignity and the right of the child to be conceived, carried in the womb, brought into the world and brought up by his own parents; it sets up, to the detriment of families, a division between the physical, psychological and moral elements which constitute those families.”³⁵⁶ Thus, a surrogacy arrangement is “contrary to the unity of marriage and to the dignity of the procreation of the human person.”³⁵⁷

Protestant traditions have varying views on gestational surrogacy. Conservative Protestant religions, such as the Southern Baptist Convention, closely align with the Roman Catholic perspective that surrogacy should not be permitted.³⁵⁸ Other Protestant denominations are more accepting of surrogacy and do not have formal position statements on surrogacy, but recommend that those using ART and surrogacy seek professional and pastoral counsel.³⁵⁹

The Greek Orthodox Church does not endorse ART but may accept it provided no surplus embryos are created. With regards to surrogacy, “The Church has difficulty in giving Her blessing to such a deviation from the natural pregnancy procedure.”³⁶⁰ Other Christian denominations such as Jehovah's Witnesses do not permit surrogacy,³⁶¹ while the Church of Jesus Christ of Latter-day Saints (Mormons) “strongly discourages” the practice.³⁶²

Within Judaism, the Reform, Orthodox and Conservative movements have different perspectives on surrogacy and ART. In addition, opinions may vary among religious scholars within and between these branches regarding the permissibility of surrogacy, although most find gestational surrogacy permissible.³⁶³ In general, ART is permitted, based upon the idea that to “be fruitful and multiply” is an obligation.³⁶⁴ Much Jewish commentary focuses on whether

surrogacy is a form of adultery, the marital status of the surrogate, and the religion of the ovum provider, as it can play a role in whether the child is Jewish.³⁶⁵

Islamic views on surrogacy differ between the Sunni and Shia branches (90% of Muslims are from the Sunni branch).³⁶⁶ In Sunni teachings, IVF is permitted for married couples in specific circumstances, but surrogacy is forbidden.³⁶⁷ Because surrogacy uses sperm from a man who is not the surrogate's husband,³⁶⁸ it violates the Qur'an, which states that spouses should "guard their private parts except from their spouses."

Shia teachings are similar with regard to IVF, but differ on surrogacy. Married couples using the husband's sperm in IVF are permitted to do so because it is viewed as a treatment for infertility.³⁶⁹ Because it is an embryo, and not sperm, that is introduced into the surrogate's uterus, no commands are violated unless the surrogate is married. If the surrogate is married, the practice may be considered infidelity. Surrogacy under Shia laws about marriage and inheritance, may create confusion about lineage.³⁷⁰ Shiite scholars liken the surrogate to a wet nurse and do not consider her to be the mother of the child. They view the surrogacy process as transferring an embryo from one uterus to another.³⁷¹ In Iran, where 90% of Muslims are Shiite, surrogacy is practiced, and while not legislated, it is permitted under religious decrees.³⁷²

Hinduism looks at surrogacy as a treatment for infertility.³⁷³ Being childless is considered a curse, and this form of "social ostracism encourages Hindus to seek any form of assisted reproductive technique as long as they are hopeful of bearing a child and fulfilling their important role of motherhood in Hindu society."³⁷⁴

Literature on Buddhist views is scarce and conflicting, and indicates that there is disagreement amongst scholars on whether surrogacy is permitted. Some Buddhists state that ART, and by extension surrogacy, may be used as "long as it does not bring pain or suffering to any parties involved"³⁷⁵ because Buddhism is concerned with relieving suffering caused by infertility.³⁷⁶ Other scholars suggest that surrogacy may be permitted in limited situations, only if children born through surrogacy are informed of the circumstances of their birth. Because the birth of a child is dependent on the child's will to be born,³⁷⁷ a person is born from his/her own choice and accord.³⁷⁸ Furthermore, a tenet of Buddhism states that an individual must "bear his own responsibilities himself."³⁷⁹ A child should be informed about the circumstances of his/her birth and be happy to have been born in order to become responsible individuals. Parents who do not inform their child about the surrogacy arrangement are denying them the opportunity to provide "reverse" informed consent to his/her birth and take responsibility for his/her life.³⁸⁰ Parents who would not want to inform a child about his/her surrogacy arrangement should not use surrogacy.³⁸¹

Other Buddhist scholars state that surrogacy should not be permitted. For example, ART, and by extension surrogacy, are thought to perpetuate a "disillusioned attachment to [the present] life which sometimes motivates human beings" reproductive desires by falsely emphasizing genetically related offspring.³⁸² In addition, surrogacy may violate the mutual equality between individuals because one individual is using "her own body as a tool for the benefit of another."³⁸³

PART II

Ethical Analysis, Deliberations, and Recommendations of the Task Force

IX. Ethical Analysis by the Task Force

The Task Force reasserts that people can have different perspectives on the values and principles of surrogacy, and on how these values can be best protected in the context of public policy on surrogacy. An analysis of the ethics of sensitive issues often results in disagreement, and there are no easy solutions. The ethical analyses and conclusions the Task Force outlined in its 1988 report were appropriate for the time. Although many of the fundamental issues remain the same, new information and a vastly different social context require a contemporary analysis.

In the 1988 surrogacy report, the Task Force identified five categories: (1) individual access to new technology; (2) interests of children; (3) individual liberty in human reproduction and attitudes about reproduction and women; (4) application of the informed consent doctrine; and (5) surrogacy's impact on society (the family unit), to provide a framework for a focused analysis of surrogacy. Today, the Task Force revisits these categories, with particular emphasis on important changes in our society and knowledge base. The Task Force concludes that if properly regulated to protect the interests of all the individuals, a surrogacy arrangement is ethically permissible.

A. New Technologies – Individual Access and Societal Intervention

In 1988, the Task Force expressed caution about the use of new technologies to assist with reproduction and debated whether the mere existence of ART necessitated its use and whether individual access to such technologies could be restricted. The Task Force concluded at the time that access to surrogacy was not a fundamental right and that government action regarding surrogacy was permissible. In addition, because there was scant research or data available that specifically addressed surrogacy, the Task Force conceded that society had “no obligation to marshal evidence of tangible harm before devising policy” and that “society can conclude that the potential or likely risks of a practice outweigh the benefits conferred without awaiting broad-scale social experimentation.”³⁸⁴

Today, the Task Force expands its analyses of new technologies by noting that the impact of surrogacy is no longer speculative and observing that surrogacy furthers important “social goods.” It fulfills individuals and couples’ interests in the formation of families by increasing equitable access to family formation to a broader segment of society. While the use of surrogacy may be limited to a small population of people, its availability to all individuals helps promote equity among all members of a community. Surrogacy can be one of several pathways for families, however constituted, to welcome a child into their familial circle. Finally, the Task Force acknowledges that there is now a growing body of research and data specifically on surrogacy. This formal, peer-reviewed research and data offer insight into what the risks, harms, and benefits are to children born through surrogacy, surrogates, intended parents and society as a whole.³⁸⁵

B. Best Interests of Children

One of the most important social judgments that speak to the norms and ethos of our society regard judgments about the emotional and physical well-being of children and the circumstances in which they are most likely to thrive and least likely to be harmed.³⁸⁶ The rights and interests of children have been expressed in state family law since as early as the 19th century. Much of the ethical analyses we apply to issues regarding children reflect an effort to determine what is in their “best interest.” This standard was the guiding principle of the Task Force’s 1988 analysis of the impact of surrogate parenting on children and once again guides our analysis here. In our earlier report, the Task Force concluded that surrogacy was not in the best interests of children because children born through surrogacy were likely to be regarded as commodities. At that time no specific or reliable data were available to assess, in practice the impact of surrogacy arrangements on the children born through surrogacy and on the surrogates’ own children. More information is now available for consideration.

Since the 1980s, two aspects of surrogacy have dramatically changed how the Task Force examined the best interests of children. First, gestational surrogacy is now the preferred and most common form of surrogacy. In gestational surrogacy where the child is genetically related to one or both intended parents, it seems illogical for the parents to “purchase” their genetically related child. Indeed, in family law, genetics plays a significant role in granting parental rights. The intended parents’ parental rights to a child are traditionally granted when a child is born to a married different-sex couple; both individuals are assumed to be genetically related to the resulting child and, therefore, both are listed as the child’s parents on the birth certificate. In surrogacy, genetics also plays an influential role. For example, many states and courts recognize the intended mother’s genetic connection to the child born through surrogacy and do not require her to adopt her own child. Instead, only an amended birth certificate is needed. If the state and courts accept that the intended parents are genetically related to the child born through surrogacy and, therefore, are the legal parents to the child, then it is incongruous to believe they can “purchase” their own child. However, even in surrogacy arrangements in which the intended parents use two sets of donor gametes and are not genetically related to the child, the gestational surrogate does not have a claim to the child because she is not genetically related to the child.

Second, a growing body of research and data on children born through surrogacy revealed that these children are not harmed by the practice.³⁸⁷ As discussed, longitudinal studies with children born through surrogacy indicate that they are psychologically as well off as children conceived without the assistance of ART.³⁸⁸ Children who are in communication with their surrogates have normal psychological development and are not confused by the surrogates’ role in their lives.³⁸⁹ Despite the different conditions of their birth, children born through surrogacy often are emotionally stable and have strong relationships with their parents because of the positive influence their parents have in their children’s lives.³⁹⁰

In addition to research on children born through surrogacy, research on the experiences of children in the surrogate’s household shows that these children do not suffer negative repercussions as a result of having a mother serve as a surrogate. Research on surrogates’ children has not shown long-term psychological effects as a result of their mothers participating in surrogacy and these children do not fear that they or a sibling will be given away. Because

surrogates describe the surrogacy arrangement to their children using age appropriate explanations and the surrogacy arrangement is an experience for the whole family, the surrogates' children understand the special role their mothers play for another family.

The Task Force recognizes that the most important aspect of a child's overall well-being does not rest solely on how they were brought into a family, but rather may be better determined by the security of the home and a positive emotional connection with their parents. Research has revealed that children born through surrogacy and other ART practices are extremely desired children and are being raised by highly committed and loving parents.³⁹¹

C. Reproductive Freedom and Attitudes about Women and Reproduction

In its 1988 report, the Task Force gave considerable attention to shielding gestation and reproduction from the flow of commerce and feared the substitution of commercial values for "the web of social, affective and moral meanings associated with human reproduction and gestation."³⁹² Although many cognizable arguments were raised to support the Task Force's concerns, little to no evidence-based research was available to assess the material likelihood of these concerns. The Task Force, therefore, was left to rely on philosophical objections to surrogacy and to stake out an overly risk adverse stance to perceived threats to the dignity of women. In hindsight, the Task Force's position was overly protective, as little damage seems to have been visited upon the dignity of women in domestic jurisdictions that have allowed commercial surrogacy arrangements. In part, this may be attributable to the robust claim to dignity that women themselves make in pursuing control over their own reproduction. For many women, reproductive freedom is wedded to the promise of human dignity, self-determination and equality. While access to health services and reproductive technology are among the most highly contested aspects of reproductive freedom, the right to make free and informed decisions regarding whether to access these resources has also come to inform notions of womanhood. A key component of reproductive freedom is the availability of options. Surrogacy is one option.

Although few women will choose to become gestational surrogates, most women value autonomy and the option to decide whether being a surrogate fits into their values, beliefs, and life choices. Research indicates surrogates are empowered by their surrogacy experiences because it provides benefits to them personally and their families.³⁹³ For example, surrogates often cite to feelings of accomplishment, pride, and confidence; positive pregnancy experiences; intimate friendships with the intended parents, and financial remuneration to invest in their own families, as motivations behind their decision to become surrogates.³⁹⁴

Little evidence of harm to women and society as a result of permitting surrogacy has been reported. The 1988 report expressed concern that surrogates would experience lasting psychological difficulties after relinquishing the child born through surrogacy to the intended parents. At the time, because no data on surrogacy were available, conclusions from adoption studies were applied to the surrogacy context. However, research and data on surrogates and their experiences of relinquishing children born through surrogacy are available and these studies reveal that overall surrogates do not experience psychological issues after relinquishing children born through surrogacy.

The Task Force was also concerned about potential exploitation of socio-economically depressed women. While surrogacy in the past occasionally engaged economically-disadvantaged women as surrogates, most surrogates today are from moderate-income families. Although the compensation associated with surrogacy is beneficial, the financial remuneration is unlikely to be an undue inducement for moderate income families because the amount provided is merely supplemental to their lives, not essential for the surrogate's survival. Furthermore, best practice guidelines on surrogacy by various medical, psychological, and legal associations recommend that low-income women be ineligible to be surrogates because these women may be compelled to be surrogates solely for financial compensation.³⁹⁵ Finally, it is unlikely that intended parents would choose a surrogate who is entirely motivated by financial remunerations because the intended parents desire a surrogate who is a committed, emotionally-engaged participant in the surrogacy arrangement.

In creating public policy, states are often charged with the task of balancing its own interests against the rights of individuals to be free from limits on their freedom. While no individual enjoys an unqualified right to be free from state action, states have a less compelling interest in the outright prohibition of practices that are ethically permissible and for which harms may be mitigated.

D. Informed Consent

Informed consent consists of information, comprehension, and voluntariness. The contractual relationship between the surrogate and the intended parents raises concerns about the balance of power and the unfettered ability of the surrogate to make an informed choice regarding her body and her own medical treatment. When the 1988 surrogacy report was issued, there was little information, research, or data on surrogacy and potential surrogates often had limited information about the potential risks and harms to them and their families. Much has changed since then, and potential surrogates now have access to significant amounts of information on surrogacy.

Data now available regarding surrogates' own experiences with surrogacy helps inform women as they weigh the risks and benefits of becoming a surrogate.³⁹⁶ Evidence of actual risks and harms can be discussed instead of those that are "potential" or "unknown." Although research has shown that risks to the surrogate are often minimal, it is helpful to know what the actual risks and harms are for the informed consent process, rather than parties having to rely on hypothetical risks and harms. In addition, research has shown that the surrogates are less likely to form an emotional bond with the fetus during the pregnancy and experience little difficulty in relinquishing the child to his/her intended parents.³⁹⁷ Surrogates often form emotional attachments with the intended parents, rather than the child born through surrogacy. In gestational surrogacy, because the surrogates are not genetically related to these children, the surrogates' understanding that these children are not "theirs" is more entrenched and clear from the beginning of the surrogacy arrangement. The most successful surrogacy arrangements are those in which surrogates and intended parents have strong emotional bonds that help foster the surrogates' goal of aiding the intended parents' dream of having a child.³⁹⁸

The amount of, and accessibility to, information about surrogacy far exceeds what was available 30 years ago. The recommendations of professional, medical, and psychological associations; legal information and best practice guidance; and first-person accounts of surrogacy experiences are widely available to anyone with internet access. Perspectives that both support and oppose the practice can help inform women as they decide whether to become surrogates.

The 1988 surrogacy report raised the concern that prior to the conception of an embryo and birth of a child, surrogates could not provide informed consent to relinquish a child born through surrogacy and also asserted that the evolving relationship between the surrogate and the fetus made such consent impossible.³⁹⁹ The Task Force rejects the idea that women are unable to make this decision for two reasons. First, it is a fundamental tenet of New York law that competent adults have the right to make decisions regarding their bodily integrity and determine the course of their lives. Women are no exception to this principle. Women now have readily available, reliable information to consider about surrogacy and its risks and benefits. Second, the Task Force is persuaded by numerous states' statutes, professional best practice guidelines, model laws, and research on surrogates indicating that surrogates can make an informed choice to relinquish children born through surrogacy prior to becoming pregnant. There is sufficient evidence that women can provide informed consent, especially if certain safeguards are met. For example, best practice guidelines and numerous laws require that the surrogate has previously been pregnant and given birth, which provides an additional source of relevant information to the potential surrogate. Have previously experienced the physical and emotional complexities associated with pregnancy and childbirth can help the potential surrogate evaluate how past experiences would affect a surrogacy arrangement and whether she is capable of relinquishing a child born through surrogacy.

E. Impact on Families and Society

The 1988 Task Force report acknowledged that while the traditional notion of the nuclear family was declining, the Task Force urged society to discourage families formed through surrogacy arrangements because the practice devalues families and fragments parenthood.⁴⁰⁰ However, the Task Force acknowledges that different perceptions of what defines a family and the various pathways families can be formed have changed dramatically and affects how surrogacy is perceived.

The Task Force affirms the notion that the family is a cornerstone of society; however, the Task Force also recognizes that modern families can be constituted in many configurations, as evidenced by the recent federal legalization of same-sex marriage. The Supreme Court's decision in *Obergefell v. Hodges* shows how far society and law have progressed with regards to the evolution of family relations. For example, one legal scholar has suggested that *Obergefell* recognizes that families are not created solely through biological procreation but also through intentional and functional parenthood.⁴⁰¹ In its decision, a legal scholar has observed that the Court grounded same-sex couples' right to marry partly in same-sex parenting.⁴⁰² Because same-sex couples have and raise children together like different-sex couples and are similarly situated with regards to parenting, the Court stated that the fundamental right to marry "appl[ies] with equal force to same-sex couples."⁴⁰³ The Court declared that a "basis for protecting the right to marry is that it safeguards children and families" and stated that same-sex couples "provide

loving and nurturing homes to their children, whether biological or adopted.”⁴⁰⁴ As a result, many states implemented mechanisms to create adoptive parent-child relationships without the formality of marriage.⁴⁰⁵ Therefore, the Court continued that many states themselves provided “powerful confirmation by the law itself that gays and lesbians can create loving, supportive families.”⁴⁰⁶

Different types of families can and do provide the foundation for a healthy society. Because society is comprised of smaller units of families and individuals, examining children born through surrogacy and their families provide a window to analyze whether these “new” normative families are negatively affected by their familial composition and structure. Research has shown that the psychological development of children born through surrogacy is within normal ranges of children not born through ART.⁴⁰⁷

Surrogacy is another option for individuals to bring children into their families. The use of technology does not devalue the concept of family; it merely provides another blueprint for how families may be formed and new protections are necessary. The use of surrogacy does not change the underlying values and function of a family – to fulfill the emotional and physical needs of its members. Children born through surrogacy and their parents practice family values of love, stability, protection, and support, and these children benefit from having families who greatly desire and cherish them.

In addition, families, however constituted, should have the opportunity to welcome children into their circle, whether through surrogacy, other ART methods, adoption, or natural conception. Surrogacy should not be perceived to be an option only for different-sex intended parents or only for LGBT intended parents or only when adoption is not available. Nor should an examination of surrogacy be taken as indicative of support of one pathway over another. All pathways to welcoming children into familial circles should be available to all intended parents so that they may determine which option best suits their families.

Furthermore, society should not treat families who utilize surrogacy or the children born from surrogacy differently from families who welcome children naturally or through adoption. In the past, children of single or divorced parents, and the parents themselves, were discriminated against and marginalized by society. Similarly, individuals in same-sex relationships were also marginalized. These past societal injustices should not be extended to families who use surrogacy arrangements or the children born through surrogacy. Regardless of how families are formed, society should support all families’ efforts to nourish and protect their children.

X. Summary of Task Force Deliberations

As the result of the 1988 surrogacy report, surrogacy agreements in New York are void and unenforceable and those who engage in compensated surrogacy arrangements are subject to civil penalties. Since the release of the report, medical, scientific, cultural, and social changes have encouraged the Task Force to revisit the ethical and legal issues regarding surrogacy. Specifically, the: (1) transition from traditional to gestational surrogacy, (2) current research and data on surrogacy, and (3) legalization of same-sex marriage in conjunction with a more inclusive social construction of the family, have persuaded the Task Force that the current law is

not in the best interest of New Yorkers. Thus, after several years of deliberation, the Task Force recommends that compensated gestational surrogacy agreements, subject to specific regulations, should be permitted and that surrogacy agreements that do not comply with the recommended protections should remain unenforceable.

Surrogacy continues to be a difficult and controversial topic. Like the general public, members of the Task Force represent a rich and diverse array of religious, philosophical, and moral traditions and values and, consequently, have a wide diversity of opinions on surrogacy. People of good will and intelligence who have the best interests of New Yorkers at heart can, and do differ, on what is the best, most prudent, and moral schema for the state with regard to surrogacy. In 1988, it was prudent for the Task Force to discourage surrogacy and recommend measures to ban commercial surrogacy. At the time, traditional surrogacy was the predominant practice; harms to surrogates and the children born through surrogacy were unknown; and the social construction of the family was strikingly narrower than the social construction is today—all of which supported the Task Force’s rationale at that time that surrogacy arrangements were dangerous for individuals and society.

A more contemporary environment compels the Task Force to reexamine surrogacy. Medical advances in ART that led to the transition from traditional to gestational surrogacy, societal perceptions about motherhood and parenthood, limited opportunities for adoption, increased use of gestational surrogacy outside of New York, legalization of same-sex marriage, passage of various states’ laws permitting gestational surrogacy, and legal uncertainties associated with altruistic surrogacy conducted in New York and its impact on children, were powerful motivators to reevaluate whether the Task Force’s conclusions from 1988 should still be applicable today.

As part of its deliberations, the Task Force reviewed medical and policy literature on surrogacy, surrogates, intended parents, and children born through surrogacy. The Task Force conducted legal research on surrogacy, reviewed model laws and guidelines from professional organizations, and analyzed case studies pertaining to surrogacy conflicts. The Task Force heard from other surrogacy stakeholders, such as psychologists, fertility specialists, surrogacy agents, ART attorneys, religious leaders, surrogacy proponents and opponents, women who have served as surrogates, and parents with children born through surrogacy. Most importantly, the Task Force engaged in extensive deliberations about the practice of surrogacy, its moral and ethical dimensions, and the implications of regulating the practice.

Upon review, the Task Force reaffirms several of its previous conclusions on surrogacy. The Task Force reaffirms that individuals do not have a fundamental right to surrogacy. In addition, the state may develop policies to regulate surrogacy and such decisions are a matter of policy. The Task Force reasserts that surrogacy has the potential to impact the lives of children and families – particularly those of the surrogates and their families, the intended parents, and the children born through surrogacy agreements – and to influence societal definitions of family. Research, particularly longitudinal research, is a valuable resource to evaluate the risks, harms, and benefits of surrogacy especially for children born through surrogacy and surrogates. The best interest standard is still the most appropriate method to evaluate how surrogacy may impact children’s emotional and physical well-being. The Task Force emphasizes the necessity of

informed consent in any endeavor that involves risks to a participant. Finally, the Task Force reaffirms that family is a cornerstone of a healthy society and that all families should be supported in their efforts to have, nourish, and protect their children.

While these fundamental aspects of the 1988 report were upheld, the Task Force diverges from its initial ethical analysis and concludes that gestational surrogacy should no longer be prohibited. Three points in particular were deeply influential on the Task Force's analyses and deliberations.

The shift from traditional to gestational surrogacy is a significant change as it pertains to perceptions of parenthood/motherhood and women's rights. The lack of a genetic relationship between the surrogate and the fetus is an important distinction. For some Task Force members, the genetic relationship between the fetus and the intended parents confirm that the resulting child is not a commodity for purchase by the intended parents as one cannot purchase what is already "theirs." Some members emphasized that it was the intent to parent, not whether there was a genetic connection to the child, which was important. Other members were persuaded by recommendations of professional, medical, and psychological associations; legal information and best practice guidance; and state statutes that specifically sanction gestational surrogacy. With regard to parental rights, most members agreed that in cases where one or both intended parents are genetically related to the children born through surrogacy, the intended parents should have parental rights. Unlike gamete donors who surrender parental rights to any children born from donor gametes, intended parents who use their gametes to create embryos for gestational surrogacy never renounce their parental rights to these children. Similarly, even in cases where the intended parents are not genetically related to the child, most members agreed that because the intended parents have deliberate intentions to parent the child, the intended parents should have parental rights. Moreover, gestational surrogates with no genetic relation to the child and who have no intention to be a parent to the child are not well positioned to receive parental rights over children born from surrogacy arrangements.

Next, the growing body of research on surrogacy, surrogates and their families, intended parents who use surrogacy arrangements, and children born through surrogacy, has revealed no significant overall negative outcomes. Because there was almost no research on surrogacy available at the time of the 1988 report, research from the adoption context was used; however, reliance on this research is less instructive because the circumstances of adoption are very different than that of surrogacy. Current research on surrogacy directly addresses many of the concerns and questions about the surrogacy experience. Many of these studies are longitudinal and ongoing so that outcomes of children born through surrogacy, surrogates, and intended parents can be tracked over the long-term. After reviewing the research, many members concluded that surrogacy could be practiced in a way that mitigates risks and harms to all parties.

Furthermore, the concept of "family" has evolved immensely over the last thirty years. There are many different family configurations and the word "family" means many things to people and family members often include those who are not genetically related. Our society has witnessed significant changes in the social construction of the family, as evidenced by groundbreaking changes in its legal definition. Many Task Force members recognized that the legalization of same-sex marriage greatly expanded the definition of family by legally

sanctioning a non-nuclear family model. Many members agreed that the overall well-being of children was more dependent upon the loving relationships within a family than the organizational structure of the family itself. Numerous members recognized that the intended parents' intention to be parents was far more important than how the family was formed.

After concluding that surrogacy is ethically permissible, the Task Force discussed surrogacy disputes. The Task Force acknowledged that disputes are inevitable. Regulations, however, can serve as a framework for parties to safeguard against disputes by imposing requirements and protections that mitigate risks for all parties and by providing clear evidence for the judiciary.

Finally, the Task Force turned its attention to policy recommendations. The Task Force could recommend prohibiting, discouraging, permitting subject to specific regulations, or promoting gestational surrogacy. The views of Task Force members ranged from those in favor of the status quo which bans compensated surrogacy to those in favor of a new framework that would permit commercial or compensated surrogacy under a tightly regulated structure. No Task Force members proposed making the current laws against surrogacy even stricter (i.e., by criminalizing surrogacy), and no members advocated the active promotion of the practice in New York. Members who do not support changing the current law assert that any attempt to permit and regulate the practice would be akin to promoting it. In their view, regulating surrogacy—despite the intent to reduce harm with regulations—would be arbitrary and ineffective (see the attached minority report). Other members support regulating surrogacy and stress that model legislation and various enacted state laws on surrogacy seemed neither arbitrary nor ineffective. Some Task Force members in favor of surrogacy regulation view the practice as a positive intervention that offers another pathway for New York families to bring children into their familial circle. Others in favor of regulating surrogacy have reservations about the practice but determine that its risks could be reduced sufficiently to bring it within the scope of conduct that should be permitted in a free society.

After several years of deliberations, the Task Force recommends that New York permit the practice of gestational surrogacy. The Task Force concludes that with proper regulation and oversight, gestational surrogacy can be practiced in an ethical manner that protects the rights and interests of all the parties. The Task Force also recommends that surrogacy agreements that do not comply with the recommended protections should remain unenforceable.

XI. Recommendations by the Task Force

The Task Force states emphatically that its support for permitting gestational surrogacy agreements is contingent upon the implementation of the protections recommended below. These protections are essential to protecting the rights and well-being of the children born through surrogacy, the surrogates, and the intended parents. After reviewing the research, the Task Force concludes that risks may be mitigated effectively with prior screening, appropriate oversight, review, and regulation of surrogacy arrangements. The Task Force agrees that the State should continue to discourage traditional surrogacy and any surrogacy arrangement/agreement that does not comply with the recommended protections. The Task Force concludes that safeguards in substantially the same form proposed are necessary for an ethically sound policy.

The Task Force engaged in extensive deliberations among its members regarding the moral dimensions and the potential risks and benefits of gestational surrogacy and the implications of regulating the practice. For each recommendation, the Task Force considered the available evidence from research literature, first-hand accounts, experts, and stakeholders. For each recommendation, the Task Force contemplated whether the requirement was necessary and sufficient to mitigate risks and protect surrogates, intended parents, and the children born through surrogacy. If there was a strong justification for the recommendation, only then did the Task Force include it as a recommended condition for a surrogacy agreement to be permitted and enforceable in New York State.

The proposed policy includes a process for establishing: (1) parental rights to intended parents; (2) requirements and restrictions on both the surrogate and intended parents; (3) regulations for attorneys, physicians, and surrogacy agencies; and (4) other additional safeguards to ensure all surrogacy arrangements are formed with full knowledge of the risks and commitment involved; and (5) state oversight of gestational surrogacy arrangements.

A. Granting Parental Rights via a Pre-Implantation Order by a Family Court

One of the key functions of a surrogacy policy is to provide a precise process for the granting of parental rights⁴⁰⁸ in the context of surrogacy births. Establishing parentage is important to secure parental rights, deter fraudulent claims of parentage,⁴⁰⁹ and prevent the abandonment of a child. It is also in the best interests of the child to have secure parental ties and to live in a stable environment not marred by protracted custody conflicts.

As discussed in Section III.E. The Legal Status of Surrogacy in New York Today, current law does not provide a statutory/regulatory process to grant parental rights to the intended parents in a legally permissible altruistic surrogacy arrangement; any process to establish such rights should also apply to commercial surrogacy. While the intended male parent of a child born through surrogacy may be listed as the father on the birth certificate, the surrogate – not the female intended parent – is listed as the mother. Even if the female intended parent is genetically related to the child, family law requires that she must adopt her child or obtain a court order to amend the original birth certificate. Both mechanisms are inconsistent, difficult, and time-consuming.

The Task Force agrees that the intended parents in a surrogacy arrangement are the legal parents once the baby is born. The Task Force considered different approaches for conferring legal recognition of parenthood to the intended parents once the child is born and recommends a different approach that offers a balance of protection and oversight to both the surrogate, the intended parents, and the child born through surrogacy.

The Task Force recommends the use of a pre-implantation order approved by a Family Court as the best method for granting parental rights in a gestational surrogacy arrangement. This approach would: (1) offer a balance of protection and oversight to both the surrogate and the intended parents, and (2) establish that the intended parents are the legal parents at the time of the child's birth and therefore avoid the adoption process.⁴¹⁰ A pre-implantation order would effectively provide stability for the child born through surrogacy and clarity of his/her parentage upon birth.

Court approval prior to implantation would give the surrogacy agreement legal standing that would be recognized by hospitals and should establish the relationship to ensure health insurance coverage for the child. At the time of the baby's birth, the order would grant the legal parental rights to the intended parents. Hospitals would know to seek consent from the intended parents for any medical procedures for the baby and to verify health insurance for the baby as a dependent of the intended parent.

The Family Court's review would ensure that all requirements for a valid surrogacy agreement have been met *before* embryo implantation. The Task Force's concern for the stability of the child's home, and clarity of its parentage upon the child's birth, is one of the most important factors in creating an ethical regulatory system for surrogacy. The Task Force has determined that review of the surrogacy agreement by a court before an embryo is implanted is an important safeguard to ensure that the interests of both the surrogate, the intended parents, and child born through surrogacy are met. Court approval helps to avoid situations where the parties are not a good match, prevents collusion or dismissal of the terms of the agreement, and reduces the potential for conflict and disputes after the surrogacy process has begun. More importantly, issuance of a pre-implantation order before an embryo is implanted ensures that a potential child is not an involuntary participant in an unethical surrogacy arrangement.

Furthermore, the Task Force does not recommend that a judge should have discretion in approving the agreement if all the conditions are met, and should be required by law to approve a surrogacy agreement that meets the conditions (i.e. they *shall* approve). As part of the review process, documents confirming that the various requirements have been met should be verified by the appropriate party (i.e., physicians, attorneys, mental health professionals, etc.) and notarized. However, in reviewing materials such as a criminal background check, the court may have some discretion in denying the validity of a surrogacy agreement.

Parental rights cannot be assigned until after the birth of a child. While a pre-implantation order would grant the intended parents a future interest in a child born through surrogacy, throughout the course of the gestation the surrogate is in control of decisions about her medical care and the care of the fetus. Future parental rights do not divest a surrogate of her right to

privacy and autonomy over her own body, nor do they confer control over decisions about the fetus (See Section XI.C. for a discussion on the contractual aspects of a surrogacy agreement regarding the surrogate's lifestyle and health choices during the pregnancy).

The Task Force recommends that the surrogate already pregnant may seek to rescind a pre-implantation order, but only in exceptional circumstances and with clear and convincing evidence. The Task Force is reluctant to permit a court to rescind such an order, but the Task Force recognizes that there may be certain rare instances in which doing so would be in the best interests of the child. For example, if an intended parent is convicted of sexual molestation of a minor after approval of the pre-implantation order, a court should weigh that as evidence to rescind the order. However, in such a situation, the intended parents should still be liable for child support. A court of competent jurisdiction would be compelled to make a custody determination based on the best interests of the child. The surrogate's objection of the relinquishing the child to the intended parents does not necessarily indicate her willingness to raise the intended child herself.

B. Compensated Traditional Surrogacy and Non-Compliant Surrogacy Agreements

The Task Force recommends that current New York surrogacy law, Domestic Relations Law (DRL) §§121-124, should not be repealed, but be amended to permit and uphold gestational surrogacy agreements (i.e., in which the surrogate has no genetic link to the child) that comply with the terms detailed below.

The Task Force recommends that New York should continue to discourage compensated traditional surrogacy arrangements in which the surrogate has a genetic relationship to the child. Although rare, these arrangements should continue to be disfavored by the state and traditional surrogacy agreements should remain unenforceable because parentage is a complicated multi-party matter.

The Task Force recommends that the statute be amended to permit and uphold gestational surrogacy agreements that comply with the protections and safeguards recommended by the Task Force. Agreements that comply with the recommendations should be permitted and be enforceable.

However, any gestational surrogacy agreements that do not include the protections enumerated in this chapter should remain unenforceable and discouraged. Agreements that do not adhere to the proposed recommendations might shield unethical practices in surrogacy. For the establishment of parental rights in gestational surrogacy agreements that do not comply with the proposed protections in this chapter, parties would be able to use all the means available under existing law to gain parental rights, which may include the adoption process. Individuals who proceed with a gestational surrogacy agreement that do not comply with the recommendations of the Task Force should not get the protections and expedited process under this policy.

C. Regulations on Parties to Surrogacy Agreements

A surrogacy agreement details the intended parents and surrogate's rights, obligations, and intentions under the surrogacy arrangement. The agreement should articulate the rights of the surrogate and intended parents, custody of the child born through surrogacy, location of the birth, health and life insurance policies for the surrogate, medical decision-making during the pregnancy, testing and screening procedures of the fetus, termination, multifetal pregnancy reduction or selective reduction, surrogate dietary and activity requirements, payment of and indemnification for medical and pregnancy related expenses, liability for complications related to the surrogacy arrangement, access to medical history of the surrogate, mental and physical health screenings of the surrogate, her spouse (if applicable) and intended parents, and whether and to what extent the intended parents are to be present at doctor visits and during the delivery. Financial considerations such as the surrogate's compensation and expenses, including lost wages, legal fees, criminal background check, child care, transportation, and maternity clothing allowance should also be set forth in the agreement. In addition, there may be provisions addressing penalties for breach of contract, i.e., in the event the surrogate chooses to keep the child, payment of damages for breach of contract and custody of the child would be sought by the intended parents through the courts. Custody should be awarded to the intended parents, at least as a rebuttable presumption, if the agreement complies with all of the articulated provisions.

In addition, a surrogacy agreement may contain a provision regarding the surrogate's duties while pregnant, which are generally limited to health and lifestyle choices to safeguard the health of the surrogate and the fetus. Examples of such include agreeing not to smoke, drink alcoholic beverages, use illegal drugs, or engage in hazardous or inappropriate activity. It may also stipulate that the surrogate should agree to follow a prenatal care schedule as prescribed by physicians and agree to undergo any medical tests or procedures advised by physicians. While these health and lifestyle stipulations interfere with a surrogate's autonomy, such provisions are similar to conditions found in employment contracts, which also permissibly curtail individual autonomy after voluntary decision-making. The decision to enter into a surrogacy arrangement is voluntary and from a surrogate's perspective, she has the right to reject any condition in a proposed surrogacy arrangement and, if she cannot come to an agreement with the intended parents, reject an agreement entirely.

The Task Force recommends that if New York State permits and regulates gestational surrogacy agreements, specific requirements should be in place for such agreements so that they: (1) are enforceable, (2) mitigate risks to the parties, and (3) ensure that the process is fair and seamless.

The Task Force recommends the following general requirements apply to parties of a surrogacy agreement:

1. Residency Requirement

To protect New Yorkers, as well as individuals of other states and countries, the Task Force recommends that only individuals who have been legal residents of New York State for at

least six months prior to seeking approval for their pre-implantation order should be permitted to enter into surrogacy agreements.⁴¹¹

This requirement serves a number of purposes. It prevents New York from becoming a magnet for surrogacy tourism.⁴¹² While regulating surrogacy is in the best interest of New Yorkers, the Task Force is concerned that individuals from other states/nations will enter surrogacy arrangements in New York recklessly without understanding the inherent complexities. For both a surrogate and intended parents, a residency requirement would ensure more frequent contact and communication, which are important elements for a successful surrogacy arrangement. In addition, a residency requirement prevents other parties, e.g., agencies, attorneys, etc., from establishing such businesses unless these parties have ties to the community and state, which will protect intended parents and a surrogate from predatory practices.

2. Compensation is Reasonable

The Task Force recommends that compensation should be permitted for surrogacy agreements. Permitting compensation would serve a number of important functions. Currently, intended parents have great difficulty in finding a woman to agree to be an altruistic surrogate. Often, an uncompensated surrogate tends to perform the service of surrogacy only for her relatives or friends out of necessity or lack of the availability of an alternate surrogate. Altruistic surrogates may be pressured to “volunteer.” Further, a familial connection or friendship does not guarantee that a surrogate shares the same views as the intended parents on pregnancy, fetal reduction, abortion, prenatal genetic testing, prenatal care, labor and delivery, or numerous other factors and choices involved in a surrogacy pregnancy. Often, women are pressured to become surrogates for family members or will volunteer without being informed of the complexities involved. Thus, the possibility of disputes and conflict is a real concern in altruistic surrogacy arrangements.

With compensated surrogacy, more surrogates will likely be available, and the partnerships they form with intended parents will be based upon shared values. A formal agreement involving compensation encourages both parties to examine the details of these arrangements, because there usually is no pre-existing relationship (i.e., kinship or friendship) between the two parties that presumes shared values. Both the intended parents and the surrogate should have discussed the “what-ifs” involved with surrogacy, which help determine whether the parties are well-matched and should reduce the likelihood of future disputes.

In addition, compensation would provide payment to the surrogate for an important service rendered to the intended parents. Although many surrogates indicate that their desire to help intended parents is a strong motivator to becoming a surrogate, most would not engage in the practice without compensation because of the time, inconvenience, and burden associated with the process. Compensation may attract women who would not otherwise participate in the surrogacy; however, proposed safeguards and protections should prevent the process from becoming exploitative or coercive.

The Task Force declines to set maximum or minimum amounts on compensation to the surrogate and instead recommends that compensation should be reasonable. Setting such limits is subjective and the current average compensation amount to a surrogate outside of New York is between \$25,000 and \$35,000. Instead, the Task Force recommends that compensation be “reasonable,” and deliberately does not define this term. The parties to a surrogacy arrangement (surrogates, intended parents, their attorneys, the surrogacy agency (if used), etc.) should participate in determining a satisfactory amount in an effort to guarantee consensus. In addition, because courts would review the surrogacy agreement as part of the pre-implantation order, any unreasonably high or low compensatory amount would likely require an adjustment before a court order is issued.

3. Surrogates

The Task Force reviewed the potential physical, psychological, legal, financial, and other risks and benefits that may affect a surrogate. In addition, the Task Force debated the ethical issues surrounding surrogacy and the potential exploitation of women who are surrogates. For a woman to qualify as a surrogate, the Task Force recommends that these requirements should be satisfied to mitigate potential risks to the surrogate and to ensure best possible outcomes for a successful surrogacy arrangement.

The Task Force emphasizes that the requirements below should not be imposed on women who wish to become pregnant with children they intend to raise, and should not be construed as an infringement on women’s reproductive rights. Instead, these requirements are specific employment conditions that must be satisfied for a woman to be hired as a surrogate. Before a woman can enter into an agreement for compensation for a service, i.e., gestate a child, she must meet the minimum qualifications.

a. A surrogate should have given birth previously to at least one child.

The Task Force recommends that a surrogate should have given birth previously to at least one child. This requirement is necessary to ensure that the surrogate is able to provide informed consent to the surrogacy arrangement. Having experienced pregnancy and birth ensure that that the surrogate understands the physical and emotional challenges that pregnancy and birth entail. A previous successful pregnancy is the best possible evidence that a surrogate will be able to achieve another uncomplicated pregnancy and birth. Furthermore, it is important for the woman to have already experienced the emotional journey of pregnancy and birth, so she can be prepared to manage any potential mental health complications, such as post-partum depression. Finally, because the surrogate has already experienced the joys of preparing for a baby with her own children, it also reduces the probability that she will form an emotional bond with the child born through surrogacy and will be able to relinquish the baby to the intended parents. While no two pregnancies are alike, having previously experienced pregnancy and birth ensures that a surrogate is able to provide informed consent to the surrogacy arrangement.

b. A surrogate should be at least 21 years old.

Depending on the context, New York State law recognizes different ages as the age of majority (i.e., adulthood). New York State DRL §2 declares the age of majority in New York to be 18. General Obligations Law §3-101 sets the legal age at which an individual can enter into a legal contract/agreement at 18.⁴¹³ In contrast, New York Penal Law §130.05 sets the minimum age of consent for sexual activity at 17.

In theory, if surrogacy agreements are permitted, at 18 years of age, a woman would be legally able to enter into a surrogacy arrangement; however, the Task Force concludes that the potential physical and emotional risks of engaging in surrogacy warrant a higher age, i.e., 21 years old. While an age minimum may be arbitrary, the Task Force recommends that a surrogate be at least 21 to help ensure that she will have the psychological and emotional maturity to be a surrogate.⁴¹⁴ Furthermore, better pregnancy and neonatal outcomes would be achieved if the surrogate is at least 21 years old and most intended parents would likely select a surrogate who is older, i.e., more mature.

c. A surrogate should have a medical screening by a licensed physician.

The Task Force recommends that a potential surrogate should undergo a medical screening by a licensed physician to determine if she is physically capable of sustaining a successful pregnancy. Preferably the screening should be done by the woman's own OB/GYN or by an OB/GYN mutually agreed upon by both the woman and the intended parents. While some may find this requirement to be unnecessary and burdensome, the Task Force concludes that because the health of the surrogate may potentially be at risk, a medical screening is necessary to determine that the woman could withstand the physical challenges associated with pregnancy and birth. In addition, prior to implantation, the surrogate, and her partner if applicable, should have blood and STD tests as determined by a licensed physician.

d. A surrogate should have a mental health screening by a licensed mental health professional.

The Task Force recommends that a potential surrogate should undergo a mental health screening by a licensed mental health professional. The screening can help determine if the surrogate is psychologically prepared for the surrogacy process and if she has any mental health conditions that might impair her ability to carry the child to term or relinquish the child upon its birth to the intended parents.

In addition, the screening would provide an opportunity for the surrogate to discuss her relationship with her spouse/partner and family to gauge the level of support she has from her friends and family. It would also be useful for the surrogate to learn how to discuss the surrogacy arrangement with her own children to address any concerns they may have. While the Task Force acknowledges that this screening may not be necessary, it is an important protection for the surrogate to ensure that she understands and is prepared for the surrogacy arrangement.

e. A surrogate should have health insurance during the pregnancy and for a recovery period after the birth (minimum 12 weeks).

The Task Force recommends that a surrogate should have health insurance before embryo implantation and such coverage extend for a minimum of 12 weeks post-birth. The insurance should include mental health services. If the surrogate does not have her own insurance, or her insurance does not cover the surrogacy birth and post-birth care, the intended parents should provide such insurance. The Task Force agrees that the health and well-being of the surrogate is of the utmost importance and health insurance coverage would ensure that proper prenatal and postnatal care would be provided. Furthermore, the intended parents should indemnify and hold harmless the surrogate for all unpaid medical bills so that the surrogate is not financially responsible for any bills related to the pregnancy or post-birth. Finally, neither the surrogate nor the intended parents should attempt to rely upon health insurance that excludes surrogacy coverage by hiding the surrogacy arrangement.

f. A surrogate should have life insurance and disability insurance during the pregnancy.

The Task Force recommends that the intended parents should be required to provide the surrogate with a life insurance policy and a disability insurance policy for the duration of the pregnancy. Because the surrogate's health and life may be at risk because of complications from the pregnancy or birth, the intended parents should be required to pay for these policies that would list the surrogate's family as the beneficiaries. These policies would protect the surrogate's family in the event that an adverse event resulted in the surrogate's disability or death.

g. A surrogate should also have a credit and criminal background check.

The Task Force recommends that a surrogate should be subject to a credit and background check. A credit check ensures that the woman is not under financial duress and not engaging in surrogacy simply for financial reasons. This recommendation is a safeguard to prevent exploitation and ensures that compensation is not an undue inducement. A background check also ensures that the woman has not engaged in any criminal or other activities that would make her a poor candidate for surrogacy.

h. A surrogate should have independent legal counsel.

The Task Force recommends that a surrogate should have independent counsel to represent her interests when negotiating the surrogacy agreement and in any future related disputes. The surrogate's attorney fees should be paid by the intended parents. For more Task Force recommendations on legal counsel, see Section XI.D below, Regulations on Professions involved in a Surrogacy Agreement.

4. Intended Parents

The Task Force emphasizes that no individual should be excluded from becoming an intended parent because of marital status or sexual orientation.⁴¹⁵ In order to safeguard the rights of intended parents (who may be an individual or two persons), protect the child born through surrogacy, and ensure the best outcomes for a successful surrogacy arrangement, the Task Force recommends the following requirements for intended parents to enter into a surrogacy agreement.

a. Intended parents should be at least 21 years old.

The Task Force recommends that 21 should be the minimum age for intended parents to enter into a surrogacy agreement.⁴¹⁶ The Task Force acknowledges that there is no minimum age to become a parent; however, the Task Force determines that intended parents should be subject to the same minimum age requirement required of surrogates. Establishing a minimum age increases the likelihood that the intended parents have the psychological and emotional maturity to enter into a surrogacy arrangement.

The Task Force declines to specify a maximum age an intended parent could be at the time of a surrogacy agreement, primarily because ART and IVF guidelines do not suggest age limits for these procedures. While there is occasionally public outcry when older individuals have children using these procedures, many men father children via sexual intercourse in their senior years. Holding individuals who utilize ART/IVF to a different standard would be inequitable.

b. Intended parents should have a mental health screening by a licensed mental health professional.

The Task Force recommends that intended parents should undergo a mental health screening by a licensed mental health professional.⁴¹⁷ Similar to a mental health screening of prospective parents in the adoption process, the screening may help assess if the intended parents are prepared psychologically to be parents and are entering a surrogacy agreement for valid reasons. The screening also provides an opportunity for intended parents to discuss expectations in the event one parent dies or the partnership is dissolved. Intended parents should also discuss their expectations with regards to their relationship with the surrogate, and the immense financial and emotional costs associated with surrogacy.

c. Intended parents, if they are providing one or both gametes for the embryo, should undergo blood and STD testing as determined by a licensed physician.

To ensure that infectious agents will not be transmitted to the surrogate with the embryo implantation, the Task Force recommends that intended parents should undergo appropriate blood and STD tests as determined by a licensed physician.

d. Intended parents should have life insurance.

In the event of the death of one or both intended parents, the Task Force recommends that intended parents should have life insurance policies. The Task Force is concerned about the financial stability of the child born through surrogacy. Surrogacy is unique because it separates gestation from the intended mother.⁴¹⁸ In a non-surrogacy context, generally the death of the pregnant woman often also entails the death of the unborn child.⁴¹⁹ However, because, in a surrogacy context, the death of the intended mother does not result in the death of her child born through surrogacy, the intended parents' life insurance policy benefits would be used to care for the intended child, and to cover legal and other expenses associated with the determination of custody and guardianship of the child. The Task Force declines to recommend a minimum policy amount because opinions on adequate coverage amount will vary, especially between upstate New York and New York City. Intended parents should determine what the appropriate policy amount would be for their family.

e. Intended parents should have a criminal background check.

The Task Force recommends that intended parents should have a criminal background check.⁴²⁰ A background check should also be required of anyone over the age of 18 residing in the home where the child born through surrogacy will live. A similar background check is required by the New York State Office of Children and Family Services for anyone seeking to adopt a child and could serve as a template for background checks involving intended parents. While a criminal record should not automatically disqualify a person from pursuing surrogacy, certain criminal histories, such as those involving sexual or child abuse, may be problematic.⁴²¹ It is not necessary to specify a list of crimes that should disqualify an intended parent, but a background check could provide important information at the time the court reviews the surrogacy agreement. A background check is an important safeguard to protect the child born through surrogacy.⁴²²

f. Intended parents should have independent legal counsel.

The Task Force recommends that intended parents should have independent counsel to represent their interests when negotiating the surrogacy agreement and in any future disputes. For more Task Force recommendations on legal counsel, see Section XI.D below.

D. Regulations on Professions involved in a Surrogacy Agreement

1. Legal Counsel

The Task Force recommends that the intended parents and the surrogate should have separate and independent legal counsel when negotiating the surrogacy agreement and to represent them in any future disputes.⁴²³ Legal counsel is an important component of negotiating a surrogacy agreement that is fair and amenable to both the intended parents and the surrogate.⁴²⁴ The attorneys should be admitted to practice law in New York and familiar with assisted reproduction/family law.⁴²⁵

The Task Force recommends the surrogate should have her own independent legal counsel to ensure that the agreement represents her best interests and not those of the intended parents. The legal fees for the surrogate's attorney should be paid by the intended parents.⁴²⁶ Some surrogates may be unable to acquire legal counsel and they should not be burdened with this expense. To address a possible conflict of interest if the legal fees for the surrogate's counsel are paid by the intended parents, the Task Force recommends that an attorney retainer/fee agreement, separate from the surrogacy agreement, should be prepared. This document would clearly state that the surrogate's counsel will only represent the surrogate and will not offer legal advice to the intended parents. The retainer/fee agreement should also state that the attorney-client relationship is with the surrogate, and not the intended parents, even though the legal fees are paid by the intended parents. Finally, while the retainer fee should be paid up front to the surrogate's counsel, a separate escrow account should include additional monies to pay for any incidental legal fees that may arise during the surrogacy arrangement.⁴²⁷

2. Physicians

The Task Force considers the physician to be an important party to the surrogacy arrangement. Doctors overseeing a surrogate's embryo implantation, prenatal care, and childbirth should be licensed to practice medicine in New York State and have a thorough understanding of the surrogacy process.

The physician should be another resource to both the surrogate and intended parents and the parties should discuss the risks and benefits of surrogacy. Physicians are especially valuable to a surrogate because she may turn to her physician if she has any concerns with the surrogacy arrangement. If an unlikely scenario occurs, (i.e., a physician suspects the surrogate is being exploited or if provisions in the surrogacy arrangement conflict with the physician's professional judgment), the physician should avoid participating in the process and inform the surrogate that she should consult her attorney.

The Task Force recommends that physicians conducting the medical screening for a potential surrogate should ensure that screenings are performed in accordance with standard medical practice and guidelines for surrogacy. Ideally, the surrogate should select the physician who will perform the initial medical screening. The Task Force recommends that physicians should follow the most recent detailed screening and testing recommendations by the American Society for Reproductive Medicine (ASRM), which issued extensive guidelines for physicians participating in a surrogacy arrangement.⁴²⁸

The Task Force recommends that the fertility specialist overseeing the surrogate's embryo implantation should not perform any procedures related to embryo implantation until a copy of the pre-implantation order is provided. In addition, the fertility specialist should abide by established medical ART guidelines and only implant the recommended number of embryos (generally 1 or 2, depending on the age of the woman who provided the egg) into the surrogate. Because a multiple-gestation pregnancy increases the risks to both the surrogate and the fetuses, the Task Force recommends that fertility physicians should abide by the ASRM's guidelines on embryo transfer.⁴²⁹ Because most surrogates are younger than 35 years of age, which increases the likelihood of pregnancy, the guidelines state that successful outcomes (i.e., a singleton birth)

can be achieved with 1 to 2 embryos transferred.⁴³⁰ In addition, informed consent should be obtained from the surrogate prior to embryo implantation.

The Task Force recommends that a surrogate and the intended parents mutually agree who should be the surrogate's obstetrics provider(s) for the entire surrogacy process. To avoid a conflict of interest, the provider(s) should not have cared for the intended parents.⁴³¹ Physicians overseeing a surrogate's prenatal care and delivery of the child should care for her as for any other obstetric patient and follow the recommended guidelines by the American College of Obstetricians and Gynecologists (ACOG).⁴³² In addition, the surrogate should be screened for depression during pregnancy.⁴³³ The physician has a doctor-patient relationship with the surrogate, not the intended parents; it is therefore the physician's duty to support the well-being of his/her patient, the surrogate.

The Task Force emphasizes that the health and well-being of the surrogate should guide any medical decisions until the child is born. Prior to the execution of a surrogacy agreement, the surrogate and the intended parents should agree on how the parties would address the reduction of the number of embryos or fetuses, the termination of the pregnancy, or medical decisions regarding the pregnancy. Any medical/health related decisions for the surrogate and the fetus require the surrogate's consent. Physicians should provide medical care that is in the best interests of both the surrogate and the fetus. Decisions regarding the pregnancy, labor, and delivery should be mutually agreed upon by both the surrogate and the intended parents.

The Task Force recommends that standard policies on privacy and confidentiality should be enforced in the surrogacy arrangement.⁴³⁴ The physician is obligated to maintain privacy and confidentiality with the surrogate. It is only with the surrogate's explicit consent that the intended parents may have access to appointments, medical screenings/procedures, lab results and other medical information about the surrogate and pregnancy. It is the surrogate's discretion whether intended parents may be present for a portion of, or throughout, any prenatal or other medical appointments.

E. Regulations on Surrogacy Agencies

While the use of a surrogacy agency is not mandatory, the Task Force recommends that intended parents and surrogates should be protected from fraudulent surrogacy agencies who charge fees for their services. The Task Force recognizes that many intended parents go to great lengths to become parents and are often vulnerable to dishonest practices by surrogacy agencies and their operators.⁴³⁵ While the Task Force acknowledges that surrogacy agencies provide an important service in screening surrogates and appropriately matching them with intended parents,⁴³⁶ not all agencies in the United States have operated in the best interests of their clients. Intended parents have been deceived into turning over significant sums of money with the hope of establishing a surrogacy arrangement, only to discover the process was a fraud. In such situations, most intended parents are unable to recover the money they expended. These exploitative agencies continue their illegal operations by launching "new" surrogacy entities with different names for their organization. In addition, these agencies may also hire surrogates who are unsuitable (i.e., socioeconomically disadvantaged, never experienced pregnancy and birth, emotionally immature, and other factors), and thus exploit them.

The Task Force recommends that surrogacy agencies should be subject to regulation and oversight to combat fraudulent practices. Only those surrogacy agencies that have incorporated the recommendations below may legally conduct surrogacy arrangements in New York State.

1. Registration

The Task Force recommends that a surrogacy agency should be a registered entity in the state of New York. An agency should file with the New York State Secretary of State in order to do business in the state.

2. Licensure and Oversight

The Task Force recommends that a surrogacy agency should have a license to operate in New York State and should be overseen by a state regulating agency. Several state agencies may be suited to perform this task, including the Department of State, the Department of Health, the Office of Children and Family Services, or the Department of Financial Services. The Task Force recommends that a single state agency should be charged with licensing and overseeing surrogacy agencies, and that the other agencies should provide input as appropriate in the process.

The Task Force recommends that each surrogacy agency should be required to have a license to operate in the state that is renewed on a periodic basis. A surrogacy agency should pay a fee that would both help fund the oversight program and create a necessary barrier to entry by permitting only those with serious and legitimate intentions to enter this business. In addition, as a condition of receiving a license to operate as a surrogacy agency, operators should be required to undergo criminal and financial background checks. The regulating state agency should deny approval if one of the owners is unsuited to operate such a business due to any negative findings in a background check, such as a history of fraud. The regulating state agency should also create and maintain a database of individuals who own or have owned surrogacy agencies that have closed, gone bankrupt, or violated any laws governing surrogacy arrangements and agencies. The regulating state agency should consult this database as part of the background check. These safeguards will help prevent unsuitable individuals from opening new surrogacy agencies after a previous failure.

3. Liability Insurance

The Task Force recommends that a surrogacy agency should carry liability insurance for the business, with a minimum policy of one million dollars (\$1,000,000). This recommendation protects intended parents and a surrogate in the event of financial difficulties, mismanagement, or fraud by the agency. Furthermore, a policy of at least one million dollars ensures that the agency is a legitimate business.

4. Financing

The Task Force recommends that the Department of Financial Services in New York State should review and approve any financing or loan arrangements offered by a surrogacy agency to help intended parents cover any costs of a surrogacy arrangement. Such offers should comply with existing reserve requirements and should be scrutinized to ensure they do not include unreasonably high interest rates or repayment conditions. This recommendation will protect intended parents from potentially burdensome financial terms.

5. Advertising

The Task Force recommends that a surrogacy agency should be prohibited from issuing false or misleading advertising. For example, advertisements that misrepresent surrogate compensation should be banned. The Task Force is concerned that advertisements would contain misleading information that would encourage women to become surrogates (i.e., suggesting that the surrogate would receive “X” dollar amount, which reflects the total cost of the surrogacy arrangement and not the actual amount provided to the surrogate, significantly less than the total cost). Advertisements should not include information suggesting to intended parents that surrogacy is simple, affordable, and always successful. Advertisements should include the name(s) of the operator of the surrogacy agency, the address of the agency, and the licensure or certification number issued by the State, so that individuals may research the agency and/or report any misleading advertisements.

6. Reporting Requirements

The Task Force recommends that a surrogacy agency should provide reports on its surrogacy arrangements to the regulating state agency. There is a need to collect data on surrogacy arrangements to evaluate whether the protections and safeguards are sufficient to protect surrogates, intended parents, and the children born through surrogacy. Data will permit the state to monitor the impact of the surrogacy regulations and adjust them as needed. The reporting should include the number of surrogacy arrangements organized, the number of surrogate births that result from such arrangements, and all adverse events, both legal and medical in nature.

F. Surrogacy Agreement Terms

In addition to meeting the requirements above, the Task Force recommends that the following provisions should be included in any surrogacy agreement to ensure that the agreement is enforceable and mitigates risks to the parties.

1. Termination of the Surrogacy Agreement

Even after the pre-implantation order has been issued, the surrogate or intended parents may terminate the surrogacy agreement, provided an embryo implantation cycle has not taken place. Termination of the agreement may also occur if the surrogate has not become pregnant after a previously agreed upon number of embryo implantation cycles.

2. Parental Rights and Custody

While it is the pre-implantation order that will legally grant the intended parents parental rights once the child is born, the Task Force recommends that the surrogacy agreement should state that the intended parents agree to accept custody of any child(ren) born from the surrogacy, regardless of sex, number, prematurity, physical, and psychological health. In addition, the agreement should state that the surrogate (and her partner, if applicable) agree to relinquish any claims to parental rights and custody. Only after the child is born do the intended parents make medical decisions regarding the child.

3. Escrow Agents

The Task Force recommends that a third party escrow agent should oversee an insured and bonded escrow account and pay the surrogate on a pre-determined schedule when conditions of the surrogacy agreement are met.

Intended parents should place money in an escrow account for the surrogate. An escrow account helps protect both the intended parents and the surrogate, as a significant problem is often the mismanagement and/or theft of these funds by a surrogacy agency or attorneys.⁴³⁷ In addition, a surrogate may be at a legal disadvantage if a surrogacy agency oversees the escrow account. If there is a conflict between the surrogate and intended parents, an agency might support the intended parents, who are paying the agency fees, and the agency could thus exert control over funds as leverage to manipulate the surrogate.

To avoid any potential fraud or mismanagement of funds, the Task Force recommends that all funds should be held in an escrow account by an independent agent with no financial or other interest in the surrogacy agreement. The third party escrow agent should pay the surrogate on a pre-determined schedule (e.g., end of a month or end of each trimester) when conditions of the agreement are met. Finally, all third party escrow accounts should be insured and bonded against fraud and theft.

4. Choice of Law

The Task Force recommends that a surrogacy agreement should have a choice-of-law clause clearly stating that only New York laws should apply in settling any dispute. This requirement aims to prevent people from circumventing protections put in place in New York by shopping for a venue with more permissive statutes.

5. Specific Performance

The Task Force recognizes and supports the principle that some reproductive rights may not be abrogable through contract while others may be (See Section IV. Constitutional Status of Claims to an Individual Right to Surrogacy). No surrogacy agreement can be remedied through a judicial order of specific performance, and no injunction should be permitted against the performance of any medical procedures by the gestational surrogate.⁴³⁸ Furthermore, the

agreement cannot require that a surrogate travel to another state or country for any purpose, including childbirth.

6. Damages

The Task Force recommends that a surrogacy agreement should state that any damages intended parents may seek from the surrogate in case of breach of the surrogacy agreement should be limited to the amount actually paid to the surrogate under the surrogacy agreement. Allowing financial damages against a surrogate for performing or failing to perform a medical procedure threatens the surrogate's right to make medical decisions. Within permissible limits, however, intended parents and a surrogate should be able to seek remedies under law and equity for noncompliance. Attorneys for the intended parents or the surrogate should be permitted to bring a claim in a court of competent jurisdiction to hear claims of contractual breach, and the petitioning attorney should have discretion regarding which venue to choose, so long as it has proper jurisdiction.

7. Divorce of Intended Parents

The Task Force recommends that a divorce by the intended parents should have no bearing on the surrogacy agreement (or pre-implantation order). In the event of a divorce, the intended parents should still be recognized as the parents of the child born through surrogacy and have full rights and responsibilities under the law. The state of the divorce proceeding should have no impact on parental rights, and the court should assume that the intended parents, not the surrogate, are the legal parents of the child born through surrogacy. The surrogate should under no circumstances be required to raise the child if the intended parents decide not to take custody of the child and exercise their parental rights. In addition, the divorcing parents' genetic relationship to the child should have no bearing on the establishment of parentage upon the birth of the child or in custody determinations. As with all divorce proceedings, decisions regarding custody of the child should be based on the best interests of the child.

8. Death of the Intended Parents

The Task Force recommends that a surrogacy agreement should include a clause stating that death of one or both intended parents does not void the surrogacy agreement or pre-implantation order once a surrogate is pregnant. If, prior to the surrogate becoming pregnant, both of the intended parents die, the surrogacy agreement and pre-implantation order should become void. However, any remunerations or reimbursement owed to the surrogate up to the point at which the agreement is void are still due to the surrogate. Because the pre-implantation order grants parental status to the intended parents once the child is born, the parents have legal responsibility for the child born through surrogacy. If one intended parent dies, the living intended parent retains custody of the child.

Although the likelihood of both intended parents dying is rare, the Task Force recommends that the intended parents should execute a will that assigns guardianship of the child born through surrogacy to another individual in the event of their death.⁴³⁹ The guardian must be notified of this potential responsibility in the event of the intended parents' deaths. By assigning

guardianship, custody of the child born through surrogacy will not be uncertain should both intended parents pass away.

9. Counseling

Disputes are less likely in surrogacy arrangements in which there is a harmonious relationship between the surrogate and the intended parents. While it is impossible to legislate harmony and empathy, steps may be taken to encourage such a relationship. The Task Force recommends that the surrogacy agreement include prepaid funds set aside for group counseling, to be used on an as-needed basis. Should discontent develop, group counseling would encourage better communication, harmony, and empathy between the parties. While counseling sessions cannot be mandated, making pre-paid sessions available may encourage the parties to diffuse disputes before the child's birth. These prepaid funds would be provided by the intended parents and would be returned if counseling was not used.

G. Additional Protections

1. Rulemaking

The Task Force recommends that relevant state agencies regulating surrogacy should be encouraged to promulgate rules pertaining to the licensing of surrogacy agencies, and any other rules that may be necessary to enact a surrogacy policy that adheres to these recommendations.

2. Education of Surrogates and Intended Parents

The Task Force recommends that regulating agencies charged with overseeing the surrogacy process should provide surrogates and intended parents with information that lists each party's rights and responsibilities. Information should be made available to educate the parties about surrogacy. In addition, information should be made available regarding how to report illegal activities by other parties, i.e., surrogacy agencies, attorneys, and physicians, to appropriate authorities without fear of reprisal.

3. Education of Professionals

The Task Force recommends that physicians, mental health professionals, attorneys, and judges should have a thorough understanding of the surrogacy process at the time they are enlisted in an arrangement. Ideally, these professionals would be educated before such an arrangement is presented to them, and never at the time when a dispute arises. For example, a physician should not become aware of a surrogacy agreement for the first time when a dispute over the child occurs during labor and delivery.

To ensure that professionals understand the complexities of surrogacy, the Task Force recommends that efforts should be made to educate courts and medical facilities about the processes and the requirements for a compensated surrogacy agreement to be legal and enforceable. Where available, these professionals should consult with their profession's trade organizations (i.e., American Society for Reproductive Medicine and the American College of

Obstetricians and Gynecologists, which are relevant for physicians and mental health professionals, and the American Bar Association for lawyers) to learn about best practices. Furthermore, the Task Force urges the Judicial Institute, the professional organization for judges and justices of the New York State Unified Court System, to develop appropriate resources to assist these professionals. The education of relevant professionals ensures that outcomes are positive because these professionals provide an additional layer of oversight and protection.

XII. Conclusion

Compensated gestational surrogacy in New York State is clearly – given the dissent attached to this report – a difficult and contentious topic. People of good will and intelligence who have the best interests of New Yorkers at heart can, and do, differ, on what is the best, most prudent, fair, and moral schema for the state. The Task Force on Life and the Law is accustomed to building consensus and forming unitary positions that undergird policy; however, unanimity is not possible on this issue.

The majority of the members of the Task Force decided that New Yorkers need to have the legally supported capacity to enter into compensated surrogacy arrangements in their home state with the most supportive legal protections that identify, secure, and protect the surrogate, the intended parents, and the child born through surrogacy. Those in the majority have found that times have changed, surrogacy has evolved, individuals desiring surrogacy have multiplied, and for intended parents to be forced to seek surrogacy arrangements out-of-state is not reasonable.

The majority, therefore, respectfully disagrees with the minority on the key policy issue, i.e., whether to permit gestational surrogacy in New York. It also affirms for the record its particularly strong objection to certain passages in the minority's report, i.e., passages that: would create new politically charged terminology (pp. 99-100); belittle the need of same sex couples to have children through surrogacy (pp. 102-103); assert that the need to prevent the dangers of surrogacy are akin to the need to protect New Yorkers from fracking (pp. 123-124); assert that the children of surrogacy are in some ways worse off than children of adoption (p. 124-125); and argue that because single parent families are generally “poorer” than two parent families, “New York should not encourage single persons to become parents in the first place by enforcing their contracts to hire a surrogate child-bearer” (p. 137-138). The majority believes that these statements are unfounded and unnecessarily provocative and do not advance this important debate.

The Task Force hopes that this report and set of recommendations will provide a foundation for legislative action that will secure new rights and legal protections for surrogates, intended parents, and the children born through surrogacy who will bring their parents fulfillment and joy.

¹ The New York State Task Force on Life and the Law, *Surrogate Parenting: Analysis and Recommendations for Public Policy*, 23 New York, NY (1988) (Task Force, *Surrogate Parenting*).

² *Id.*

³ N.Y. Dom. Rel. Law §§121-124.

⁴ Established by Executive Order in 1985, the Task Force is comprised of 23 Governor-appointed leaders in the fields of religion, philosophy, law, medicine, nursing, and bioethics. The Task Force develops public policy on issues arising at the interface of medicine, law, and ethics, and has issued influential reports on cutting-edge bioethics issues.

⁵ Task Force, *Surrogate Parenting*, *supra* note 1, at 2.

⁶ Two experts who work in the surrogacy field who presented to the Task Force have estimated that approximately 50 to 70% of different-sex intended parents contribute both sets of gametes to create the embryo to be implanted into the surrogate. They also estimate that with same-sex intended parents, 95% of embryos created use the gametes of one intended parent. Andrea Braverman, Clinical Associate Professor with a joint appointment in the Department of Obstetrics and Gynecology and Psychiatry and Behavioral Medicine at Thomas Jefferson University (presentation to the Task Force on February 25, 2014 and e-mail correspondence on June 16, 2016), and Melissa B. Brisman, the sole owner of Reproductive Possibilities, LLC, an agency based in New Jersey that facilitates gestational surrogacy arrangements, and Surrogate Fund Management, LLC, a company that manages escrow accounts in connection with reproductive arrangements (presentation on November 21st, 2013 and e-mail correspondence on June 16, 2016).

⁷ In some instances, a donated embryo may be used.

⁸ Diane Hinson, Creative Family Connections LLC, *Gestational Surrogacy Law Across the United States: State-by-State Interactive Map for Commercial Surrogacy* (2015), <http://www.creativefamilyconnections.com/#!/surrogacy-law-by-state/f49jq> (Hinson, *Gestational Surrogacy Law Across the United States*).

⁹ Susan Markens, *Surrogate Motherhood and the Politics of Reproduction*, 2007 University of California Press, at 126.

¹⁰ Lawrence Van Gelder, “Noel Kean, 58, Lawyer in Surrogate Mother Cases, Is Dead,” *N.Y. Times* (January 28, 1997), <http://www.nytimes.com/1997/01/28/nyregion/noel-keane-58-lawyer-in-surrogate-mother-cases-is-dead.html>.

¹¹ See e.g., Dava Sobel, “Surrogate Mothers: Why Women Volunteer,” *N.Y. Times* (June 29, 1981), <http://www.nytimes.com/1981/06/29/style/surrogate-mothers-why-women-volunteer.html>; see also Nadine Brozan, “Surrogate Mothers: Problems and Goals,” *N.Y. Times* (February 27, 1984), <http://www.nytimes.com/1984/02/27/style/surrogate-mothers-problems-and-goals.html>.

¹² *In re Baby M*, 537 A.2d 1227 (N.J. 1988).

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.* at 1234.

¹⁹ *Id.*

²⁰ Editorial Board of the New York Times, “Justice for All in the Baby M Case,” *N.Y. Times* (February 4, 1988), <http://www.nytimes.com/1988/02/04/opinion/justice-for-all-in-the-baby-m-case.html>; Robert Hanley “Baby M’s Mother Wins Broad Visiting Rights,” *N.Y. Times* (April 7, 1988), <http://www.nytimes.com/1988/04/07/nyregion/baby-m-s-mother-wins-broad-visiting-rights.html>.

²¹ N.Y. Pub. Health Law §4130.

²² Under the common law principle *mater semper certa est* (the mother is always certain), which deems the woman who gives birth is the mother. Rita D’alton-Harrison “*Mater Semper Incertus Est: Who’s Your Mummy?*” *Medical Law Review*, 22 (2014):357, 357.

²³ See *Michael H. v. Gerald D.* 491 US 110 (1989).

²⁴ N.Y. Dom. Rel. Law §240.

²⁵ Richard F. Storrow, *Donor Dads*, at 21 (unpublished manuscript).

²⁶ *Id.* at 22.

²⁷ For example, outside of New York, it is unclear whether some states will refuse to apply the marital presumption and list both adults in a same-sex relationship as the parents on a birth certificate. With a male same-sex couple, a birth certificate would not list both males as the parents since the woman who gave birth to the child would be listed as the mother. However, because it is possible for one female in a same-sex female relationship to give birth to the child, some states will list her female partner/spouse as the other parent.

²⁸ See *Alison D. v Virginia M.*, 77 N.Y.2d 651, 572 N.E.2d 27, 569 N.Y.S.2d 586. The Appellate Court affirmed that although the partner of the genetic parent developed a close relationship with the child that her partner conceived by artificial insemination, that since the non-genetic partner was not the biological or adoptive parent of the child, she did not have standing to seek visitation rights under Domestic Relations Law §70. See *Matter of Paczkowski v*

Paczkowski, 128 A.D.3d 968. The Family Court judge ruled that the non-genetic parent of a female same-sex couple did not have legal standing to seek joint custody of a two year old boy the couple was raising together since his birth.

²⁹ See Matter of Brooke S.B. v Elizabeth A.C.C., N.Y.3d 2016 NY Slip Op 05903. Soon after the Brooke S.B. decision, in a case regarding parental rights for an unmarried domestic partner not genetically related to the child, the Appellate Court held that where a partner to a biological parent "shows by clear and convincing evidence that the parties agreed to conceive a child and to raise the child together, the non-biological, non-adoptive partner has standing to seek visitation and custody under Domestic Relations Law §70(a)," In the Matter of Frank G. v Renee P.-F. 2016 NY Slip Op 05903.

³⁰ Formal adoption or an Order of Parentage may be preferential to seeking judicial recognition in family court because New York case law regarding parental rights is limited to child support, custody, and visitation. It does not include inheritance rights and benefit payments, such as social security. In addition, the burden of providing clear and convincing evidence of both parties' agreement to conceive and raise a child may be difficult. For example, fertility clinics may not retain documentation of the couple's use of the fertility services and informed consent forms. Finally, should a couple move to another state, New York State case law would not apply and only court orders would provide the same protections of parental rights for interstate full faith and credit purposes.

³¹ In re Baby Girl L.J., 505 N.Y.S.2d 813 (N.Y. Sur. Ct. Nassau Co. 1986).

³² *Id.*

³³ *Id.*

³⁴ *Id.* at 815.

³⁵ Task Force, *Surrogate Parenting*, *supra* note 1, at 61.

³⁶ *Id.* at 71.

³⁷ *Id.* at 73.

³⁸ *Id.* at 75.

³⁹ *Id.*

⁴⁰ *Id.* at 78.

⁴¹ *Id.* at 83 and 86-87.

⁴² *Id.* at 82-83.

⁴³ *Id.* at 88-89.

⁴⁴ *Id.* at 74.

⁴⁵ *Id.* at 76.

⁴⁶ *Id.* at 80.

⁴⁷ *Id.* at 87 and 89.

⁴⁸ *Id.* at 85.

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ In re Adoption of Paul, 550 N.Y.S.2d 815 (N.Y. Fam. Ct., Kings Co. 1990).

⁵² In re Baby M., 537 A.2d 1227 (N.J. 1988).

⁵³ In re Adoption of Paul, 550 N.Y.2d 815 (N.Y. Fam. Ct., Kings Co. 1990).

⁵⁴ New York State Department of Health, *The Business of Surrogate Parenting*, New York, NY (1992).

⁵⁵ N.Y. Dom. Rel. Law §§121-124.

⁵⁶ The law passed the Senate on June 24, 1992 by a vote of 52-0. It passed the Assembly on June 26, 1992 by a vote of 104-39. The governor signed it into law on July 17, 1992. In the Bill Jacket, a number of sources, including the Department of Health, cited the Task Force's 1988 surrogacy report in support of their recommendation to sign the bill into law. One member of the Assembly, G. Oliver Koppell, cited the Department of Health report, *The Business of Surrogate Parenting*, in his memo in opposition to the bill. He noted that the report found up to 4,000 surrogate births in the country, but only a handful of problems. The Women's Bar Association of the State of New York cited the Department of Health report as evidence that surrogacy was flourishing in the unregulated environment in New York.

⁵⁷ N.Y. Dom. Rel. Law §121.

⁵⁸ N.Y. Dom. Rel. Law §123.

⁵⁹ Denise Seidelman and Nina E. Rumbold, Partners in Rumbold & Seidelman, LLP, presentation at a Task Force meeting, October 17th, 2013.

⁶⁰ *Id.*

⁶¹ N.Y. Dom. Rel. Law §124.

⁶² A large number of New Yorkers engaging in commercial gestational surrogacy will travel primarily to Pennsylvania, Massachusetts, Rhode Island, and Connecticut. In these states, commercial surrogacy is permitted, and it is easier for intended parents to acquire parental rights after the birth. Melissa B. Brisman, the sole owner of Reproductive Possibilities, LLC, an agency based in New Jersey that facilitates gestational surrogacy arrangements, and Surrogate Fund Management, LLC, a company that manages escrow accounts in connection with reproductive arrangements. Presentation at a Task Force meeting, November 21st, 2013.

⁶³ When the individuals are married, the adoption of a partner's child is called a step-parent adoption. When the individuals are not married, the adoption of a partner's child is called a second-parent adoption. As a result of *Obergefell v. Hodges*, 135 S. Ct. 2584, 2599 (2015) (*Obergefell v. Hodges*) married same-sex couples can petition for joint adoption or for step-parent adoption. Movement Advancement Project (MAP), Foster and Adoption Laws, Joint Adoption, June 30, 2016, http://www.LGBTmap.org/equality-maps/foster_and_adoption_laws.

⁶⁴ Michigan, North Dakota, and Virginia have such religious exemption laws for child welfare agencies. *Id.* Mississippi also had such a statute, but it was declared unconstitutional by the U.S. District Court for the Southern District of Mississippi. <http://www.nytimes.com/aponline/2016/07/01/us/ap-us-religious-objections-mississippi.html>. LGBT couples may adopt in New York because “any two unmarried adult intimate partners together” may adopt, and the law states that prospective adoptive parents should not be discriminated against *solely* (emphasis added) on the basis of sexual orientation. *See* N.Y. Dom. Rel. Law §110 and 18 NYCRR §421.16(h)(2). The New York State Office of Children and Family Services issued an informational letter stating that the regulation's intent is to prohibit discrimination based on sexual orientation in the adoption study assessment process.

⁶⁵ *McDonald v. McDonald*, 196 A.D.2d 7 (N.Y. 1994).

⁶⁶ *Johnson v. Calvert*, 851 P. 2d 776 (Cal. 1993).

⁶⁷ *Id.* at 782.

⁶⁸ *Id.*

⁶⁹ *McDonald v. McDonald*, 196 A.D.2d 7 (N.Y. 1994).

⁷⁰ *Arredondo by Arredondo v. Nodelman*, 622 N.Y.S.2d 181 (N.Y. Sup. Ct. 1994).

⁷¹ *Id.*

⁷² *Id.*

⁷³ New York State Task Force on Life and the Law, *Assisted Reproductive Technologies: Analysis and Recommendations for Public Policy*, 327 New York, NY (1998) (Task Force, *Assisted Reproductive Technologies*).

⁷⁴ *Id.* at 336.

⁷⁵ *Id.* at 352-353.

⁷⁶ *Id.* at 353.

⁷⁷ *Id.* at 354.

⁷⁸ The recommendations did not specify what legal rights or responsibilities a genetic parent who does not have custody would entail. *Id.* at 355.

⁷⁹ *Id.* at 357. (It is unclear what was meant by this regarding who would raise the child.)

⁸⁰ *Id.*

⁸¹ *Doe v. N.Y. City Bd. of Health*, 782 N.Y.S.2d 180 (N.Y. Sup. Ct. 2004) (*Doe v. N.Y. City Bd. of Health*).

⁸² *Id.* at 183.

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ N.Y. Dom. Rel. Law §124.

⁸⁶ *Id.*

⁸⁷ *Doe v. N.Y. City Bd. of Health*, *supra* note 81, at 185.

⁸⁸ *Matter of Sebastian*, 879 N.Y.S.2d 677 (N.Y. Sur. Ct. 2009).

⁸⁹ *Id.* at 681 (N.Y. Sur. Ct. 2009).

⁹⁰ *Id.*

⁹¹ *Id.* at 681

⁹² *Id.* at 682.

⁹³ *Id.* at 687-688.

⁹⁴ *Id.* at 688.

⁹⁵ *Id.* at 689.

⁹⁶ *Id.* at 692.

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *Feigenbaum v. New York State Dept. of Health*, 2010 NY Slip Op 33838(U) (N.Y. Sup. Ct. Oct. 22, 2010).

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ T.V. (Anonymous) v. New York State Dept. of Health, 88 A.D.3d 290 (N.Y. App. Div. 2d Dep't 2011).

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ N.Y. Pub. Health Law §4130.

¹¹¹ T.V. (Anonymous) v. New York State Dept. of Health, 88 A.D.3d 290, 295 (N.Y. App. Div. 2d Dep't 2011).

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ Task Force, *Assisted Reproductive Technologies*, *supra* note 73, at xxvi.

¹¹⁷ In the Matter of Frank G. v Renee P.-F. 2016 NY Slip Op 05903.

¹¹⁸ *Id.*

¹¹⁹ *Id.*

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² *See supra* note 29.

¹²³ In the Matter of Frank G. v Renee P.-F. 2016 NY Slip Op 05903.

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ *See Brooke S.B. v. Elizabeth A.C.C.*, N.Y.3d 2016 NY Slip Op 05903.

¹²⁷ Task Force, *Surrogate Parenting*, *supra* note 1, at 61.

¹²⁸ A number of court cases also support this conclusion. In *Doe v. Kelley*, 307 N.W.2d 438 (Mich. Ct. App. 1981), the Michigan Court of Appeals concluded that the fundamental right to conceive a child did not prohibit the state from interfering with the plaintiffs' surrogacy agreement. The court reasoned that the statute precluded payments in conjunction with the use of the state's adoption procedures, but did not directly prohibit the parties from having the child as planned. Although it recognized that the decision to bear a child was a fundamental interest protected by the United States Constitution, the court determined that the plaintiffs' surrogacy agreement was an attempt to use the state's adoption laws to gain parental rights, which was not within the realm of fundamental interests protected by the right to privacy from reasonable governmental regulation. In *re Adoption of Paul*, 146 Misc.2d 379 (N.Y. Fam. Ct., Kings Co. 1990), a New York Family court found that "the plaintiffs' contractual agreement disclosed a desire to use the adoption code to gain parental right and the court held that this desire was not a fundamental interest protected by the right to privacy. This court, based upon the same reasoning as that applied by the Michigan court, also finds no constitutionally protected right to participate in surrogate parenting arrangements. In *Baby M.*, the New Jersey Supreme Court stated that the right to procreate does not extend beyond "the right to have natural children, whether through sexual intercourse or artificial insemination." The court rejected the premise that the right to procreate includes a right to enter into and enforce a surrogacy agreement. The court held that a person's constitutional right to procreate neither establishes a right to attain custody through a surrogacy agreement nor the right to terminate the parental rights of a surrogate mother. In *re Baby M*, 537 A.2d 1227(N.J. 1988).

¹²⁹ There have been some legal scholars who suggest that ART could be understood as a constitutionally protected right. *See e.g.*, Douglas NeJaime, "Griswold's Progeny: Assisted Reproduction, Procreative Liberty, and Sexual Orientation Equality," *Yale Law Forum* 124 (2015): 340, 347 (referencing John A. Robertson, *Children of Choice: Freedom and the New Reproductive Technologies*, Princeton University Press (1994): 39-40), and John A. Robertson, "Assisting Reproduction, Choosing Genes, and the Scope of Reproductive Freedom," *George Washington Law Review* 76 (2008): 1490, 1491-1494).

¹³⁰ Though traditional surrogacy may still be used, it is rare today. For example, Andrew Vorzimer stated that when he started his practice, 99% of his cases were traditional surrogacies, but today, the numbers have dropped dramatically, less than one percent. Of these, nearly all were privately arranged by the intended parents and the surrogate themselves. Andrew Vorzimer, Partner at Vorzimer Masserman, a fertility and family law center, presentation at a Task Force meeting, November 20th, 2014.

¹³¹ See *supra* note 6.

¹³² T.J. Mathews and Brady E. Hamilton, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Delayed Childbearing: More Women Are Having Their First Child Later in Life*, 1 Hyattsville, MD (National Center for Health Statistics, 2009), <http://blogs.sgmcb.com/glassceilinggrubbyfloor/research/NHCS%20Data%20Brief%2021%20-%20Delayed%20Childbearing.pdf>.

¹³³ Anjani Chandra et al., U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Infertility and Impaired Fecundity in the United States, 1982–2010: Data from the National Survey of Family Growth*, National Health Statistics Reports Hyattsville, MD (National Center for Health Statistics 2013), <http://www.cdc.gov/nchs/data/nhsr/nhsr067.pdf>.

¹³⁴ For example, a study of 42 couples in the United Kingdom with a one-year-old child born through surrogacy found that the couples had been trying to get pregnant for 7.5 years before resorting to surrogacy. In this study, the most common reasons for seeking surrogacy were repeated failed IVF cycles, medical conditions such as damaged or missing uterus, medical contraindication (pregnancy would be life threatening), or multiple miscarriages. Fiona MacCullum et al., “Surrogacy: The Experience of Commissioning Couples,” *Human Reproduction* 18 (2003): 1334, 1336. See e.g., Raymond M. Anchan, et al., “Gestational Carriers: A Viable Alternative for Women with Medical Contraindications to Pregnancy,” *Open Journal of Obstetrics and Gynecology* 3 (2013): 24, 26; Shohre Beski, et al., “Gestational Surrogacy: A Feasible Option for Patients with Rokitansky Syndrome,” *Human Reproduction* 15 (2000): 2326, 2327; American College of Obstetricians and Gynecologists, “Müllerian Agenesis: Diagnosis, Management, and Treatment, Committee Opinion No. 562,” *Obstetrics & Gynecology* 121 (2013): 1134, 1134; R. Al-Nasser et al., “P-10: Factors Influencing Success in Gestational Surrogacy,” *Fertility and Sterility*, 86 (2006): S132, S132; American Cancer Society, *Fertility and Women with Cancer*, 7, 9-12 (2013), <http://www.cancer.org/acs/groups/cid/documents/webcontent/acspc-041244-pdf.pdf>; Godwin I. Meniru and Ian L. Craft, “Experience with Gestational Surrogacy as a Treatment for Sterility Resulting from Hysterectomy,” *Human Reproduction* 12 (1997): 51-54; F.Y. Huq and R.A. Kadir, “Management of Pregnancy, Labour and Delivery in Women with Inherited Bleeding Disorders,” *Haemophilia* 17 (2011): 20–30; N Kevin Krane, Medscape, *Renal Disease and Pregnancy*, (2013), <http://emedicine.medscape.com/article/246123-overview>; Sahar Naderi and Russell Raymond, Cleveland Clinic, *Pregnancy and Heart Disease*, (2014), <http://www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/cardiology/pregnancy-and-heart-disease/>; John Hopkins Medicine, *Multiple Sclerosis and Pregnancy*, http://www.hopkinsmedicine.org/healthlibrary/conditions/physical_medicine_and_rehabilitation/multiple_sclerosis_and_pregnancy_85,P01160/; Lupus Foundation of America, *Can I Still Plan a Pregnancy?*, (2013), <http://www.lupus.org/answers/entry/lupus-and-pregnancy>.

¹³⁵ Donna Zemlickis et al., “Fetal Outcome After In Utero Exposure to Cancer Chemotherapy” *Archive of Internal Medicine* 152 (1992): 573, 575; Brady P. Selig et al., “Cancer Chemotherapeutic Agents as Human Teratogens,” *Birth Defects Research Part A: Clinical and Molecular Teratology* 94 (2012): 626, 628-29; Ha T.T. Nguyen, Verinder Sharma, and Roger S. McIntyre, “Teratogenesis Associated with Antipolar Agents,” *Advances in Therapy* 26 (2009): 281, 284-86; Kimberly A. Yonkers et al., “Management of Bipolar Disorder during Pregnancy and the Postpartum Period,” *American Journal of Psychiatry* 161 (2004): 608, 608; http://www.health.harvard.edu/newsletter_article/Prescribing_during_pregnancy

¹³⁶ For some intended parents who have been exposed, or at risk of being exposed, to a contagious disease that could affect fetal development (e.g., Zika virus), surrogacy may be sought to reduce the risk of birth defects.

¹³⁷ Sharon Vandivere and Karin Malm of Child Trends, and Laura Radel at the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Adoption USA. A Chartbook Based On The 2007 National Survey Of Adoptive Parents*, (Washington, D.C.) 2009.

¹³⁸ Prior to 1973, 9% of babies born to never-married women in the United States were placed for adoption, compared to approximately 1% between 1996 and 2002. Jo Jones, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Adoption Experiences of Women and Men and Demand for Children to Adopt by Women 18–44 years of Age in the United States, 2002*. National Center for Health Statistics. Vital Health Stat 23:27 (2008): 34. Foreign adoptions have also been declining significantly over the past decades. International adoptions peaked in 2004 with a total of 22,991, and the number fell to 5,648 in 2015. U.S State Department Statistics, https://travel.state.gov/content/dam/aa/pdfs/2015Annual_Intercountry_Adoption_Report.pdf and <https://travel.state.gov/content/adoptionsabroad/en/about-us/statistics.html>. Of the recent international adoptions, most of these children were deemed to have special needs by their country of origin. Center for Adoption Policy (CAP), *Facts and Figures*, <http://www.adoptionpolicy.org/facts.html>. Many countries that had been sending children to the United States dramatically reduced the number of children available for adoption by American citizens. Alan

Greenblatt, “Fewer Babies Available for Adoption by U.S. Parents,” *NPR* (November 17, 2011), <http://www.npr.org/2011/11/17/142344354/fewer-babies-available-for-adoption-by-u-s-parents>.

¹³⁹ Of the 102 licensed adoption agencies, 81 are in-state and 21 are out-of-state. Most of the in-state agencies only place older children who are currently in the foster care system. New York State Office of Children and Family Services, NYS Authorized Voluntary Agencies and Out-of-State Authorized Voluntary Agencies, <http://ocfs.ny.gov/adopt/adagency.asp> and ocfs.ny.gov/adopt/oosagency.asp.

¹⁴⁰ LGBT couples may adopt in New York because “any two unmarried adult intimate partners together” may adopt, and the law states that individuals should not be discriminated against *solely* (emphasis added) on the basis of sexual orientation. See N.Y. Dom. Rel. Law §110 and 18 NYCRR §421.16(h)(2). The New York State Office of Children and Family Services issued an informational letter stating that the regulation’s intent is to prohibit discrimination based on sexual orientation in the adoption study assessment process.

http://ocfs.ny.gov/main/policies/external/OCFS_2011/INFs/11-OCFS-INF-05%20Clarification%20of%20Adoption%20Study%20Criteria%20Related%20to%20Length%20of%20Marriage%20and%20Sexual%20Orientation%20.pdf.

¹⁴¹ Calls were made to the 102 agencies to inquire if they would work with a same-sex male couple to adopt an infant. Only 28 agencies (27 percent) stated they would work with a LGBT couple to adopt an infant (18 in-state agencies and 10 out-of-state agencies).

¹⁴² New York State does not have any official data regarding whether LGBT individuals face discrimination when trying to work with adoption agencies. However, there is anecdotal evidence suggesting that because there are few adoption agencies licensed in New York available who will work with LGBT individuals, many LGBT individuals turn to private placement adoption.

¹⁴³ Email correspondence with Diane Kunz, Executive Director of Center for Adoption Policy, September 26, 2015.

¹⁴⁴ *Id.* In FY 2014, nine children were adopted from Brazil, 12 from Mexico City, and 24 from South Africa.

¹⁴⁵ Susan Donaldson James, “More Gay Men Choose Surrogacy to Have Children,” *ABC News* (March 12, 2008), <http://abcnews.go.com/Entertainment/OnCall/story?id=4439567&page=1> and Anemona Hartocollis, “And Surrogacy Makes 3,” *N.Y. Times* (February 19, 2014) <https://www.nytimes.com/2014/02/20/fashion/In-New-York-Some-Couples-Push-for-Legalization-of-Compensated-Surrogacy.html>.

¹⁴⁶ For a discussion of the potential importance of the genetic dimension of kinship for gay men, see Deborah Dempsey, “Surrogacy, Gay Male Couples and the Significance of Biogenetic Paternity,” *New Genetics and Society* 32 (2013): 37–53. Furthermore, single male individuals and transgendered individuals may use gestational surrogacy to have a genetically related child. In some instances, a male couple may choose to have each parent’s sperm fertilize two donor eggs and both resulting embryos are implanted into the gestational surrogate’s uterus.

¹⁴⁷ Same-sex marriage was legalized in New York in 2011 (Marriage Equality Act, ch. 95, 2011 N.Y. Sess. Laws 749) and in the United States in 2015 Supreme Court ruling in *Obergefell v. Hodges*, *supra* note 63.

¹⁴⁸ Email correspondence with Eleanor Nicoll, Public Affairs Manager, American Society of Reproductive Medicine (ASRM), on June 14, 2017.

¹⁴⁹ In surrogacy disputes involving celebrity intended parents, the courts have upheld the surrogacy agreement and rules that the intended mother – not the surrogate – is the legal mother of the child. See *e.g.*, *Baby S.*, 2015 Pa Super. 244. Sherri Shepherd and her husband, Lamar Sally, used a surrogate to have their child using her husband’s sperm and an egg donor. When the surrogate was six months pregnant, Shepherd filed for divorce and declared she would not be the child’s mother or legally responsible for the child. The trial court in Pennsylvania ruled that Shepherd and Sally were the legal parents and upheld the validity of the surrogacy agreement and that Shepherd had breached it. Shepherd appealed but the appellate court rejected her argument and affirmed that she was the legal mother to the child because she voluntarily undertook the steps to conduct a surrogacy arrangement. The surrogate should not be responsible for a child she did not see as her own and only became the surrogate because Shephard and Sally paid for her services as a surrogate. As part of the appellate court’s opinion, the court noted the “growing acceptance of alternative reproductive arrangements” and the long established Pennsylvania Department of Health procedure that named the intended parents on the birth certificate when the baby was born via surrogate as evidence of acceptance to the use of gestational surrogacy. Joanna L. Grossman, “Baby Mama: Appellate Court Declare Sherri Shepherd Is the Legal Mother of a Child Born to Her via Surrogate,” December 1, 2015, <https://verdict.justia.com/2015/12/01/baby-mama-appellate-court-declares-sherri-shepherd-is-the-legal-mother-of-a-child-born-to-her-via-surrogate>

¹⁵⁰ See *e.g.*, Anemona Hartocollis, “And Surrogacy Makes 3,” *N.Y. Times* (February 19, 2014), <http://www.nytimes.com/2014/02/20/fashion/In-New-York-Some-Couples-Push-for-Legalization-of-Compensated-Surrogacy.html>; Michael Ollove, “Some States Create Welcoming Environment for Surrogacy,” *The Pew Charitable Trusts* (November 6, 2015), <http://www.pewtrusts.org/en/research-and->

analysis/blogs/stateline/2015/11/06/some-states-create-welcoming-environment-for-surrogacy; Leslie Morgan Steiner, “It’s Time to Make Paid Surrogacy Legal in New York,” *New York Post*, (November 16, 2013), <http://nypost.com/2013/11/16/its-time-to-make-paid-surrogacy-legal-in-new-york/>

¹⁵¹ Hinson, *Gestational Surrogacy Law Across the United States: State-by-State Interactive Map for Commercial Surrogacy*, *supra* note 8.

¹⁵² *Id.* The following five states ban or otherwise restrict surrogacy via a statute: Arizona, Indiana, Michigan, Nebraska, and New York. Nineteen states and Washington, D.C. permit surrogacy via a statute, many with varying restrictions and regulations on how surrogacy is practiced and how parentage is established for intended parents. California, Delaware, Illinois, Maine, Nevada, New Hampshire, and Washington, D.C. are the most “permissive” states with regard to gestational surrogacy, as they not only permit compensated surrogacy agreements but also provide regulatory structure for all types of intended parents to obtain parentage orders (minimizing uncertainty and the need for a hearing). Other states’ statutes, such as Florida, Texas, Utah, and Virginia, require a court hearing to validate the surrogacy agreement or establish parental status. Seven additional states permit gestational surrogacy agreements via statute/code, but provide limited detail than other states’ laws on gestational surrogacy: Arkansas, Connecticut, Iowa, New Mexico, North Dakota, Tennessee, and West Virginia. One state, Washington, will only enforce uncompensated gestational surrogacy agreements. Of these 19 states and one jurisdiction, some states place restrictions on who may engage in surrogacy, such as the intended parents must be a married different-sex couple (Louisiana, Tennessee, and Virginia), or surrogacy agreements are only permitted if compensation is restricted to medical and ancillary costs (Florida, Louisiana, and Virginia).

¹⁵³ *Id.* In six states – Ohio, Massachusetts, Maryland, Pennsylvania, South Carolina, and Wisconsin – case law supports surrogacy, but there are no governing statutes. Only one state, New Jersey, bans compensated surrogacy via case law.

¹⁵⁴ *Id.* In the following 19 states: Alabama, Alaska, Colorado, Georgia, Hawaii, Idaho, Kansas, Kentucky, Minnesota, Mississippi, Missouri, Montana, North Carolina, Oklahoma, Oregon, Rhode Island, South Dakota, Vermont, and Wyoming, there is no statute or published case law addressing surrogacy.

¹⁵⁵ Because of current New York surrogacy law, many attorneys are reluctant to assist clients pursuing altruistic gestational surrogacy. Many attorneys are concerned that their assistance would qualify them as a “surrogacy agency” under New York law, and they could be liable for fines and possible felony charges. Even in cases of uncompensated surrogacy, there is concern that the attorney could be characterized as a surrogate broker. While there are several New York State attorneys who do assist these clients, most of the clients usually seek legal assistance only after the altruistic surrogacy arrangement has become problematic. Denise Seidelman and Nina E. Rumbold, Partners, Rumbold & Seidelman, LLP, presentation at a Task Force meeting, October 17th, 2013.

¹⁵⁶ See e.g., American Society for Reproductive Medicine (ASRM), “Using Family Members as Gamete Donors or Surrogates,” 98 *Fertility and Sterility* 2012: 797-803. In Israel, a gestational surrogate may not be the mother, daughter, granddaughter, sister, aunt, or cousin of one of the intended parents to avoid “any potential pressure on relatives to become surrogate mothers and subsequent complications within the family.” Abraham Benshushan and Joseph G. Schenker, “Legitimizing Surrogacy in Israel,” *Human Reproduction* 12 (1997): 1832, 1832.

¹⁵⁷ American Medical Association, *AMA Code of Medical Ethics, Opinion 2.18– Surrogate Mothers*, (1994), <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion218.page>.

¹⁵⁸ *Id.*

¹⁵⁹ *Id.*

¹⁶⁰ Executive Board, American College of Obstetricians and Gynecologists (ACOG), *Ethical Issues in Surrogate Motherhood, Statement of Public Policy*, 56 Washington, D.C. (1983).

¹⁶¹ Examples of “medical need” include the lack of a uterus or a uterus capable of sustaining a pregnancy, or where the “wife has a medical condition that makes pregnancy a genuine threat to her health.” Committee on Ethics, ACOG, “Ethical Issues in Surrogate Motherhood, Committee Opinion No. 88,” *International Journal of Gynecology & Obstetrics* (1990): 139, 140-141 (ACOG, *Ethical Issues in Surrogate Motherhood* 1990).

¹⁶² Committee on Ethics, ACOG, *Surrogate Motherhood, (Committee Opinion No. 397)* Washington, D.C. (2008): 1-6, <http://www.acog.org/-/media/Committee%20Opinions/Committee%20on%20Ethics/co397.pdf?dmc=1&ts=20141008T1127474954>

¹⁶³ *Id.* at 3.

¹⁶⁴ Committee on Ethics, ACOG, *Family Building Through Gestational Surrogacy, (Committee Opinion No. 660)* Washington, D.C. (2016): 1-7 and 2 (ACOG, *Family Building Through Gestational Surrogacy* 2016).

¹⁶⁵ *Id.* at 1.

¹⁶⁶ *Id.* at 2-5.

¹⁶⁷ *Id.* at 1.

¹⁶⁸ However, one exception is the reproductive endocrinology and infertility specialists who has treated the intended parents. This person(s) would also manage the preconception and early pregnancy care of the surrogate. *Id.* at 4-5.

¹⁶⁹ *Id.* at 2-4.

¹⁷⁰ *Id.* at 2 and 4.

¹⁷¹ *Id.* at 4-5.

¹⁷² *Id.* at 5.

¹⁷³ *Id.*

¹⁷⁴ *Id.* at 5-6.

¹⁷⁵ Ethics Committee, ASRM, *Consideration of the Gestational Carrier: A Committee Opinion*, (2013), http://www.sart.org/uploadedFiles/ASRM_Content/News_and_Publications/Ethics_Committee_Reports_and_State_ments/Cosideration%20of%20the%20gestational%20carrier2013.pdf (ASRM, *Consideration of Gestational Carrier*).

¹⁷⁶ *Id.* at 1841.

¹⁷⁷ Ethics Committee, ASRM, *Misconduct in Third-Party Assisted Reproduction: A Committee Opinion* (2014), http://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Ethics_Committee_Reports_and_State_ments/Misconduct%20in%20third%20party%20assisted%20reproduction2013.pdf.

¹⁷⁸ For example, if a surrogate has an issue, the physician should encourage the surrogate to self-disclose the issue to the intended parents and only after this disclosure should the physician discuss the issue with the intended parents. Another example involves a situation in which the intended parents' relationship dissolves. For most gestational arrangements, it is required that the intended parents remain an intact couple. If a physician discovers that the intended parents plan to separate, the physician should encourage the couple to disclose the separation. However, since the physician does not have a patient/provider relationship with the intended parents, s/he is not bound by the professional duty of confidentiality. *Id.* at 41.

¹⁷⁹ Assistance may include contacting the surrogacy agency (if appropriate), law enforcement, or relevant licensing authorities. *Id.*

¹⁸⁰ T. Allen Merritt et al., "National Perinatal Association Position Statement – Ethical Use of Assisted Reproductive Technologies: A Call for Greater Transparency, Better Counseling of Prospective Parents and Single Embryo Transfer to Improve Outcomes for Mothers and Babies," *Neonatology Today* (2014): 12, 13.

¹⁸¹ However, the NPA recognized an exception for situations in which the non-American surrogate was a family member. *Id.*

¹⁸² The Uniform Law Commission (ULC) is a non-profit, unincorporated association, founded in 1892 with the goal of "provid[ing] states with non-partisan, well-conceived and well-drafted legislation that brings clarity and stability to critical areas of state statutory law." Uniform Law Commission, *About the ULC*, (2014), <http://www.uniformlaws.org/Narrative.aspx?title=About%20the%20ULC>.

¹⁸³ ULC, *Parentage Act*, <http://www.uniformlaws.org/Act.aspx?title=Parentage%20Act>.

¹⁸⁴ The ULC made Article 8 optional out of a "concern that state legislatures may decide that they are still not ready to address gestational agreements, or that they want to treat them differently from what Article 8 provides." National Conference of Commissioners on Uniform State Laws, *Uniform Parentage Act*, 68-69 (2002), http://www.uniformlaws.org/shared/docs/parentage/upa_final_2002.pdf. (*UPA*). While all states have adopted some version of the Uniform Parentage Act (UPA), only ten have adopted the 2002 version: Alabama, Delaware, Maine, New Mexico, North Dakota, Oklahoma, Texas, Utah, Washington and Wyoming. Of these, only two states, Utah and Texas, have adopted a version of the optional Article 8. Maine has passed a modified version of the UPA which includes elements of Article 8, including a requirement for a judicial order to enact a surrogacy agreement.

¹⁸⁵ Article 8 also states that non-validated gestational surrogacy agreements are unenforceable and requires determinations of parentage to be decided under Article 2 of the UPA, which governs determination of the parent-child relationship. *Id.* at §809(a-b). (Under Article 2, the birth mother, i.e., the surrogate, is the legal mother of the child, unless there is an adoption or an adjudication of maternity. Even where an agreement is otherwise unenforceable, parties to it may nonetheless be held liable for support of the resulting child.)

¹⁸⁶ *Id.* at §803.

¹⁸⁷ *Id.* at §801(e)-(f).

¹⁸⁸ *Id.* at §802(b)(1).

¹⁸⁹ *Id.* at §803(b)(2). If a home study is performed, the intended parents must meet the standards of suitability applicable to adoptive parents.

¹⁹⁰ *Id.* at §803(b)(4).

¹⁹¹ *Id.* at §805.

¹⁹² *Id.* at §806(a). In addition, the UPA states that neither the surrogate nor her husband if married, is liable to the intended parents for terminating the agreement before pregnancy occurs. *Id.* at §806(b).

¹⁹³ *Id.* at §806(b).

¹⁹⁴ *Id.* at §807(a).

¹⁹⁵ American Bar Association, *American Bar Association Model Act Governing Assisted Reproductive Technology* (February 2008), (2008), Prefatory Note at 1, <http://apps.americanbar.org/family/committees/artmodelact.pdf> (ABA Model Act). The ABA Model Act sought to resolve confusing and contradictory issues that arose from attempts to apply existing statutory and common law to situations utilizing advances in ART. The Model Act's stated purpose is "to give assisted reproductive technology (ART) patients, participants, parents, providers, and the resulting children and their siblings clear legal rights, obligations, and protections." *Id.* at 1.

¹⁹⁶ ABA Model Act, *supra* note 195, at §802.

¹⁹⁷ *Id.*

¹⁹⁸ While the UPA uses the term gestational mother the ABA Model Act uses the term gestational carrier.

¹⁹⁹ Alternative A's requirements "introduce inherent and potential unexpected delays and additional expense to [the] already extended process of becoming a parent" (in the cases of infertile couples who have often struggled for years to become parents). It allows, at least theoretically, for intended parents to enter into an agreement with a potential surrogate and spend a great deal of time and money getting it approved, only to have the surrogate change her mind or fail to become pregnant. "For these and other reasons, many ART practitioners opposed the inclusion of the judicial preapproval requirements of Alternative A in the Model Act. However, the drafters of the Model Act chose to include Alternative A in recognition of the fact that the UPA endorses it and that some legislatures may wish to approve a surrogacy law, but only if judicial approval is involved." Charles P. Kindregan, Jr. and Steven H. Snyder, "Clarifying the Law of ART: The New American Bar Association Model Act Governing Assisted Reproductive Technology," *Family Law Quarterly* 42 (2008): 203, 222 (Kindregan and Snyder, *Clarifying the Law of ART*).

²⁰⁰ See ABA Model Act, *supra* note 195, at §707(1)(a) and (c) (Alternative A) and UPA, *supra* note 184, at §807(a)(1) and (3).

²⁰¹ Kindregan and Snyder, *Clarifying the Law of ART*, *supra* note 199, at 223 and ABA Model Act §§701-712 (Alternative B).

²⁰² Kindregan and Snyder, *Clarifying the Law of Art*, *supra* note 199, at 220-221.

²⁰³ ABA Model Act §701(2) (Alternative B).

²⁰⁴ *Id.* at §705 (Alternative B).

²⁰⁵ *Id.*

²⁰⁶ *Id.* at §702(1) (Alternative B).

²⁰⁷ *Id.* at §702(2) (Alternative B).

²⁰⁸ *Id.* at §703((2)(f) (Alternative B).

²⁰⁹ *Id.* at §§703(2)(a)-(b) (Alternative B).

²¹⁰ *Id.* at §703(3)(b) (Alternative B).

²¹¹ *Id.* at §703(3)(c) (Alternative B).

²¹² *Id.* at §§703(4)(a)-(b) (Alternative B).

²¹³ *Id.* at §§703(4)(c)-(d) (Alternative B) and §703(2)(e) (Alternative B).

²¹⁴ The intended parents must accept custody of the children "regardless of number, gender, or mental or physician condition." *Id.* at §703(3)(d) (Alternative B).

²¹⁵ *Id.* at §704 (Alternative B).

²¹⁶ *Id.* at §709 (Alternative B).

²¹⁷ *Id.* at §709(2) (Alternative B).

²¹⁸ *Id.* at §710 (Alternative B).

²¹⁹ *Id.* at §712 (Alternative B).

²²⁰ Task Force, *Surrogate Parenting*, *supra* note 1, at 116-117.

²²¹ There are online communities of surrogates who discuss their surrogate experiences on message boards. One such site, <http://www.surromomsonline.com> (SMO), contains forums where surrogates discuss various aspects of the arrangement, such as screening, matching, pregnancy, disputes with intended parents, medical issues involving the pregnancy, and coping after birth. In these forums, surrogates express great pride in their surrogate births. Many post banners displaying the number of children they have as well as the number of children they have delivered as a surrogate.

²²² The surrogate community refers to a surrogacy arrangement as a "journey," and they include the intended parents as parties to this journey once they are matched. Surrogates speak lovingly of the matching process, which shows their altruism and the view that, in addition to being a financial transaction, surrogacy is a gift exchange. Surrogates

describe chemistry with couples, use dating terminology to discuss matching, talk about falling in love with their couples, and discuss the finding the right match as something destined. Zsuzsa Berend, “The Romance of Surrogacy,” *Sociological Forum* 27 (2012): 913, 913 and 922 (Berend, *Romance of Surrogacy*).

²²³ Many of the recent studies come from The Centre for Family Research (Centre for Family Research) at the University of Cambridge, England. Both uncompensated gestational surrogacy and uncompensated traditional surrogacy are permitted in the United Kingdom, so many of these studies include children of both types of surrogacy arrangements. While surrogates in the United Kingdom are not permitted to be compensated, the Surrogacy Arrangements Act 1985 does allow them to be reimbursed for reasonable expenses, which now average £15,000. The courts do not have clarity on what constitutes reasonable expenses, and one court on record has permitted clear compensation for surrogacy. Often, surrogates in the United Kingdom are compensated more than they are in the U.S., but under the rubric of “reasonable expenses.” Martin Beckford and Tim Ross, “Childless Couples Win the Right to Pay Surrogate Mothers,” *The Telegraph* (Dec. 8, 2010), http://www.telegraph.co.uk/health/children_shealth/8190131/Childless-couples-win-the-right-to-pay-surrogate-mothers.html.

²²⁴ The Task Force’s 1988 surrogacy report describes various risks to the surrogate. The biggest risk of artificial insemination is improper screening of the sperm against infections and disease, such as STDs, HIV virus, and other diseases. Risks of IVF include “risks associated with general anesthesia, ectopic pregnancy, multiple births, prematurity, still birth, newborn death, and the necessity for cesarean section.” Medical procedures such as amniocentesis and abortion, pregnancy-related illness, impairment and possible death are the risks associated with pregnancy. Task Force, *Surrogate Parenting*, *supra* note 1, at 20, 23, and 24.

²²⁵ Embryos are examined for the quality of their development, and only those without abnormalities are selected for transfer. In the past, clinics implanted embryos on day three, but recommendations now encourage the transfer on day five. Practice Committee, ASRM, “Criteria for Number of Embryos to Transfer: A Committee Opinion,” *Fertility and Sterility* 99 (2013): 44, 44 (ASRM, *Criteria for Embryo Transfer*). By allowing the embryos to develop longer, those that are not developing as expected are discarded since they either stop growing or have significant abnormalities that would not result in a healthy embryo. For example, the number of cells, size and shape of the cells, and appearance of the cytoplasm are examined and often a large number of the embryos are determined not suitable for transplantation. This extra step permits physicians to select the “best” embryos in order to increase the probability of successful implantation and reduces the number of embryos that are frozen. Dr. Harry J. Lieman, presentation at Task Force meeting Feb. 25, 2014.

²²⁶ For example, gonadotropin releasing hormone agonists such as Lupron can have side effects, the most common being hot flashes, vaginal dryness, headaches, mood changes, depression and forgetfulness. Rare, but serious and potentially life-threatening side effects include thinning of bones, fluid retention, epilepsy, asthma, migraines and changes in vision, such as double vision or blindness. Lupron Depot, *Use and Important Safety Information*, <http://www.lupron.com/important-safety-information.cfm>. Estrogen can increase the risk of endometrial/uterine cancer, ovarian cancer, breast cancer, dementia, stroke, heart attacks and life-threatening blood clots and common side effects include upset stomach, nausea/vomiting, bloating, breast tenderness, headache and weight changes. WebMD.com, *Estradiol Oral: Uses, Side Effects, Interactions, Pictures, Warnings & Dosing*, <http://www.webmd.com/drugs/drug-5186-estradiol+oral.aspx?drugid=5186&drugname=estradiol+oral>. With progesterone, common side effects include upset stomach, changes in appetite, weight gain, fluid retention and swelling, breast discomfort or enlargement, acne, fatigue and headache. The drug is not recommended for women who have arterial disease, depression or liver disease, and may increase the risk for breast cancer. WebMD.com, *Pregnancy Hormone: (PROGESTERONE): Uses, Side Effects, Interactions and Warnings*, <http://www.webmd.com/vitamins-supplements/ingredientmono-760-Pregnancy%20Hormone%20%28PROGESTERONE%29.aspx?activeIngredientId=760&activeIngredientName=Pregnancy%20Hormone%20%28PROGESTERONE%29>.

²²⁷ Magdalena Gugucheva, Council for Responsible Genetics, *Surrogacy in America*, 18 (2010) (Gugucheva, *Surrogacy in America*).

²²⁸ See e.g., Talha Al-Shawaf, et al., “Safety of Drugs Used in Assisted Reproduction Techniques,” *Drug Safety* 28 (2005): 513, 524; Louise Brinton et al., “Fertility Drugs and the Risk of Breast and Gynecological Cancers,” *Seminars in Reproductive Medicine*, 30 (2012): 131, 131; Louise Brinton, et al., “In Vitro Fertilization and Risk of Breast and Gynecologic Cancers: A Retrospective Cohort Study Within the Israeli Maccabi Healthcare Services,” *Fertility and Sterility* 99 (2013): 1189, 1195.

²²⁹ All pregnancies can cause side effects such as fatigue, nausea, indigestion, constipation, weight gain, bloating, muscle pain, difficulty sleeping, and dermatologic and mood changes. Occasionally, a woman may experience more serious complications such as preeclampsia, gestational diabetes, preterm delivery, placenta previa, anemia and

maternal death. In addition, pregnancies with these medical or obstetric co-morbidities are at risk for miscarriage and prolonged hospitalization. Gugucheva, *Surrogacy in America*, *supra* note 227, at 23.

²³⁰ *Id.*

²³¹ See, e.g., Richard L. Naeye, “Maternal Age, Obstetric Complications, and the Outcome of Pregnancy,” *Obstetrics & Gynecology* 61 (1983): 210-216; Katherine H. Campbell et al., “Maternal Morbidity and Risk of Death at Hospitalization,” *Obstetrics & Gynecology* 122 (2013): 627-33.

²³² Although cesarean sections are common in the United States, the procedure is major abdominal surgery that involves risks to the pregnant woman and baby. The most common risks associated with C-sections to the mother include infection, hemorrhage, injury to the bladder or bowel, increased risk for future pregnancy complications and increased maternal mortality (versus vaginal birth). Risks to the baby include breathing and respiratory problems and fetal injury by the scalpel. American Pregnancy Association, *Risks of a Cesarean Procedure*, (2014), <http://americanpregnancy.org/labor-and-birth/cesarean-risks/>.

²³³ Gugucheva, *Surrogacy in America*, *supra* note 227, at 23.

²³⁴ New York State Department of Health, *Hypertensive Disorders in Pregnancy: Guideline Summary*, 5 (2013), citing E.V. Kuklina, C. Ayala, and W.M. Callaghan, “Hypertensive Disorders and Severe Obstetric Morbidity in the United States,” *Obstetrics & Gynecology* 113 (2009):1299-1306.

²³⁵ Viveca Söderström-Anntila et al., “Surrogacy: Outcomes for Surrogate Mothers, Children and the Resulting Families- A Systematic Review,” *Human Reproduction Update* 0 (2015): 1, 6 (Söderström-Anntila et al., *Surrogacy Outcomes*).

²³⁶ Robert M. Silver, “Abnormal Placentation: Placenta Previa, Vasa Previa, and Placenta Accreta,” *Obstetrics & Gynecology* 126 (2015): 654, 654.

²³⁷ Söderström-Anntila et al., *Surrogacy Outcomes*, *supra* note 235, at 6.

²³⁸ *Id.*

²³⁹ Task Force, *Surrogate Parenting*, *supra* note 1, at 24.

²⁴⁰ *Id.*

²⁴¹ “Another study of 30 women who had babies as surrogates found that all the women experienced some degree of grief.” Task Force, *Surrogate Parenting*, *supra* note 1, at 25. However, a source was not provided for this statement. While a *N.Y. Times* article also cited the same data, the article identified the author of the study as Philip Parker. Daniel Goleman, “Motivations of Surrogate Mothers,” *N.Y. Times* (January 20, 1987), <http://www.nytimes.com/1987/01/20/science/motivations-of-surrogate-mothers.html?pagewanted=all>. While Philip Parker did publish an article on potential surrogates, the article does not mention the statement above. Philip J. Parker, “Motivation of Surrogate Mothers: Initial Findings,” *American Journal of Psychiatry* 140 (1983): 117-118.

²⁴² The 1988 surrogacy report stated, “Ten percent were so distraught after relinquishing the infant that they sought therapeutic counseling.” Task Force, *Surrogate Parenting*, *supra* note 1, at 25. The report attributes this statement to an article on female psychiatric patients who had relinquished their first child for adoption during their adolescence. This article does not address surrogates who are older and have already had children. Edward K. Rynearson, “Relinquishment and Its Maternal Complications: A Preliminary Study,” *American Journal of Psychiatry* 139 (1982): 338, 339. The report also cited Eva Deykin, Lee Campbell and Patricia Patti, “The Post-Adoption Experience of Surrendering Parents,” *American Journal of Orthopsychiatry* 54 (1984): 271-280.

²⁴³ Elly Teman, “The Social Construction of Surrogacy Research: An Anthropological Critique of the Psychosocial Scholarship on Surrogate Motherhood,” *Social Science and Medicine* 67 (2008):1104, 1108 (Teman, *Social Construction of Surrogacy Research*).

²⁴⁴ *Id.*

²⁴⁵ Söderström-Anntila et al., *Surrogacy Outcomes*, *supra* note 235. See Supplementary Table IV Surrogate Mothers: Psychological Aspects (Motivation, Social and Psychological Profile), Relinquishing Issues, Quality of Life).

²⁴⁶ See e.g., Susan Imrie and Vasanti Jadva, “The Long-Term Experiences of Surrogates: Relationships and Contact with Surrogacy Families in Genetic and Gestational Surrogacy Arrangements,” *Reproductive BioMedicine Online* 29 (2014): 424-435 (Imrie and Jadva, *Long-Term Experiences*); Vasanti Jadva et al., “Surrogacy: The Experiences of Surrogate Mothers,” *Human Reproduction* 18 (2003): 2196-2204 (Jadva et al., *Surrogacy: Experiences of Surrogate Mothers*); Olga van den Akker, “Genetic and Gestational Surrogate Mothers’ Experience of Surrogacy,” *Journal of Reproductive and Infant Psychology* 21 (2003): 145-161 (van den Akker, *Genetic and Gestational Surrogate Mothers*); and Hazel Baslington, “The Social Organization of Surrogacy: Relinquishing a Baby and the Role of Payment in the Psychological Detachment Process,” *Journal of Health Psychology* 7 (2002): 57-71 (Baslington, *Social Organization of Surrogacy*).

²⁴⁷ van den Akker, *Genetic and Gestational Surrogate Mothers*, *supra* note 246, at 152.

²⁴⁸ Jadva et al., *Surrogacy: Experiences of Surrogate Mothers*, *supra* note 246, at 2203.

²⁴⁹ *Id.* at 2200.

²⁵⁰ *Id.* at 2203.

²⁵¹ *Id.* at 2201.

²⁵² The researchers examined if there were any differences between surrogates who participated in the follow-up study and those who did not. They concluded that “no differences were found for any of the variables [of interest in this study], including type of surrogacy undertaken, psychological well-being, relationship and contact with the surrogacy family and feelings towards the child.” Furthermore, the researchers concluded that there were “no differences in terms of their psychological well-being and experiences of surrogacy at age 1 year [i.e., the first study], suggesting there were no systematic biases.” *Id.* at 374-375 and 378. V. Jadva, et al., “Surrogate Mothers 10 Years On: A Longitudinal Study of Psychological Well-Being and Relationships with the Parents and Child,” *Human Reproduction* 30 (2014): 373, 374-375 and 378 (Jadva et al., *Surrogate Mothers 10 Years On*).

²⁵³ *Id.* at 377.

²⁵⁴ See S. Fisher and I. Gilman, “Surrogate Motherhood: Attachment, Attitudes and Social Support,” *Psychiatry* 54 (1991): 13-20; E. Blyth, “I Wanted to be Interesting. I Wanted to be Able to Say ‘I’ve Done Something Interesting with My Life’ Interviews with Surrogate Mothers in Britain,” *Journal of Reproductive and Infant Psychology* 12 (1994): 189-198; and Olga van den Akker, “The Importance of a Genetic Link in Mothers Commissioning a Surrogate Baby in the UK,” *Human Reproduction* 15 (2000): 1849-1855.

²⁵⁵ Olga van den Akker, “Psychological Trait and State Characteristics, Social Support and Attitudes to the Surrogate Pregnancy and Baby,” *Human Reproduction* 22 (2007): 2287, 2291 and 2293 (van den Akker, *Psychological Trait and State Characteristics*).

²⁵⁶ *Id.* at 2293.

²⁵⁷ See e.g., Jadva et al., *Surrogate Mothers 10 Years On*, *supra* note 252, at 373-379; Imrie and Jadva, *Long-Term Experiences*, *supra* note 246, at 424-435; Söderström-Anntila et al., *Surrogacy Outcomes*, *supra* note 235.

²⁵⁸ At year one, 12 surrogates reported no special bond and at year 10, 9 surrogates reported no special bond and three surrogates said there was a special bond. Eight surrogated who reported a special bond at year one reduced to six surrogates and the other two reported no special bond at year 10. Jadva et al., *Surrogate Mothers 10 Years On*, *supra* note 252, at 377.

²⁵⁹ *Id.*

²⁶⁰ One example of a “special bond” response was: “... to think that I was part of the reason she’s here and I just think she’s, you know, she’ll always be really special, um, and just always a big part of what I did in my life.” This comment reveals that while the surrogate may envision there is a special bond, the child does not play an active role, rather the child is a reminder of the surrogate’s accomplishment and the role she played in helping another couple have a child. Conversely, an example of a “no a special bond” response was: “... I don’t feel for my surrogate children like I feel for my own. So, when we’re on the phone and we have a little chat it’s just a little friendly chat.” This statement suggests that the surrogate does not think of the child born through surrogacy as one of her own, and she does not have a deep emotional connection to the child. *Id.*

²⁶¹ For example, one surrogate commented, “I am pregnant with my 3rd Surro Baby and all I feel is a sense of obligation to them (to be healthy, etc.), but no maternal feelings at all.” Berend, *Romance of Surrogacy*, *supra* note 222, at 925.

²⁶² For example, one surrogate stated that “we are carrying someone else’s CHILD! No matter how you look at it you are carrying the child for someone else therefor that child IS THEIRS! No amount of biology can change [this fact].” *Id.*

²⁶³ Zsuzsa Berend, “Surrogate Losses: Understandings of Pregnancy Loss and Assisted Reproduction among Surrogate Mothers,” *Medical Anthropology Quarterly* 24 (2010): 240, 242.

²⁶⁴ See Section VI. Professional Medical and Legal Guidance on Gestational Surrogacy.

²⁶⁵ See e.g., Janice C. Ciccarelli and Linda J. Beckman, “Navigating Rough Waters: An Overview of Psychological Aspects of Surrogacy,” *Journal of Social Issues* 61 (2005): 21-43, 32 (Ciccarelli and Beckman, *Rough Waters*); Baslington, *Social Organization of Surrogacy*, *supra* note 246, at 67; and M.M. Hohman and C.B. Hagan, “Satisfaction with Surrogate Mothering: A Relational Model,” *Journal of Human Behavior in the Social Environment* 4 (2001): 61-84.

²⁶⁶ Berend, *Romance of Surrogacy*, *supra* note 222, at 922.

²⁶⁷ *Id.* at 925.

²⁶⁸ *Id.* at 923-924.

²⁶⁹ Of 34 surrogates, 33 surrogates reported a harmonious relationship with the intended mother, and 32 surrogates reported the same with the intended father. One surrogate expressed dissatisfaction/coldness of her relationship with

the intended mother during the last three months of pregnancy and two surrogates expressed the same with the intended father. Jadvā et al., *Surrogacy: Experiences of Surrogate Mothers*, *supra* note 246, at 2199.

²⁷⁰ Imrie and Jadvā, *Long-Term Experiences*, *supra* note 246, at 432.

²⁷¹ The one surrogate who stated she had no relationship with the intended parents revealed that the intended mother did communicate via letters one or twice a year. Jadvā et al., *Surrogate Mothers 10 Years On*, *supra* note 252, at 376.

²⁷² For example, one surrogate stated “well because, you know, at the start, [...] it’s always at the back of a couple’s mind that you might change your mind and keep the baby, and also, when you’re carrying the baby, you’re still getting to know them. But you know, once I’ve given the baby up, it’s, they’re, it’s like a different mask, their whole demeanor, it relaxes, and ‘oh my god, we’ve got our son’ and ‘thanks [surrogate]’, ‘you’re great’, and so it’s light, a lighter feel to the relationship, because there’s no worries there anymore.” Another example of a positive change in the relationship reported by a surrogate, “... when I was being a surrogate for them we were very close and, you know, used to go out for dinner and talk on the phone several times a week so yeah it has changed, but I think for the better because I think it’s better for the child.” *Id.* at 376-377.

²⁷³ *Id.* at 377.

²⁷⁴ Ciccarelli and Beckman, *Rough Waters*, *supra* note 265, at 32.

²⁷⁵ Jacqueline N. Gutmann and Andrea M. Braverman “What’s in a Name? The Evolution of Gestational Surrogacy,” *Infertility and Reproductive Medicine Clinics of North America*, 13 (2002): 595, 603.

²⁷⁶ *Id.* at 604.

²⁷⁷ *Id.*

²⁷⁸ Berend, *Romance of Surrogacy*, *supra* note 222, 926.

²⁷⁹ *Id.*

²⁸⁰ *Id.* at 929.

²⁸¹ See e.g., Imrie and Jadvā, *Long-Term Experiences*, *supra* note 246, at 424-435; Jadvā et al., *Surrogate Mothers 10 Years On*, *supra* note 252, at 373-379; C.H. Klinepeter and M.M. Hohman, “Surrogate Motherhood: Personality Traits and Satisfaction with Service Providers,” *Psychological Report* 87 (2000):957-970; E.S. Lorenceau et al., “A Cross-Cultural Study on Surrogate Mother’s Empathy and Maternal-Foetal Attachment,” *Women Birth* 28 (2015): 154-159; T.D. Pizitz et al., “Do Women who Choose to Become Surrogate Mothers have Different Psychological Profiles Compared to a Normative Female Sample? *Women Birth* 26 (2013): e15-e20; van den Akker, *Genetic and Gestational Surrogate Mothers* *supra* note 246, at 145-161; van den Akker, *Psychological Trait and State Characteristics*, *supra* note 255, at 2287-2295.

²⁸² Andrea Mechanick Braverman and Stephen L. Corson, “Characteristics of Participants in a Gestational Carrier Program,” *Journal of Assisted Reproduction & Genetics* 9 (1992): 353, 356.

²⁸³ Jadvā et al., *Surrogate Mothers 10 Years On*, *supra* note 252, at 376.

²⁸⁴ The researchers note that 8 of 34 surrogates developed psychological health issues after completing a surrogacy arrangement, although the surrogates disclosed most were not related to the surrogacy arrangement. Of the eight, four completed additional surrogacy arrangements after they had recovered. Imrie and Jadvā, *Long-Term Experiences*, *supra* note 246, at 431-433.

²⁸⁵ Practice Committee, ASRM, “Recommendations for Practices Utilizing Gestational Carriers: An ASRM Practice Committee Guideline,” *Fertility and Sterility* 97 (2012): 1301, 1304-1306 (ASRM, *Recommendations for Practices Utilizing Gestational Carriers*).

²⁸⁶ Katherine Wisner, “Postpartum Depression,” *NEJM*, 347 (2002): 194, 198.

²⁸⁷ Committee on Obstetric Practice, “ACOG Committee Opinion No. 630: Screening for Perinatal Depression,” *Obstet. Gynecol.* 125 (2015): 1268-1271; and Albert L. Siu and the United States Preventive Services Task Force, “Screening for Depression in Adults: U.S. Preventative Services Task Force Recommendation Statement,” *JAMA*, 315 (2016): 380-387.

²⁸⁸ The nature of surrogacy itself is not what leads to the devaluation of a child with a disability, but rather is society’s prejudice and bias against individuals with disabilities. This perspective can only change when the public’s perception about disability evolves and better intuitional support is provided to disabled individuals and their families. Until individuals and societal views change, as a safeguard, a surrogacy agreement should stipulate that the intended parents are responsible for the child born through surrogacy.

²⁸⁹ See *supra* note 149, *Baby S.*, 2015 Pa. Super. 244.

²⁹⁰ See ASRM, *Recommendations for Practices Utilizing Gestational Carriers*, *supra* note 285, at 1307.

²⁹¹ Berend, *Romance of Surrogacy*, *supra* note 222, 923.

²⁹² *Id.*

²⁹³ *Id.*

²⁹⁴ Jadva et al., *Surrogate Mothers 10 Years On*, *supra* note 252, at 377.

²⁹⁵ Task Force, *Surrogate Parenting*, *supra* note 1, at 77.

²⁹⁶ In one study examining 36 children of surrogates, most of these children had no memory of the experience of their mothers handing over the child born through surrogacy to the intended parents or the surrogates' children indicated they had no difficulties. Only one of the 36 children experienced "some difficulties." Vasanti Jadva and Susan Imrie, "Children of Surrogate Mothers: Psychological Well-Being, Family Relationships and Experiences of Surrogacy," *Human Reproduction* 29 (2014): 90, 93 and 95 (Jadva and Imrie, *Children of Surrogate Mothers*).

²⁹⁷ Andrea Braverman, Clinical Associate Professor with a joint appointment in the Department of Obstetrics and Gynecology and Psychiatry and Behavioral Medicine at Thomas Jefferson University. Presentation to the Task Force, February 25, 2014.

²⁹⁸ Jadva and Imrie, *Children of Surrogate Mothers*, *supra* note 296, at 90.

²⁹⁹ *Id.* at 94.

³⁰⁰ *Id.* at 94-95.

³⁰¹ *Id.* at 94.

³⁰² *Id.* at 93.

³⁰³ ASRM, *Consideration of Gestational Carrier*, *supra* note 175, at 1840.

³⁰⁴ Jadva and Imrie, *Children of Surrogate Mothers*, *supra* note 296, at 91, and Jadva et al., *Surrogacy: Experiences of Surrogate Mothers*, *supra* note 246, at 2196.

³⁰⁵ Ciccarelli and Beckman, *Rough Waters*, *supra* note 265, at 30.

³⁰⁶ Berend, *Romance of Surrogacy*, *supra* note 222, at 916.

³⁰⁷ Teman, *Social Construction of Surrogacy Research*, *supra* note 243, at 1109. *See also* Jadva et al., *Surrogacy: Experiences of Surrogate Mothers*, *supra* note 246, at 2204.

³⁰⁸ Bryn Williams-Jones, "Commercial Surrogacy and the Redefinition of Motherhood," *Journal of Philosophy, Science, and Law*, 2 (2002): 1, 4 (Williams-Jones, *Commercial Surrogacy*).

³⁰⁹ Berend, *Romance of Surrogacy*, *supra* note 222, at 924.

³¹⁰ *Id.*

³¹¹ *Id.* at 925.

³¹² Williams-Jones, *Commercial Surrogacy*, *supra* note 308, at 4.

³¹³ *Id.*

³¹⁴ van den Akker, *Genetic and Gestational Surrogate Mothers*, *supra* note 246, at 150-151. *See also*, Elly Teman, *Birthing a Mother: The Surrogate Body and the Pregnant Self*, 31 (University of California Press 2010).

³¹⁵ For details regarding ovarian stimulation and oocyte retrieval, *see* Task Force, *Assisted Reproductive Technologies*, *supra* note 73, at 53-55.

³¹⁶ Side effects include bleeding, discomfort, mood swings and cramps. The woman may develop redness or mild bruising around the drug injection site or an allergic reaction to the medication, although this is very rare. New York State Task Force on Life and the Law, *Thinking of Becoming an Egg Donor*, 15 (New York, NY) 2002.

³¹⁷ In extremely rare cases, OHSS can be a serious medical condition that, if left untreated, can lead to blood clots, kidney failure, infertility, ovary removal and death. Institute of Medicine, *Assessing the Medical Risks of Human Oocyte Donation for Stem Cell Research: Workshop Report*, 18-19 (Washington, D.C.) (Linda Giudice et al., eds., The National Academies Press) 2007.

³¹⁸ *Id.* at 26. There is speculation that hormonal stimulation is linked to cancer, several studies have found no increased risk for breast or ovarian cancer. More research is needed to determine any link between fertility drugs and an increased risk for cancer.

³¹⁹ *Id.* at 32-33 and 34-37.

³²⁰ If a surrogacy agency is not used to assist with the matching of the intended parents with a surrogate, most intended parents use the internet, social media, personal ads (print or online such as Craigslist), or word-of-mouth to locate potential surrogates. For example, there is a surrogacy meet-up group on Facebook to help connect intended parents with surrogates. Surrogacy Meet-up Group, Facebook page, <https://www.facebook.com/groups/surrogacymeetup/>. In addition, some fertility clinics that offer surrogacy services can assist in finding a surrogate. Of 467 fertility clinics who reported ART data to the CDC, 86% offered gestational surrogate services. Centers for Disease Control and Prevention, American Society for Reproductive Medicine, Society for Assisted Reproductive Technology, *2013 Assisted Reproductive Technology National Summary Report*, Atlanta, GA (U.S. Department of Health and Human Services. 2012), 5, http://www.cdc.gov/art/pdf/2013-report/art_2013_national_summary_report.pdf.

³²¹ Deborah L. Spar, *The Baby Business: How Money, Science, and Politics Drive the Commerce of Conception*, 92 (Harvard Business Review Press 2006).

³²² Melissa B. Brisman, the sole owner of Reproductive Possibilities, LLC, an agency based in New Jersey that facilitates gestational carrier arrangements, and Surrogate Fund Management, LLC, a company that manages escrow in connection with reproductive arrangements. Presentation at a Task Force meeting, November 21st, 2013.

³²³ The highest costs are those allocated to the surrogacy agency (if used), surrogate, and attorneys. The surrogacy agency's fees can range from \$13,900 to \$20,500, depending on the extent of the services provided. Reproductive Possibilities, *Estimated Costs of Surrogacy* http://www.reproductivepossibilities.com/parents_exp.cfm. Gestational surrogates usually earn between \$25,000 and \$30,000. *See e.g.*, Lorraine Ali, "The Curious Lives of Surrogates," *Newsweek* (March 29, 2008), <http://www.newsweek.com/curious-lives-surrogates-84469>; Alex Kuczynski, "Her Body, My Baby," *N.Y. Times* (Nov. 28, 2008), <http://www.nytimes.com/2008/11/30/magazine/30Surrogate-t.html?pagewanted=all>; Elisabeth Eaves, "Want To Work For \$3 An Hour?" *Forbes* (July 24, 2009), <http://www.forbes.com/2009/07/23/surrogate-motherhood-minimum-wage-opinions-columnists-elisabeth-eaves.html>. In addition to the medically-related fees of surrogacy, there are also legal fees associated with the drafting the surrogacy agreement, medical insurance review, and any court pre-birth or post-birth orders related to the birth certificate or parental rights. Reproductive Possibilities, *Estimated Costs of Surrogacy* http://www.reproductivepossibilities.com/parents_exp.cfm.

³²⁴ For example, the compensation amount to the surrogate may increase if she is pregnant with multiples (i.e., twins) or on the basis of her experience as a "successful" surrogate (i.e., she previously gave birth to a child born through surrogacy). In addition to compensation, surrogates may receive reimbursement for expenses incurred because of the pregnancy, such as missed work or child care for the surrogate's children. Finally, health insurance for the surrogate during pregnancy and for several weeks post-childbirth is often required. Because many insurers do not cover expenses related to a surrogacy pregnancy, intended parents must provide this coverage. The Essential Health Benefits for Federal Employees sampled insurance companies and most exclude surrogacy pregnancies. Institute of Medicine, *Essential Health Benefits: Balancing Coverage and Cost*, 222 (The National Academies Press 2011).

³²⁵ Some surrogacy agencies and independent financing companies offer loans to intended parents to cover the cost of surrogacy. For example, Circle Surrogacy in Boston, MA has financing options that list loans up to \$100,000 on its website. <http://www.circlesurrogacy.com/parents/surrogacy-financing>. The Task Force is aware of at least one independent company, New Life Fertility Finance, that offers loans for surrogacy and other forms of ART. The company also offer insurance for surrogacy arrangements. <http://newlifefertilityfinance.com/>.

³²⁶ Task Force, *Surrogate Parenting*, *supra* note 1, at 120.

³²⁷ Susan Golombok et al., "Families Created through Surrogacy Arrangements: Parent-Child Relationships in the First Year of Life," *Developmental Psychology* 40 (2004): 400-411 (Golombok et al., *Families Created through Surrogacy at Age 1*).

³²⁸ *Id.* at 408.

³²⁹ Susan Golombok et al., "Surrogacy Families: Parental Functioning, Parent-Child Relationships and Children's Psychological Development at Age 2," *Journal of Child Psychology and Psychiatry* 47 (2006): 213-222 (Golombok et al., *Surrogacy Families: Age 2*).

³³⁰ Susan Golombok et al., "Non-Genetic and Non-Gestational Parenthood: Consequences for Parent-Child Relationships and the Psychological Well-Being of Mothers, Fathers and Children at Age 3," *Human Reproduction* 21 (2006): 1918-1924 (Golombok et al., *Non-Genetic and Non-Gestational Parenthood: Age 3*).

³³¹ Golombok et al., *Surrogacy Families: Age 2*, *supra* note 329, at 219 and 220; Golombok et al., *Non-Genetic and Non-Gestational Parenthood: Age 3*, *supra* note 330, at 1922.

³³² Susan Golombok et al., "Families Created through Surrogacy: Mother-Child Relationships and Children's Psychological Adjustment at Age 7," *Developmental Psychology* 47 (2011): 1579-1588 (Golombok et al., *Surrogacy Families: Age 7*).

³³³ Susan Golombok et al., "Children Born through Reproductive Donation: A Longitudinal Study of Psychological Adjustment," *Journal of Child Psychology and Psychiatry* 54 (2013): 653, 657-58 (Golombok et al., *Children Born through Reproductive Donation*).

³³⁴ Golombok et al., *Surrogacy Families: Age 7*, *supra* note 332, at 1585.

³³⁵ *Id.* at 1586. This finding may not be relevant to children of gestational surrogacy because the child is genetically related to the intended parents.

³³⁶ *Id.*

³³⁷ Golombok et al., *Children Born through Reproductive Donation*, *supra* note 333, at 657.

³³⁸ *Id.*

³³⁹ *Id.*

³⁴⁰ *Id.* at 658.

³⁴¹ Vasanti Jadva et al., “Surrogacy Families 10 Years On: Relationship with the Surrogate, Decisions over Disclosure and Children’s Understanding of their Surrogacy Origins,” *Human Reproduction* 27 (2012):3008-3014 (Jadva et al., *Surrogacy Families 10 Years On*). The sample consisted of families who had used genetic surrogacy and gestational surrogacy. The study examined the parents’ and children’s relationship with the surrogate, the parents’ decision whether to disclose the circumstances of the child’s birth, and children’s understanding of their surrogacy birth.

³⁴² *Id.* at 3012.

³⁴³ *Id.* Data were not available for two children (9%) which explain why the total percentage does not equal 100%.

³⁴⁴ *Id.*

³⁴⁵ See *supra* note 6.

³⁴⁶ Task Force, *Assisted Reproductive Technologies*, *supra* note 73, at 287-288. See also, Elizabeth Marquardt et al., Institute for American Values, *My Daddy’s Name is Donor: A New Study of Young Adults Conceived Through Sperm Donation*, 77 and 79 Washington, DC (Institute for American Values 2010).

³⁴⁷ Golombok et al., *Surrogacy Families: Age 2*, *supra* note 329, at 219.

³⁴⁸ Golombok et al., *Families Created through Surrogacy at Age 1*, *supra* note 327, at 408.

³⁴⁹ Golombok et al., *Surrogacy Families: Age 2*, *supra* note 329, at 219.

³⁵⁰ Susan Golombok, et al, “Families with Children Conceived by Donor Insemination: A Follow-Up at Age Twelve,” *Child Development* 73 (2002): 952, 965.

³⁵¹ Golombok et al., *Surrogacy Families: Age 2*, *supra* note 329, at 219.

³⁵² A Pew survey reports that the breakdown of self-reported religious tradition or affiliation in New York is approximately 31% Catholic; 26% Protestant (Mainline Protestant - 11%, Evangelical Protestant - 10%, Historically Black Protestant - 5%); 7% Jewish; 2% Muslim; 1% each Orthodox Christian, Jehovah’s Witness, Buddhist and Hindu; 2% Other Faiths; and < 1% Other Christian or Other World Religions. Twenty-seven percent said they are unaffiliated status and 1% indicated “don’t know.” Data collected in 2014. +/- 2.5% margin of error, 1,966 cases. Pew Forum on Religion and Public Life, *U.S. Religious Landscape Study, Adults in New York*, <http://www.pewforum.org/religious-landscape-study/state/new-york/>.

³⁵³ Hanna Klaus, Natural Family Planning Program, United States Conference of Catholic Bishops, *Reproductive Technology (Evaluation & Treatment of Infertility) Guidelines for Catholic Couples*, (2009), <http://uscbb.org/issues-and-action/human-life-and-dignity/reproductive-technology/upload/Reproductive-Technology-Evaluation-Treatment-of-Infertility-Guidelines.pdf>. ART is morally right and permitted in limited circumstances, where the procedure “assists marital intercourse in reaching its procreative potential.” *Id.* The moral conscience “does not necessarily proscribe the use of certain artificial means destined solely either to the facilitating of the natural act [i.e., sexual intercourse] or to ensuring that the natural act normally performed achieves its proper end. If the technical means facilitates the conjugal act or helps it to reach its natural objectives, [i.e., pregnancy] it can be morally acceptable. If, on the other hand, the procedure were [sic] to replace the conjugal act, it is morally illicit.” See Congregation for the Doctrine of the Faith, *Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation Replies to Certain Questions of the Day*, Section II, A., 6, (1987), http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19870222_respect-for-human-life_en.html (Congregation for the Doctrine of the Faith, *Respect for Human Life*). Furthermore, “medical intervention respects the dignity of persons when it seeks to assist the conjugal act either in order to facilitate its performance or in order to enable it to achieve its objective once it has been normally performed.” *Id.* Section II, A., 7. Thus, the following techniques of ART for treating infertility within marriage would be morally acceptable: (1) Hormonal modulation of menstrual cycle irregularities; (2) Surgical correction of tubal occlusions; (3) Resolution of endometriosis; (4) Fertility drugs for anovulation; (5) Viagra or other agents/approaches to address erectile dysfunction; (6) Techniques to boost male sperm production in the testis; (7) Techniques to correct hypospadias; (8) Techniques to address premature ejaculation; (9) NFP - natural family planning and fertility awareness, with appropriate timing of intercourse - for family building; (10) LTOT - low tubal ovum transfer - eggs retrieved and transplanted into the uterus or fallopian tube at a point likely to increase probability of fertilization following marital relations; and (11) Other NaPro (Natural Procreative) Technologies. E-mail correspondence with Rev. Tadeusz Pacholczyk, Director of Education, National Catholic Bioethics Center on November 13, 2014.

³⁵⁴ Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, Part II, Chapter 5, Section III, b., 235 (2004), [http://www.vatican.va/roman_curia/pontifical_councils/justpeace/documents/rc_pc_justpeace_doc_20060526_comp_endio-dott-soc_en.html#The family is the sanctuary of life](http://www.vatican.va/roman_curia/pontifical_councils/justpeace/documents/rc_pc_justpeace_doc_20060526_comp_endio-dott-soc_en.html#The%20family%20is%20the%20sanctuary%20of%20life).

³⁵⁵ *Id.* See also Congregation for the Doctrine of the Faith, *Respect for Human*, *supra* note 353, Section II, A. and B.

³⁵⁶ Congregation for the Doctrine of the Faith, *Respect for Human Life*, *supra* note 353, Section II, A., 3.

³⁵⁷ *Id.*

³⁵⁸ Russell D. Moore, the president of the Ethics & Religious Liberty Commission (ERLC), stated that “Surrogacy for hire is bad for children and bad for women.” Tom Strode, *Jindal Vetoes ‘Surrogacy for Hire’ Bill*, (June 25, 2013), <http://erlc.com/article/jindal-vetoes-surrogacy-for-hire-bill>. The ERLC is an entity of the Southern Baptist Convention.

³⁵⁹ Examples include the United Methodist Church (UMC), United Church of Christ (UCC), Episcopal Church, Presbyterian Church (U.S.A). *See also* National Council of the Churches of Christ in the U.S.A., Policy Development Committee on Human Biotechnologies, *Fearfully and Wonderfully Made: A Policy on Human Biotechnologies*, Section II.C, (2006), <http://nationalcouncilofchurches.us/common-witness/2006/biotech.php>. The National Council of Churches of Christ in the U.S.A includes multiple mainline Protestant and Orthodox denominations, and includes racial/ethnic specific denominations, such as the African Methodist Episcopal Church. For a list of members, see National Council of the Churches of Christ in the U.S.A., *Member Communions*, <http://www.nationalcouncilofchurches.us/about/member-communications.php>.

³⁶⁰ Metropolitan Nikolaos, “The Greek Orthodox Position on the Ethics of Assisted Reproduction,” *Reproductive Biomedicine Online* 17 (2008): 29.

³⁶¹ Jehovah’s Witnesses, *Questions from Readers* (2012), <http://www.jw.org/en/publications/magazines/w20121215/view-of-in-vitro-fertilization/#sidebar>; Jehovah’s Witnesses, *The Choices, the Issues*, (2004): 6-11, <http://wol.jw.org/en/wol/d/r1/lp-e/102004682?q=surrogate&p=par>.

³⁶² The Church of Jesus Christ of Latter Day Saints, *Handbook 2: Administering the Church*, Policies on Moral Issues, Section 21.4.16, <https://www.lds.org/handbook/handbook-2-administering-the-church/selected-church-policies/21.4>.

³⁶³ *See e.g.*, Central Conference of American Rabbis “American Reform Responsa: 159: Surrogate Mother” Vol. XCII (1982) 205-207; Rabbi Aaron Mackler and Rabbi Elie Spitz, “On the Use of Birth Surrogates” EH 1:3.1997a

³⁶⁴ *See e.g.*, Rabbi Leonard A. Sharzer, “Assisted Reproductive Technologies and their Risks: Jewish Ethics and the Mitzvah ‘Be Fruitful and Multiply,’” Lecture/Discussion, Jewish Theological Seminary, NY, NY, (March 31, 2014); Joseph G. Schenker, “Assisted Reproduction Practice: Religious Perspectives,” *Reproductive Biomedicine Online* 10 (2005): 310, 314-315; Joseph G. Schenker “Assisted Reproductive Technology: Perspectives in Halakha (Jewish Religious Law),” *Reproductive Biomedicine Online* 17 (2008): 17-24; Rabbi Aaron Mackler and Rabbi Elie Spitz, “On the Use of Birth Surrogates” *Even HaEzer* 1:3.1997a, http://www.rabbinicalassembly.org/sites/default/files/public/halakhah/teshuvot/19912000/macklerspitz_surrogates.pdf

³⁶⁵ *See e.g.*, Central Conference of American Rabbis, “American Reform Responsa: 159: Surrogate Mother” 92 (1982) 205-207, <https://ccarnet.org/responsa/arr-505-507/>; Rabbi David Golinkin, “What Does Jewish Law Have to Say about Surrogacy?” 7 (2012) The Schechter Institutes, <http://www.schechter.edu/responsa.aspx?ID=71>; John Loike and Rabbi Moshe Tendler, “Gestational Surrogacy,” *Hakirah: The Flatbush Journal of Jewish Law and Thought* 16 (2013): 113, 120-132; Jewish Values Online: Multijewish Perspectives on Moral and Ethics, *Does Judaism allow couples struggling with infertility to hire a surrogate mother? What do Jewish Ethics say about paying someone to carry another’s child to gestation? Are there any limitations on who can act for this purpose?* <http://www.jewishvaluesonline.org/question.php?id=550>.

³⁶⁶ *See* K. Aramesh, “Iran’s Experience with Surrogate Motherhood: An Islamic View and Ethical Concerns,” *Journal of Medical Ethics* 35 (2009): 320, 321, (Aramesh, *Iran’s Experience with Surrogate Motherhood*). *See also* Gamal I. Serour “Islamic Perspectives in Human Reproduction,” *Reproductive Biomedicine Online* 17 (2008): 34-38.

³⁶⁷ Aramesh, *Iran’s Experience with Surrogate Motherhood*, *supra* note 366, at 321 (Aramesh, *Iran’s Experience with Surrogate Motherhood*).

³⁶⁸ *Id.*

³⁶⁹ *Id.*

³⁷⁰ Hossam E. Fadel, “The Islamic Viewpoint on New Assisted Reproductive Technologies,” *Fordham Urban Law Journal* 30 (2002): 147, 150-151 and 153-154.

³⁷¹ Aramesh, *Iran’s Experience with Surrogate Motherhood*, *supra* note 366, at 321.

³⁷² *Id.*

³⁷³ T.C. Kumar, “Ethical Aspects of Assisted Reproduction—An Indian Viewpoint.” *Reproductive BioMedicine Online* 14 (2007): 141.

³⁷⁴ *Id.* at 140.

³⁷⁵ Shoyo Taniguchi, “Biomedical Ethics from a Buddhist Perspective,” *Pacific World News* (1987): 75, 80 (Taniguchi, *Biomedical Ethics*).

³⁷⁶ Laurie Zoloth and Alyssa A. Henning, “Bioethics and Oncofertility: Arguments and Insights from Religious Traditions,” *Cancer Treatment and Research* 156 (2010): 261, 274 (Zoloth and Henning, *Bioethics and Oncofertility*).

³⁷⁷ In addition to fertilization of an egg by sperm, Gandhabba - the arrival of consciousness of the individual - must also be present for a child to be created. Taniguchi, *Biomedical Ethics*, *supra* note 375, at 80.

³⁷⁸ Shoji Mori, “Bioethics from the View of Buddhism,” *Journal of Oriental Studies* 17 (2007) 41, 50-51.

³⁷⁹ *Id.* at 51.

³⁸⁰ *Id.* at 52. While informed consent from the unborn child cannot be obtained, it is important that the child later in life understands and accepts the circumstances of his/her birth.

³⁸¹ *Id.* at 55.

³⁸² Zoloth and Henning, *Bioethics and Oncofertility*, *supra* note 376, at 275.

³⁸³ Susumu Shimazono, “Transcending a Bioethics of Buddhist Compassion,” *Dharma World Magazine*, October-December 2007, http://www.rk-world.org/dharmaworld/dw_2007odtranscending.aspx.

³⁸⁴ Task Force, *Surrogate Parenting*, *supra* note 1, at 116-117.

³⁸⁵ See Section VII. Evaluation of Potential Risks and Benefits of Gestational Surrogacy, for a discussion on the research and data on the risks, harms, and benefits are to children born through surrogacy, surrogates, and intended parents.

³⁸⁶ Task Force, *Surrogate Parenting*, *supra* note 1, at 75.

³⁸⁷ See Section VII.C. Potential Risks and Benefits to the Child Born through Surrogacy for a discussion on the longitudinal research and data on children born through surrogacy.

³⁸⁸ Golombok et al., *Surrogacy Families: Age 7*, *supra* note 332.

³⁸⁹ Jadva et al., *Surrogacy Families 10 Years On*, *supra* note 341, at 3012.

³⁹⁰ Golombok et al., *Children Born through Reproductive Donation*, *supra* note 333, at 657.

³⁹¹ Golombok et al., *Families Created through Surrogacy at Age 1*, *supra* note 327, at 408.

³⁹² Task Force, *Surrogate Parenting*, *supra* note 1, at 120.

³⁹³ See Section VII.A.5. Benefits of Surrogacy to the Surrogate.

³⁹⁴ *Id.*

³⁹⁵ See Section VI. Professional Medical and Legal Guidance on Gestational Surrogacy.

³⁹⁶ See Section VII.A. Evaluation of the Potential Risks and Benefits to the Surrogate and to Her Family.

³⁹⁷ See Section VII.A.2. Psychological Risks to the Surrogate.

³⁹⁸ van den Akker, *Genetic and Gestational Surrogate Mothers*, *supra* note 246, at 154.

³⁹⁹ Task Force, *Surrogate Parenting*, *supra* note 1, at 88.

⁴⁰⁰ *Id.* at 122-123.

⁴⁰¹ See Douglas NeJaime, “Marriage Equality and the New Parenthood,” *Harvard Law Review* 129 (2016): 1185, 1231. “For the purposes of a model of marriage that takes childrearing as ‘a central premise,’ the Court conceptualized same-sex and different-sex couples as similarly situated.” *Id.* at 1240 (NeJaime, *Marriage Equality and the New Parenthood*)

⁴⁰² *Id.* at 1239.

⁴⁰³ NeJaime, *Marriage Equality and the New Parenthood*, *supra* note 401, at 1236-1237 and *Obergefell v. Hodges*, *supra* note 63, at 2599.

⁴⁰⁴ NeJaime, *Marriage Equality and the New Parenthood*, *supra* note 401, at 1240 and *Obergefell v. Hodges*, *supra* note 63, at 2600.

⁴⁰⁵ NeJaime, *Marriage Equality and the New Parenthood*, *supra* note 401, at 1240.

⁴⁰⁶ NeJaime, *Marriage Equality and the New Parenthood*, *supra* note 401, at 1240 and *Obergefell v. Hodges*, *supra* note 63, at 2600.

⁴⁰⁷ See Section VII.C. Potential Risks and Benefits to the Child Born through Surrogacy for a discussion on the longitudinal research and data on children born through surrogacy.

⁴⁰⁸ For the purpose of this section, the term “parental rights” will include the right to custody of the child, the right to make medical decisions for the child, and the legal recognition of being the child’s parent. If there is an instance in which these rights are separated, it will be noted.

⁴⁰⁹ For example, without a clear mechanism to grant parental rights, inconsistent practices could lead to fraudulent claims of parentage. Whether claims of parentage are valid should not be resolved in a health care setting. Such claims could enable a third party to claim parentage and wrongfully obtain custody of the child.

⁴¹⁰ To enact such changes, without requiring a post-birth court order, Public Health Law §4130 will need to be amended to recognize the intended mother as the mother of the child at birth in a situation where there is an approved pre-implantation order. Without amendments to that section of law, intended parents would, subsequent to the birth, need another court order to amend the birth certificate pursuant to Public Health Law §4138(b)(1).

⁴¹¹ New Hampshire has a similar restriction.

⁴¹² The Uniform Parentage Act (UPA), the American Bar Association (ABA) Model Act, and a number of states including Utah, Texas, and Washington, D.C. have a 90-day residency requirement for either the surrogate or intended parents. Louisiana requires that the surrogate and the intended parents have 180 days of residency. The ABA Model Act and the UPA require that the carrier or the intended parents have 90 days of residency. This requirement helps prevent forum shopping by intended parents. The petition to the court must be filed in the state where the surrogate or the intended parents have been residing. However, this requirement does not prevent surrogacy tourism because only one party, i.e. the surrogate or the intended parents must be a resident of the state. Intended parents could still locate a surrogate from a state with more “permissive” laws.

⁴¹³ Specifically, the law states a contract cannot be disaffirmed on the ground of infancy if the party is older than eighteen.

⁴¹⁴ Delaware, Illinois, New Hampshire, Maine, Utah, and Washington, D.C. all require a surrogate to be at least 21 years of age. Florida requires the surrogate to be at least 18. Louisiana requires that the surrogate be at least 25, and no older than 35. The ABA Model Act also has a requirement of 21 for eligibility.

⁴¹⁵ Some jurisdictions also preclude gestational surrogacy for non-medical reasons, such as convenience or pure preference, or as a means for a single male or a male same-sex couple to have a child.

⁴¹⁶ Currently, Utah and Washington, D.C. are the only states that require intended parents to be at least 21 and Florida requires intended parents to be at least 18.

⁴¹⁷ Although potential surrogates must have a medical screening to determine whether they are physically capable of withstanding the rigors of pregnancy and childbirth, the Task Force decided not to recommend a similar medical screening for intended parents, because determining medical conditions that preclude someone from becoming a parent was arbitrary and exclusionary. Additionally, it would be likely that the psychological screening would help to discourage intended parents who may not be prepared to raise a child because of their own medical history.

⁴¹⁸ For example, if the intended parents are in a fatal car accident, the surrogate would not be affected and still proceed with the pregnancy and birth of the child.

⁴¹⁹ Unless the fetus is viable and at least 23 weeks gestational age, it is unlikely the fetus will survive should the pregnant woman be mortally ill or die. Most neonatologists suggest that life-saving measures, such as CPR, not be performed on neonates less than 23 weeks old. American Academy of Pediatrics and American Heart Association, *Textbook of Neonatal Resuscitation*, 9-5 (John Kattwinkel, ed., 5th edition, 2013).

⁴²⁰ Currently, none of the state or model laws on surrogacy require a background check. The state of Victoria in Australia requires such checks for altruistic surrogacies, and there have been calls for wider adoption of the standard in other Australian states. Richard Ackland, “Surrogacy is Still Available to Pedophiles. This Must Change – but How?” *The Guardian* (August 14, 2013), <http://www.theguardian.com/commentisfree/2014/aug/15/surrogacy-is-still-available-to-paedophiles-this-must-change-but-how>

⁴²¹ The Task Force recommended this requirement after the outcry in Australia where an intended parent who was convicted for sex offenses involving minor girls was able to have a child via gestational surrogacy in Thailand. *Id.*

⁴²² While a home study is often used in the adoption context, the Task Force declined to require a home study in the surrogacy context because such a study is not required or recommended for intended parents using other forms of ART where a child is being created (versus a child who already exists).

⁴²³ A lawyer who has violated the rules of professional misconduct should be reported to the appropriate professional authority.

⁴²⁴ Should a dispute arise, the child born through surrogacy would not acquire legal representation because the court would make its decision based on the best interests of the child standard. For example, children in divorce proceedings do not have counsel.

⁴²⁵ Legal counsel should be familiar with reproductive/family law. Ideally, they would be members of the American Academy of Assisted Reproductive Attorneys (AAARTA), <http://www.aaarta.org/aaarta/home>.

⁴²⁶ The Task Force assumes that legal fees by the surrogate’s attorney would be reasonable. Abnormally high or low fees would be subject to scrutiny.

⁴²⁷ Any monies unused would be returned to the intended parents.

⁴²⁸ ASRM, *Recommendations for Practices Utilizing Gestational Carriers*, *supra* note 285, at 1304-1305.

⁴²⁹ ASRM, *Criteria for Embryo Transfer*, *supra* note 225.

⁴³⁰ *Id.* at 44-45.

⁴³¹ However, the intended parents' physician for ART may also treat the surrogate for her embryo pre-implantation, embryo implantation, and procedures related to confirmation of a pregnancy. However, once the surrogate is pregnant, her care should be overseen by an obstetrician of her choosing.

⁴³² ACOG, *Family Building Through Gestational Surrogacy* 2016, *supra* note 164.

⁴³³ *See supra* note 287.

⁴³⁴ These protections fall under the practice of medicine. If there is a need to clarify privacy and confidentiality issues, amending the Public Health and Education laws to state that sharing a surrogate's medical information with intended parents is not permitted, or adding a specific violation regarding this type of scenario to the code of professional medical should be considered.

⁴³⁵ Several cases in California highlight the potential for abuse and malfeasance by disreputable surrogacy agencies and the need for strong regulations and oversight of surrogacy agencies. For example, in 2012, an attorney in California was convicted of fraud for a black market operation for unborn children. The attorney, Theresa Erickson, paid surrogates to travel to the Ukraine to be implanted with fertilized embryos and then in their second trimester, offered the children for sale to American couples by misinforming that a surrogate's prior surrogacy agreement was no longer valid. *See* Nancy Dillon, "Noted Surrogacy Lawyer Theresa Erickson Sentenced for her Role in Baby-Selling Scheme," *Daily News* (February 24, 2012), <http://www.nydailynews.com/news/crime/noted-surrogacy-lawyer-theresa-erickson-sentenced-role-baby-selling-scheme-article-1.1028320>. Ms. Erickson has claimed her fraud was not unique and that the surrogacy industry in California is like the "wild, wild west." *See* Rory Devine and R. Stickney, "Convicted Surrogacy Attorney: I'm Tip of Iceberg," *7 San Diego* (February 29, 2012), <http://www.nbcsandiego.com/news/local/Theresa-Erickson-Surrogacy-Abuse-Selling-Babies-140942313.html>. In 2014, another surrogacy agency in California, Planet Hospital, was under investigation for arranging fraudulent international surrogacy arrangements and in many instances absconding with intended parents' money without proceeding with a surrogacy. *See* Tamar Lewin, "A Surrogacy Agency that Delivered Heartache," *N.Y. Times* (July 27, 2014), http://www.nytimes.com/2014/07/28/us/surrogacy-agency-planet-hospital-delivered-heartache.html?_r=0 (Lewin, *Surrogacy Agency that Delivered Heartache*).

⁴³⁶ Some intended parents will utilize a surrogacy agency to assist with matching them with a surrogate who shares their values and views and understanding on what the agreed course of action should be in "what-if" scenarios. Because a surrogate often forms an emotional connection with the intended parents, rather than with the child, a positive relationship with the intended parents is vital to ensuring a smooth surrogacy arrangement. By matching parties based on shared values and beliefs, it reduces the likelihood of disputes.

⁴³⁷ Reports are common where agencies have stolen millions of dollars in client funds and intended parents have been left with little recourse for compensation. In some cases, people seeking to have children have lost their life savings due to theft and fraud. Lewin, *Surrogacy Agency that Delivered Heartache*, *supra* note 435.

⁴³⁸ Both the ABA Model Act (Alternative A) and UPA state that "A gestational agreement may not limit the right of the gestational mother to make decisions to safeguard her health or that of the embryo(s) or fetus." ABA Model Act (Alternative A), *supra* note 195, at §701(6) and UPA, *supra* note 184, at §801(f). In addition, both Texas (Texas Family Code 160.754) and Utah (Utah Code Title 78B, Chapter 15, Part 8) mirror this provision. While a provision in the surrogacy agreement reaffirming a surrogate's constitutional right to abort or not abort the pregnancy is not required in a surrogacy agreement, many agreements include this provision to explicitly state this fact. It provides assurances that this concept was discussed among the parties. In addition, in the event the agreement is reviewed by a court, having the provision in the agreement prevents a court from invalidating an agreement. In Louisiana, if a surrogacy agreement requires the surrogate to terminate a pregnancy for any reason, the agreement is null and unenforceable (R.S. 9 §2720)

⁴³⁹ Although such a scenario where both intended parents die would be unlikely, the Task Force determined it was best to have clear guidance to avoid controversy before such a scenario arises.

Minority Report

MINORITY REPORT ON SURROGATE CHILD-BEARING

Drafted by Donald P. Berens, Jr.

Joined by Karl P. Adler, Rabbi J. David Bleich, Sheryl Dicker, Fr. Joseph W. Koterski, John D. Murnane, Rev. H. Hugh Maynard-Reid,

INTRODUCTION

New Yorkers love liberty; but at times they will limit its exercise by some in order to prevent harm to others. This Task Force now weighs whether, notwithstanding its claimed benefits, surrogate child-bearing risks such frequent or serious harm to society, families, and individuals that New York ought to limit it, and – if so – how.

In 1988, this Task Force unanimously concluded that New York ought to discourage surrogate child-bearing in both its genetic and non-genetic forms, then respectively called “traditional” and “gestational” surrogacy. It recommended, again unanimously, that New York ought to declare surrogacy contracts void and unenforceable as against public policy, prohibit the payment of fees to surrogate child-bearers, and bar surrogacy brokers from operating in the state. It rejected the option of regulating surrogacy contracts, because regulation would be tantamount to endorsement. It proposed that surrogacy arrangements – though discouraged and unenforced – should not be criminalized when they are noncommercial and remain undisputed. It proposed a framework for the resolution of any custody disputes arising out of surrogacy to be resolved in the best interests of the child. In 1992, New York State enacted statutes implementing those recommendations which remain the law today.

The measurable evidence concerning the existence or absence of long-term harms caused by surrogacy is scanty, equivocal, sometimes biased, and often anecdotal. Members of the Task Force appraise that evidence differently. All agree that surrogacy risks some harms, but they weigh the nature, frequency, and severity of the harms differently. All agree that surrogacy creates some tension between adult desires and child welfare, but they disagree about the nature and consequences of that tension and how best to resolve it. All agree that it is legally permissible for New York State to regulate surrogacy and to discourage, even to ban, some forms of it, but disagree about which forms ought to be regulated and which prohibited. All agree that disputes over custody and parentage of children born through surrogacy ought to be avoided or resolved quickly, but disagree about what mix of policies will minimize, not only the harms caused by such disputes, but also the other harms risked by surrogacy.

The current Task Force unanimously supports present New York State policy regarding so-called “traditional” or genetic surrogacy. It should be discouraged, contracts to use it should remain unenforceable under state law, and its commercial forms should be prohibited. The members disagree about so-called “gestational” or non-genetic surrogacy. All propose policies meant to limit at least some of its risks, but disagree about what mix of policies will most effectively minimize those risks.

Today's majority argues that the present policy concerning non-genetic surrogacy ought to be revisited because of developments since 1988, especially those since 2011. The minority finds these developments collateral and the arguments unpersuasive. See Part 5.

Upon revisiting surrogacy, the majority believes there is insufficient evidence of harm to fully justify the current prohibition of commercial surrogacy, and proposes that New York should permit, and even enforce, compensated arrangements for non-genetic surrogacy if they meet dozens of specific regulatory conditions. We in the minority believe that there is insufficient evidence of safety to risk tampering with New York's current, well balanced policies. We find that no regulation, particularly the one proposed by the majority, can address adequately the most significant harms of surrogacy. Indeed, we think that any such regulation, while perhaps mitigating some of the rare incidental harms, would actually encourage the more frequent use of surrogacy with its attendant inherent and irremediable harms.

Accordingly, the minority recommends that in New York: (1) all forms of surrogate child-bearing, both genetic and non-genetic, compensated and uncompensated, should still be discouraged; (2) contracts for all forms of surrogacy should remain void and unenforceable as against public policy; (3) those who enter contracts for compensated surrogacy or who arrange for others to do so should continue to be subject to a monetary fine for violation; (4) voluntary, uncompensated contracts for either genetic or non-genetic surrogacy should be tolerated with neither government enforcement nor criminal penalty; and (5) in all cases of surrogacy, post-birth judicial adoption proceedings should remain New York's preferred method to resolve parentage in the best interest of the child.

A detailed statement of the minority's reasons follows. In Chapter 1, we offer general observations about parents, children, and the creation of families. In Chapter 2, we explain the terms we will use and we supplement the majority's description of surrogate child-bearing. In Chapter 3, we describe some risks and harms of surrogacy. In Chapter 4, we apply our ethical analysis to the facts we see. In Chapter 5, we discuss reasons, or lack thereof, to revisit surrogacy. In Chapter 6, we analyze the majority's proposed regulation. Finally, in our Conclusion, we summarize our findings and policy recommendations.

Chapter 1 – PARENTS, CHILDREN, AND THE CREATION OF FAMILIES

Parenting is vital to humanity as a whole. It is essential to the continued biological life of the human species, the social life of communities, and the individual life of children as they grow. Parenting is widely thought to aid the psychological and even the spiritual growth of the adults who practice it; many consider it to be sacred.

Many adults welcome or eagerly seek parenthood and in most cases it is a happy development. Many who seek to become parents – by unaided sexual intercourse, by assisted reproductive technologies (ART), or by adoption – must undertake persistent, even sacrificial efforts to do so. The failure of such efforts to unite them with a child can be heartbreaking.

We acknowledge the joy of loving adults united with a child, and – no matter how the union occurred – we hope all families will thrive. We urge society to take prudent steps to support all such families. However, because we see heightened risks for the children of surrogacy, we believe that society should discourage that method of family creation.

Parenting is vital for children, but it is not so for adults. Children need some form of adult protection in order to live to maturity; without it, they suffer and die. Adults often want to be parents; but without parenthood they can still live happily. Many prospective parents would prefer to control the timing and method of conception and birth, and to select wanted traits for their children, but compliance with such preferences is not essential to their life, health or happiness. There is a difference between desire, even intense desire, and necessity.¹

Children are the ontological equals of adults, that is, they are individuals who are morally distinct and, in an important sense, ought to be independent of the control of others.² But parenting is not a relationship of equally capable persons. Children are more vulnerable than adults. They are utterly reliant on an adult woman to carry them to birth. For years after birth, children remain dependent on adults. Even as they become more self-sufficient, they require the guidance and protection of adults, to navigate the physical and social challenges of their environment. The primary and basic purpose of parenting is the nurture and protection of vulnerable children. Gratification of adults may be a happy, intermittent by-product, but it is not the fundamental purpose of parenting. Certainly adult gratification should not outweigh child protection. Adult control of children for purposes other than their protection and development is morally suspect.

Some discussions of surrogacy insist that its children have only interests, not rights, without explicit definition of the difference, but with a tacit suggestion that such interests may be more

¹ Neither surrogacy nor parenting is necessary for any particular adult. “Childlessness is a disappointment for many but not all, a tragedy for few.” Richard A. Posner, *Sex and Reason*, Harvard University Press, 1992, at page 306. Kajsa Ekis Ekman cites Swedish intellectual Nina Bjork who has written that one sign of an affluent society is having difficulty distinguishing desires from needs. Ekman argues that the longing for children becomes the right to use another woman's womb backed by the logic of profitability, which makes it too easy for the wishes of the economically strong to be transformed into self-evident rights. Kajsa Ekis Ekman, *Stop Surrogacy Before It Is Too Late*, viewed on September 1, 2016 at <https://medium.com/festival-of-dangerous-ideas/stop-surrogacy-before-it-is-too-late-9910035a63f0#pyxibsp8m>.

² Rachel Lu, *The Perils of Surrogacy*, *The Human Life Review*, Summer 2014, pp. 41-43.

readily compromised than rights. We agree that children of surrogacy have at least interests in it, that is, claims to be respected. But we believe that they have more than mere interests; they have rights based in their status as human beings which rights are based on prior moral justice inherent in human nature, whether or not they are recognized by positive law.

Children have rights, both negative rights not to be manufactured, sold or unnecessarily separated from their genetic and gestational parents, and, once conceived, positive rights – where at all possible – to a familial connection with the man and woman who conceived and carried each of them. These rights are not necessarily found in explicit positive law, but like other inalienable rights, they are endowed by another source which, depending on one's view, forms the natural or transcendent order of things.³ These rights have been at least partially recognized and outlined in different ways, including in the context of surrogacy.

Philosophical, social and religious thinkers have put it as follows. “Subordinating children from their very conception to the motives of their would-be parents (even if those motives are basically benevolent) is a violation of their dignity and of their moral freedom. It instrumentalizes them in a morally unacceptable way.”⁴ “Children's rights are human rights. We all have a right to know where we came from. We all have a right to be raised by our mother and father, where possible; and if it isn't possible, to have at the very least a mother and father to love, if a living parent of each sex is available, or to remember, if one has passed away. We all have a right to be born free, not bought, sold, or manufactured. ... [Violation of these rights] is a violence against the family tree to which another human being is entitled by the eternal life cycle that unites all of us.”⁵ “Our children have the right to be procreated, not produced.”⁶

Government bodies have recognized at least some aspects of such children's rights. The United Nations has said “[A] child of tender years shall not, save in exceptional circumstances, be separated from his mother.”⁷ The European Parliament of the European Union has called surrogacy a serious problem, noted that it constitutes exploitation of women and children, subjecting them to being regarded as commodities, and augments the trafficking of women and children.⁸ The same parliament has condemned the practice of surrogacy which undermines

³ The United States Declaration of Independence lists three such rights, but the list is illustrative, not exhaustive.

⁴ Rachel Lu, *The Perils of Surrogacy*, *The Human Life Review*, Summer 2014, at p. 46.

⁵ Robert Oscar Lopez, *The Call of the Child*, *Jephthah's Daughters*, © 2015, International Children's Rights Institute, at p. 26. In fact, Lopez and others argue that, even without racial oppression or physical abuse, the exchange of money for children who are thus separated from at least one of their biological parents is akin to slavery. See Alana Newman, *Introduction to Section I* (p. 15, *et seq.*), Rivka Edelman, *Secular Israel, Gays, and Surrogacy* (p. 143, *et seq.*), and Robert Oscar Lopez, *Slavery* (p.272, *et seq.*), all anthologized in *Jephthah's Daughters*, 2015.

⁶ Fr. Tadeusz Pacholczyk, *The Ethics of 'Correcting' Mitochondrial Disease*, National Catholic Bioethics Center, September 2009, viewed on September 1, 2016 at http://www.ncbcenter.org/index.php/download_file/force/250/158/.

⁷ *United Nations Declaration of the Rights of the Child*, Principle 6, November 20, 1959. In 1959, the UN likely did not contemplate surrogate child-bearers. But in the years since such women have appeared, the UN has not amended Principle 6. In fact, in 1989, the UN said “The child ... shall have ... as far as possible, the right to know and be cared for by his or her parents.” *United Nations Convention on the Rights of the Child*, Article 7(1), November 20, 1989.

⁸ *European Parliament resolution on priorities and outline of a new EU policy framework to fight violence against women*, at #s 20-21, adopted April 5, 2011.

human dignity.⁹ The Parliamentary Assembly of the Council of Europe (PACE) has rejected a recommendation to legalize and regulate surrogacy in its 47 member nations.¹⁰ And this very Task Force in 1988 has said, “Rather than accept [a] contractual model as a basis for family life and other close personal relationships, society should discourage the commercialization of our private lives and create the conditions under which the human dimensions of our most intimate relationships can thrive.”¹¹

There is no recognized moral or legal right to have a child, nor should there be. In 1988, the Task Force found that any purported right to enter into and enforce surrogate parenting arrangements was not protected by the New York or United States Constitution. Nor did the Task Force accept it as a basic moral entitlement.¹² Even current Task Force members who favor the enforcement and regulation of some surrogate child-bearing do not argue that there is any moral entitlement or constitutional right to enter or enforce such arrangements.

All persons, including children, thrive with a sense of identity, context and relationship to others, including – if possible – to their genetic and gestational parents. Yet, parenthood sometimes arises, continues or ends in less than ideal circumstances. Some parents are unwilling or unable to care for a child. Some parents separate or divorce. Some parents die.

Although healthy societies should encourage adults (including single, step, foster and adoptive parents) to support children who have suffered separations from a biological parent, societies should not encourage behaviors that lead to such separations. Acceptance of misfortune, or adaptation to it, is sometimes necessary. So New York makes foster care and adoption available for children separated after birth from their genetic and gestational parents. But it is unwise to endorse behaviors that risk such ills. So New York does not – and should not – endorse the creation of children conceived with the intent to separate them from some or all of their biological parents.

Traditionally, no more than two adults are the genetic, gestational and – usually – social parents of any child. Of course, for millennia the only way that human beings could bring a child to birth was for a man and a woman to have sexual intercourse with each other, resulting in fertilization by the man's sperm of the woman's egg in the woman's body (that is, the conception of an embryonic human being), its implantation, nourishment and growth in the woman's uterus, and the birth of a baby. Very often the same two adults who conceived the baby have stayed together to raise the infant to maturity. Many societies – for practical, economic, social, moral, or even theological reasons – have by law and custom encouraged the parents to live with each other and both to care for their children after birth. For the most part, this has worked well. Departure from such traditions risks harm to families and society. We discuss this in detail at Part 6.

⁹ European Parliament resolution on the Annual Report on Human Rights and Democracy in the World 2014 and the European Union's policy on the matter, at # 114, adopted November 30, 2015.

¹⁰ *PACE rejects draft recommendation to “Children's rights related to surrogacy,”* October 11, 2016 session, viewed on October 18, 2016 at <http://assembly.coe.int/nw/xml/News/News-View-EN.asp?newsid=6355&lang=2&cat=8>.

¹¹ NYS TFL, *Surrogate Parenting*, 1988, p. 123.

¹² NYS TFL, *Surrogate Parenting*, 1988, pp. iv, 61 and 116.

Society has an interest in the well-being of parents, children and families that might justify state intervention. In 1988, the Task Force found that society has a basic interest in protecting the best interests of children, shielding gestation and reproduction from the flow of commerce, and protecting and promoting those social institutions it deems primary to its collective life.¹³ No current Task Force member claims that the state lacks power to intervene in family relationships for the good of parents, children, families and society. In fact, all current members think it wise to ban some surrogacy arrangements and most of them think it would be wise to regulate others. We in the minority agree that society has an interest and right to intervene, but we believe that interest is more prudently advanced by discouraging all surrogate child-bearing, rather than encouraging, enforcing or regulating some forms of it.

¹³ NYS TFL Surrogate Parenting, 1988, pp. iv and 115.

Chapter 2 – DEFINITIONS AND DESCRIPTION OF SURROGATE CHILD-BEARING

Part 2A – Definitions and Terminology

Sloppy language makes it easier to think foolishly.¹⁴ Sometimes the jargon used to describe surrogate child-bearing is misleading, but it has become so customary that it is difficult to communicate when using objectively accurate but unfamiliar terms. Despite the difficulty, we think it worthwhile to try to write and think clearly.

No surrogate child-bearing is traditional and all such child-bearing is gestational. We will distinguish: (a) genetic, so-called “traditional” surrogacy where the child-bearing woman has also provided the genetic material of her egg; and (b) non-genetic, so-called “gestational” surrogacy where she has provided no genetic material to the embryo she bears.

Many of the gametes provided for *in vitro* fertilization (IVF), including IVF for surrogacy, are sold rather than donated.¹⁵ We will distinguish: (a) donors: and (b) vendors, and use collective terms, like “providers” that do not imply donation when there has been a sale. We do so because we think the difference matters for many children of ART.

There is more to biology than genetics. Gestation too is biological. Yet, some call “biological” only those parents who contributed genetic material to their child and omit to call the non-genetic surrogate child-bearer a biological parent. We will acknowledge that a gestational mother is a biological parent.

Terms like “surrogate parenting” are ambiguous. In non-genetic surrogacy agreements, is the egg provider, the child-bearer, or the intended social mother the “surrogate mother?” The term “surrogate parent” could logically refer to any of the adults involved in DNA provision, gestation, or child-rearing, so we prefer not to use it. We will use terms like “gamete provider, donor or vendor” for the genetic parents, “surrogate child-bearer” or “surrogate” or “carrier” for the woman who (sometimes in place of the genetic mother and always in place of any woman who intends to raise the child) bears the child, and “intended parents” for the adults who want to become the legal or social parents responsible to raise the child. And because the child does not, and should not, substitute for anybody else, we will use terms like “child of surrogacy” or “child born through, of or by surrogacy,” rather than “surrogate child.”

Not all change, including technological change, is an “advance.” Unless one knows where one wants to go, one cannot know, or even guess, whether a change marks or enables progress toward the goal or regression away from it.

Our quest for linguistic accuracy cannot ignore the fact that much has been written about surrogacy, including by this Task Force in 1988, by others who object to surrogacy, and by

¹⁴ See George Orwell, *Politics and the English Language*, 1946.

¹⁵ George J. Annas, *Fathers Anonymous: Beyond the Best Interests of the Sperm Donor*, *Family Law Quarterly*, XIV, 1, Spring 1980, at p. ??, reprinted in *Child Welfare*, LX, 3, March 1981, at page 165. See also, Robert Black and Janna C. Merrick, *Human Reproduction, Emerging Technologies, and Conflicting Rights*, (c) 1995 Congressional Quarterly, Inc..

researchers, using terms we find potentially misleading. Accordingly, when we quote or describe those prior writings, we will use the terms they used. When we state our own views, we will use the terms we think most accurate. And sometimes we will use multiple terms to remind readers how to translate one expression to another.

Part 2B – Supplemental Description of Surrogate Child-bearing

The majority's descriptions of artificial insemination, *in vitro* fertilization (IVF), genetic and non-genetic surrogacy are mostly accurate as far as they go. So too, the majority's descriptions of the biomedical issues facing monogamous same-sex couples and infertile opposite-sex couples. But some of the majority's claims about what gestational surrogacy is, why it is desired and how it is practiced by one group or another of would-be parents, are incomplete. As a result, some arguments offered to justify surrogacy in some described cases do not necessarily apply to other undescribed cases. And some technological and social aspects of surrogacy which the majority does not mention or notes only briefly bear further discussion here. Eight examples follow.

First, the majority usually (and the minority always) defines “gestational” or non-genetic surrogacy as surrogate child-bearing where the child-bearer has no genetic connection to the child. This definition includes surrogacy where none, one or two intended parents provide gametes. But sometimes the majority suggests that in such surrogacy the child is genetically related to one or both intended parents, and then argues that such relatedness means that the intended parents are not buying the child.

Whatever the merits of the majority's argument that paying for genetically related children is not buying them (as set forth at Parts 3D, and 4B, we think it unpersuasive), it does not apply at all to cases where neither intended parent is so related to the child. Yet the majority would permit state enforcement of contracts for non-genetic surrogacy even in cases of children lacking any genetic relation, not only to the child-bearer, but even to the intended parents. Its proposed regulation would not require even one intended parent to be genetically related to the child to be implanted in, and surrendered by, the surrogate child-bearer.

Second, the majority variously claims that “many” surrogacy arrangements use gametes from one or both intended parents, that “many” use the gametes of both intended parents, and that “some” use an anonymous donor to contribute the sperm, egg, or both. These claims are based in part on “expert” estimates, but fail to note that the two selected experts qualified their responses by saying that they were, in one case, “just a guess” and, in the other case, “anecdotally” based.

Whether or not any of the Majority's claims is true for many cases, or even for many cases of opposite-sex couples, it is not true for all cases. And it cannot be true that both sets of gametes come from same-sex couples who intend to be parents, or from persons who intend to be single parents. There are biological limits to how far arguments about procreation based on notions of equity can be extended to all.

Nonetheless, the majority uses these claims about the source of gametes, claims that cannot always be true, to downplay the risks associated with anonymous gamete “donors” by claiming that in many surrogacy arrangements the embryo is created from the gametes of the intended

parents. Yet the majority would permit and enforce non-genetic surrogacy even in cases where nobody knows the identity of any gamete donor, vendor or provider.

Third, IVF, including IVF for surrogacy, typically collects and fertilizes more human eggs, and creates more embryos, than are immediately wanted for implantation and gestation.¹⁶ By embryos, we mean individual embryonic human beings like those from which all adult writers and readers of these reports have grown. Some IVF embryos are deliberately aborted after implantation. Others, never implanted, are doomed to indefinite storage, subjection to potentially harmful research, or to accidental or deliberate destruction. Most of the minority thinks this deserves more attention than the majority gives it.

Fourth, the United Kingdom has approved a technique to treat infertility and prevent mitochondrial disease, where the nuclear DNA of one woman and the mitochondrial DNA of another woman are combined in a single egg.¹⁷ The US FDA is considering whether to approve similar techniques.¹⁸ If approved and effective, such techniques could lead to so-called “three-parent IVF” where a man and two women contribute DNA to the embryo. In fact, it has happened despite the current U.S. ban. Recently, after a Mexican clinic performed IVF using mitochondrial DNA transfer, a baby was born in New York to a Jordanian couple.¹⁹

Three-parent IVF could add to the number of persons collaborating with a surrogate child-bearer. A child could have six such parents, contributing: (1) male DNA; (2) female nuclear DNA; (3) female mitochondrial DNA; (4) a womb (5) social mothering; and (6) social fathering. In addition to the foregoing 4-mom/2-dad combination, same-sex marriage or same-sex partnering make possible 5-mom/1-dad and 3-mom/3-dad combinations. Even without three-parent IVF, a child could have five parents in a 3-mom/2-dad, 4-mom/1-dad, or 2-mom/3-dad combination. Of course social parents could total one, two, three or more.

¹⁶ According to: (1) the Genetics & Public Policy Center of Johns Hopkins University page on Assisted Reproductive Technologies; (2) the Society for Assisted Reproductive Technology page “ART: Step-by-Step Guide;” and (3) data presented to the Task Force by reproductive endocrinologist Dr. Howard Lieman, the average number of oocytes retrieved from an IVF patient is eight to fifteen, the average fertilization rate is about 70%, and one would be lucky to get two “perfect embryos” from that group. The minority calculates that on average five to eleven embryos are created for each patient and at least three to as many as nine such embryos are deemed less than perfect: $[(8 \text{ to } 15) \times 70\% = (5.6 \text{ to } 10.5), \text{ say } (5 \text{ to } 11)]$ and $[(5 \text{ to } 11) - 2 = (3 \text{ to } 9)]$. These sources have not provided information about the disposition of those embryos deemed less than perfect. Other sources estimate that about five in six embryos created in IVF will die. See Dr. Kristina Pakiz, cited by Lindsay Steele, *Beyond IVF: Hope for infertile Catholics*, The Catholic Messenger, October 23, 2014.

¹⁷ Dario Thuborn, *Britain authorises 'three-parent' babies*, Agence France-Presse, February 3, 2015, viewed on February 3, 2015 at <http://news.yahoo.com/british-lawmakers-vote-three-parent-babies-205650783.html: vlt=A> ... ; and Hannah Devlin, *Britain's House of Lords approves conception of three-person babies*, The Guardian, February 24, 2015, viewed on March 27, 2015 at <http://www.theguardian.com/politics/2015/feb/24/uk-house-of-lords-approves-conception-...>

¹⁸ Sharon Begley, U.S. FDA weighs evidence on producing 'three-parent' embryos, Reuters, February 25, 2014, viewed on September 1, 2016 at <https://www.yahoo.com/news/u-fda-weighs-evidence-producing-39-three-parent-011702701-finance.html?ref=gs>; and Matt Smith, FDA considering 3-parent embryos, CNN, February 27, 2014, viewed on March 4, 2014 at <http://www.cnn.com/2014/02/26/health/ivf-mitochondria/index.html>.

¹⁹ Gina Kolata, *Birth of Baby With Three Parents' DNA Marks Success for Banned Technique*, New York Times, September 27, 2016.

Fifth, some heterosexual fertile women seek surrogacy for so-called “social,” non-medical reasons. Cases include a photographer who did not want to disrupt her business, a physician who could not “afford” to be pregnant, a socialite who did not want to get fat, and an amateur runner who had an upcoming marathon.²⁰ Some unknown number of fertile single adults seek surrogacy to acquire a child whom they intend to raise alone.

Sixth, while scholars disagree about whether human sexual preference is innate (perhaps determined by genes or hormones) and more or less unchangeable,²¹ or constructed by social or cultural forces and more or less malleable,²² there is broad, though not universal, agreement that the sexual behavior of individuals can exhibit some variety, despite their preferences.²³ In other words, sexual preferences, or at least sexual behavior, need not be exclusively heterosexual or homosexual. Some number of coupled parents who identify themselves as lesbian, gay, bisexual or transgender (LGBT) have a child conceived by heterosexual intercourse by one of them. Estimates of the numbers or proportions of such couples vary, but they are higher than zero.²⁴ Some number of self-identified LGBT persons who wish to become parents could engage in fertile heterosexual intercourse to conceive a child,²⁵ or could adopt a child, but would rather not to do so, preferring instead to acquire a child by some other means, sometimes by surrogacy. We do not opine here on whether sexual preference is innate or learned, unchangeable or sometimes changing; nor do we opine on the precise portion of self-identified LGBT persons who are capable of fertile heterosexual intercourse. We do not advocate that government or society

²⁰ Sarah Elizabeth Richards, Birth Rights: Inside the Social Surrogacy Debate, *Elle Magazine*, April 17, 2014.

²¹ See, e.g., Richard A. Posner, *Sex and Reason*, Harvard University Press, 1992, at pages 87, 224, 296, 436

²² See, e.g., David F. Greenberg, *The Construction of Homosexuality*, The University of Chicago Press, 1988, at pages 18, 110, 117, 283, 463-464.

²³ Posner, 1992, op. cit., at pages 100, 114, 436-437. Greenberg, op. cit., at pages 26, 40, 66, 463-464.”

²⁴ Chirlane McCray (a former lesbian activist, now married to the male Mayor of New York City with whom she has two children) has said that there is a “fluidity” to romantic and sexual attraction along a “spectrum.” Katie McDonough, *Bill de Blasio's wife, Chirlane McCray, on the “fluidity of love” and the political spotlight*, *Salon*, May 9, 2013, viewed on July 30, 2017 at http://www.salon.com/2013/05/09/bill_de_blasios_wife_chirlane_mccray_on_the_fluidity/; Ross Barkan, 'Are You Still a Lesbian?' Bill de Blasio's Wife Doesn't Have an Answer, *Observer*, May 21, 2015, viewed on July 30, 2017 at <http://observer.com/2015/05/are-you-still-a-lesbian-bill-de-blasios-wife-doesnt-have-an-answer/>; Elizabeth Daley, *Are We Beyond Sexual Labels? NYC First Lady Says Yes*, *The Advocate*, June 3, 2016, viewed on July 30, 2017 at <http://www.advocate.com/bisexuality/2016/6/03/are-we-beyond->.

Robert Oscar Lopez (a self-described bisexual, raised by two lesbians, and now a father in a heterosexual marriage), has stated that most LGBT parents, no matter what their current patterns of sexual attraction or behavior, are or were bisexuals who engaged in fertile heterosexual intercourse. *The Lost Manifesto of Manuel Half, Jephthah's Daughters*, 2015, 36; and *Growing Up With Two Moms: The Untold Children's View*, *The Public Discourse*, August 6, 2012, viewed on July 13, 2016 at <http://www.thepublicdiscourse.com>.

²⁵ “Very few men, even among those who have a strong preference for homosexual over heterosexual relations, are incapable of erection and ejaculation in heterosexual intercourse.” Posner, op. cit., at 100, citing Marcel T. Saghir and Eli Robins, *Male and Female Homosexuality: A Comprehensive Investigation*, Baltimore, Williams and Wilkins, 1973, at page 102.

Persons who call themselves homosexual have often had heterosexual experience. Greenberg, op. cit., at 491, citing Albert J. Reiss, *Journey into Sexuality: An Exploratory Voyage*, Englewood Cliffs, N.J., Prentice-Hall, 1986, Alfred C. Kinsey, et al., *Sexual Behavior in the Human Male*, Philadelphia, W.B. Saunders, 1948, Charlotte Wolfe, *Love Between Women*, New York, St. Martin's Press, 1971, Saghir and Robins, *ibid.*, at 84-91, Alan P. Bell and Martin S. Weinberg, *Homosexualities: A Study of Diversity among Men and Women*, New York, Simon and Schuster, 1978, and Ruben Ardilla, 'La Homosexualidad en Colombia,' *Acta psiquiatrica y psicologia de America Latina* 31:191-210.”

should try systematically to change those who define themselves as LGBT, and we certainly do not want such persons to be persecuted or oppressed. We simply note that some, perhaps many, persons in same-sex relationships do not need surrogate child-bearing in order to conceive and/or raise a child genetically related to one of them.

Seventh, some same-sex male couples hiring a surrogate child-bearer will mix their sperm in order to obscure to themselves and their children which of them is the genetic father.²⁶ Of course, DNA testing of each of them and the child would reveal which of them is the genetic father; but unless such testing is done, there is uncertainty about male genetic parentage. The practice deliberately introduces confusion (albeit remediable confusion) about the child's heritage in order to allow each adult to imagine that he might be the genetic father.

Finally, superfetation is the fertilization of an egg and subsequent development of another embryo, fetus or embryonic human being when one is already present in the uterus. It is extremely rare in humans, but apparently somewhat more likely in women who have undergone fertility treatments.²⁷ One such woman who entered a contract for commercial non-genetic surrogacy in California bore two boys in late 2016. One developed from an embryo created through IVF, genetically related to a Chinese couple, not genetically related to the child-bearer, and implanted with the intent that he would be surrendered to the Chinese couple. The second was thought during pregnancy to be a twin of the first, but later after post-natal suspicions arose he was shown by DNA testing to be the genetic child of the California woman, conceived after the implantation of the first and without ART. Nonetheless, at birth both boys were taken from the woman who bore them and given to the Chinese woman whose name appeared as the mother on both birth certificates. Disputes arose about custody, the birth certificate, who might have authority to put the boy up for adoption, compensation or rebates under the surrogacy contract, and claims for additional compensation to the surrogacy broker.²⁸ It is reasonable to believe that these events and disputes would not have happened if California had not begun to enforce contracts for commercial non-genetic surrogate child-bearing.

We note these additional facts in order to highlight the point that policy regarding surrogacy should account for more than a few idealized families. Of course, many of those seeking surrogacy are opposite-sex couples who for medical reasons cannot conceive or carry a child by themselves. Others who seek it are same-sex couples who for reasons of fundamental biology cannot conceive and carry a child by themselves. But there are others who are capable of joining with a person of the opposite sex to conceive and carry a child, but who for non-medical reasons nonetheless seek surrogacy.

²⁶ Anemona Hartocollis, *And Surrogacy Makes 3*, New York Times, February 19, 2014. For a critique of the Hartocollis article, see Rivka Edelman, *The NY Times Gussies Up Reproductive Slavery*, Jephthah's Daughters, at p. 151 et seq.

²⁷ Khalil A. Cassimally, "Superfetation: Pregnant while already pregnant," April 27, 2011, <https://blogs.scientificamerican.com/guest-blog/superfetation>, viewed Nov 7, 2017.

²⁸ Jane Ridley, "I rented out my womb – and they almost took my own son," Oct 25, 2017, <http://nypost.com/2017/10/25/i-rented-out-my-womb-and-they-took-my-own-son/>, viewed Nov 7, 2017; and "Surrogate mother of 'twins' finds one is hers," Nov 3, 2017, <http://www.bbc.com/news/health-41858232>, viewed Nov 6, 2017.

We also note these facts in order to show that policy regarding surrogacy needs to account for more than the child born by surrogacy, but also for the children conceived but never implanted for surrogacy, and that policy might soon need to account for more than two female genetic parents.

Chapter 3 – THE HARMS OF SURROGACY

We will discuss the following persons who are subjected by surrogacy to risks of measurable harms: (A) the offspring born of surrogacy; (B) the embryonic and other children conceived by IVF for surrogacy; and (C) other persons including: surrogate child-bearers, intended parents, and family members of both of them. We will also discuss some of the unmeasurable harms of surrogacy.

The current evidence concerning the harms of surrogacy, or the alleged lack thereof, is scanty, equivocal, sometimes biased, and often anecdotal. Those on all sides of the debate must be careful to evaluate with care what little evidence exists. Because the evidence is incomplete, one must make reasonable guesses about what is unmeasured or even unmeasurable. Rational extrapolations are sometimes needed, but they must be used with caution.

Part 3A – Offspring Born of Surrogacy

Does commercial surrogacy, particularly non-genetic, so-called “gestational” surrogacy and subsequent social parenting as it is practiced in the US – that is, sometimes with gametes from one or two intended parents, but sometimes with gametes from one or more persons who are not the intended parents, and sometimes with gametes from one or more persons unknown, and perhaps unknowable, to the child or even to the intended parents – does such surrogacy have risks, including long-term risks, of measurable harm to the offspring of such surrogacy at rates higher than for other children, including adoptees or the children of natural conception born by their genetic mothers and raised by their genetic parents? No one knows.

We do know that some adolescent and adult children of commercial surrogacy have expressed confusion, shame, anger or feelings of loss stemming from such surrogacy.²⁹ One teenager said: “It looks to me like I was bought and sold. ... Yes I am angry. Yes I feel cheated.”³⁰ Another adult said: “My biological mother was paid \$10,000 for her services. ... I was devastated.”³¹

These witnesses are often offspring of genetic “traditional” surrogacy, probably because so few offspring of non-genetic “gestational” surrogacy – a recently more popular technology – have yet lived long enough to mature and tell their stories. The reports now available tell us that some children of commercial surrogacy suffer. But no one knows at what rates or for how long they suffer, especially the offspring of commercial non-genetic surrogacy.

²⁹ See, for example, Jennifer Lahl, *Anonymous Father's Day* (2012) and *Breeders: a Subclass of Women?* (2014) two films produced by The Center for Bioethics and Culture Network. The first is cited by Ann Carey, *The Who Am I? Generation*, *Our Sunday Visitor*, March 23, 2014. The second is discussed by Joan Frawley Desmond, *Jennifer Lahl's 'Breeders' Completes Trilogy on Reproductive Technology*, *National Catholic Register*, January 23, 2014. See also, Anonymous Us at <http://anonymousus.org>.

³⁰ Brian C., *Son of a Surrogate* blog, posted August 9, 2006, viewed on May 25, 2016 at <http://sonofasurrogate.tripod.com>.

³¹ Jessica Kern, *I Am a Product of Surrogacy* blog, quoted by S. Brinkman, *Children of Surrogates Campaign Against Practice*, *Women of Grace* blog posted June 19, 2014, viewed on September 1, 2016 at <http://www.womenofgrace.com>.

We are glad to hear reports from or about children of surrogate child-bearing who are thriving without any apparent ill effects arising from their surrogacy origins. But the collection of anecdotes, either pro or con, is unsystematic and does not tell us at what rates any harm might be suffered, especially long-term harm to offspring of commercial non-genetic surrogacy.

We have found no published studies of adolescent or adult offspring of commercial surrogacy, whether with anonymous or non-anonymous gametes. British studies of young children of non-commercial surrogacy do not answer questions about adolescent or adult offspring of commercial US surrogacy with sometimes anonymous gamete “donation.”

For reasons we will discuss more fully in the Analysis at Part 4, we think it is useful to review some published studies of offspring of sperm “donation” or sale. Such studies, of course, are not studies of the offspring of surrogacy; in that sense they study apples not oranges. But there are reasons to think they offer some useful analogies. And because some studies compare the apples to peaches and others compare the oranges to peaches, we might make some plausible comparisons of the apples and oranges.

Neither anecdotes nor published studies directly and fully address our question about commercial, non-genetic surrogacy which sometimes uses commercially obtained gametes and sometimes uses anonymous gametes. So we will consider whether what we can reasonably know about such surrogacy (even if we cannot measure it) might be supplemented by a philosophical view of cultural anthropology outlined at Part 1 and supplemented in our Analysis at Part 4. We now turn to published studies.

Subpart 3A1 – British Studies

The majority relies (we think it over-relies) on small British studies of young children of non-commercial surrogacy for its conclusions supporting commercial non-genetic surrogacy in New York State. In its discussion of the psychological risks to surrogates, intended parents, and children of surrogacy, the majority cites a series of studies from the Centre for Family Research (“UK/CFR”) in Cambridge, England, principally authored by Susan Golombok and Vasanti Jadva.³² The authors have studied the satisfaction of some surrogates and intended parents. For

³² Susan Golombok, et al., *Families Created Through Surrogacy Arrangements: Parent-Child Relationships in the 1st Year of Life*, Developmental Psychology, Vol. 40, No. 3, (2004), pp. 400-411, hereafter “2004 UK Study at Age 1.” Susan Golombok, et al., *Surrogacy Families: parental functioning, parent-child relationships and children's psychological development at age 2*, Journal of Child Psychology and Psychiatry, 47: 2 (2006), pp. 213-222, hereafter “2006 UK Study at Age 2.”

Susan Golombok, et al., *Non-genetic and non-gestational parenthood: consequences for parent-child relationships and the psychological well-being of mothers, fathers and children at age 3*, Human Reproduction, Vol. 21, No. 7 (2006), pp. 1918-1924, hereafter “2006 UK Study at Age 3.” Susan Golombok, et al., *Families created through surrogacy: Mother-child relationships and children's psychological adjustment at age 7*, Developmental Psychology, 47: 6, (2011), pp. 1579-1588, (hereafter “2011 UK Study at Age 7.” Vasanti Jadva, et al., *Surrogacy families 10 years on: relationship with the surrogate, decisions over disclosure and children's understanding of their surrogacy origins*, Human Reproduction, Vol. 27, No. 10, (2012), pp. 3008-3014, hereafter “2012 UK Study at Age 10.” Susan Golombok, et al., *Children Born Through Reproductive Donation: A Longitudinal Study of Psychological Adjustment*, Journal of Child Psychology and Psychiatry, 54: 6, (2013), pp. 653-660, hereafter “2013 UK Study at Age 10.”

purposes of this argument, the findings about those adults do not concern the minority. Instead, we focus on the claims about children of surrogacy based on those studies.

The UK/CFR researchers recruited British families of four types created in 2000 to 2002: 42 surrogacy families, 51 egg “donation” families, 50 “donor” insemination families, and 80 natural conception families, each with a 1-year-old child, representing, respectively, 61%, 75%, 50% and 73% of the families who were invited to participate. By the time the child was aged 10, the study participants had dwindled to 33 surrogacy families, 30 egg “donation” families, 34 “donor” insemination families, and 55 natural conception families. Researchers administered questionnaires to the mother at home when the child was 3, 7 and 10 years old, and to teachers when the child was 7 and 10. Researchers evaluated the mother's tone of voice and facial expressions in addition to her verbal report of her relationship with her child.³³

The majority cites these UK/CFR studies to claim that parents of children born through surrogacy had more warmth and attachment behavior toward their infants, and that the parents reported more positive family experiences and more positive parent-child relationships, than the parents of other sorts of families. It claims the studies show that the psychological adjustment of 7- and 10-year-old children of surrogacy was within normal ranges for children from other family types.

The UK/CFR authors said “Although children born through reproductive donation obtained SDQ [Strengths and Difficulties Questionnaire] scores within the normal range, surrogacy children showed higher levels of adjustment difficulties at age 7 than children conceived by gamete donation.”³⁴ They found “The absence of a gestational connection to the [intended or social] mother may be more problematic than the absence of a genetic link.”³⁵ The authors and the majority note that the behavior problems of surrogacy children had reduced by age 10, but no statements were made about the behavior of adolescent or adult children of surrogacy because the study subjects had not yet reached those older ages.

The UK/CFR authors note that the British sample sizes were not large, that parents most concerned about secrecy of genetic origins may have been less likely to participate, and that children's difficulties may have been under-reported by reproductive donation mothers who may have wished to present their children in a positive light as a reaction to the stigma associated with these somewhat controversial routes to parenthood.³⁶

The UK/CFR studies make a poor foundation on which to build a claim that commercial, non-genetic surrogacy, sometimes using purchased anonymous gametes, does not harm the children born by it. There are at least six reasons that they do not support a claim of low long-term risk to the children of such surrogacy. First, they were done in the UK where commercial surrogacy is illegal and so they did not study its effects.³⁷ Second, they had an initially small sample size

³³ 2004 UK study at Age 1 and 2013 UK Study at Age 10, each first cited at n. 32 above.

³⁴ 2013 UK Study at Age 10, first cited at n. 32 above.

³⁵ 2013 UK Study at Age 10, first cited at n. 32 above.

³⁶ 2013 UK Study at Age 10, first cited at n. 32 above.

³⁷ The majority suggests at Section VII, note 212, that because the UK allows generous reimbursement of surrogates' expenses, the British version of uncompensated surrogacy is substantially similar to the American version of paid surrogacy. But it is reasonable to expect that a child born to a US surrogate who is candidly paid not only for her

which dwindled to only 33 surrogacy families as the study progressed and the children aged. Third, the studies had a selection bias in that they studied only the children of mothers who permitted their families to participate; 25% to 50% of each type of family invited to participate failed to do so. Fourth, they often allowed questions about the young children's adjustment to be answered by parents or teachers, or evaluated family relationships by assessing the mothers' tone of voice and facial expression. Fifth, they have studied children no older than 10 and to date have not reported studies of adolescent or adult children of surrogacy. Sixth, the UK/CFR studies have not been replicated by any other published studies. There may be a seventh reason. The UK/CFR families were recruited from those created before Britain banned anonymous gamete donation in 2005,³⁸ but we don't know how many of the ART families used anonymous gametes, so we don't know how, if at all, such anonymity might have affected the results.

Overall, the UK/CFR studies find that some young UK children of nominally unpaid surrogacy, still living at home with their mothers, have coped with their family circumstances to the satisfaction of the adults who raise, teach or study them. The mothers who participated may have been more likely than non-participants to have a good family life that they were willing to let researchers study. They may have had an emotional stake in ART or surrogate parenting that led them to paint a rosy picture. It may well be that some young UK children, maybe the lucky or the strong, have adjusted to their origins as children of surrogacy. But that sheds little light on the question whether other young children of surrogacy have failed to adjust, whether some of the youngsters will report problems when they grow old enough to be more independent, or how the studied UK families might compare with unstudied US families.

Neither the UK/CFR studies, nor anecdotes about the children of surrogacy can tell us much about what to expect as such children age into adolescents and adults who, compared with infants and young children, will have a more mature understanding of their genetic and gestational origins, and will be more independent of the adults who raised them and so will be freer to express their reactions to their origins. This is in part a function of the relative ages of the cohorts of children created with different technologies which emerged at different times. Generally, artificial insemination began in the nineteenth century and so preceded egg “donation” and surrogacy which began in the late twentieth century.³⁹ Accordingly, there are many children of sperm “donation” to tell anecdotes and to be studied, but not so many children of egg “donation” and very few children of surrogacy.⁴⁰

Subpart 3A2 – Other Studies

expenses, but also for the use of her womb and the surrender of the child, would be more likely to find the arrangement distasteful and upsetting. Thus the studies of UK surrogacy (whether truly, or only nominally, uncompensated) have limited bearing on US surrogacy for pay.

³⁸ D. R. Beeson, et al. *Offspring searching for their sperm donors: how family type shapes the process*, Human Reproduction, Vol.26, No. 9, 2011, pp. 2415-2424, at p. 2416. See also the UK Human Fertilisation and Embryology Authority website at www.hfea.gov.uk.

³⁹ NYS TFL, Assisted Reproductive Technologies, 1998, pp. 49, 76.

⁴⁰ The majority cites ASRM statistics showing that US babies born through surrogacy increased from 738 in 2004 to 2,236 in 2014, an increase of over 200% in ten years. Despite the large percentage increase, the number remains small and is less than one-tenth of one percent of the approximately 3.9 million annual US births.

There are as yet no large-scale studies without selection bias of adult or even adolescent children of commercial non-genetic surrogacy. There are reports from adolescents and adults who feel loss, abandonment, anger or shame arising out of their commercial ART conception (often anonymous sperm donation or sale). Examples follow. “The effects ... vary from donor child, but the overwhelming response is that we are damaged individuals because of donor conception.” “I am part of a generation of children that derive from billion dollar corporations commercializing life, corporations that sell human beings.” “I hate that my dad got paid... ”⁴¹ But neither the UK/CFR studies nor anecdotes can form a reasonable basis to predict the quantitative scale of long-term results of commercial surrogacy in New York. So, we consider whether there is any other evidence about children of ART which might give us grounds to be confident or fearful about the future for children of surrogacy.

In this setting, it is reasonable to ask whether we might extrapolate from what we know about the children of gamete “donation” to make reasonable, albeit imprecise, projections about the children of surrogacy. We turn to evidence about the children of gamete “donation.”

A study by Elizabeth Marquardt and others surveyed three groups of 18 to 45 year old US adults: 485 who said their mother used a sperm “donor” to conceive them, 562 who were adopted as infants, and 563 who were raised by their biological parents.⁴² The study is notable for its large, albeit self-selected, sample size, the use of comparison groups, the relatively older age of those studied, and – we presume – their relative maturity, independence and willingness to report candidly about relationships with the adults who raised them, compared with younger children still living at home.

Marquardt found that sperm “donor offspring” are 1.5 to 2 times as likely as biological offspring to report problems with the law before age 25, mental health problems, or substance abuse problems. “Donor offspring” whose parents kept their origins a secret (leaving the offspring to learn the truth in an accidental or unplanned way) were more likely to report depression or other mental health issues, struggles with substance abuse, or problems with the law. While “donor offspring” who said that their parents were always open with them about their origins fared better than those whose parents tried to keep it a secret, they still reported a higher rate of substance abuse and legal problems than biological offspring.⁴³ In addition to such heightened risks of delinquency, depression and drug use, Marquardt also found evidence that “donor offspring” had unique concerns about anonymous commercial gamete “donation,”⁴⁴ and

⁴¹ The quotations are from AnonymousUs.org and are reported by Ann Carey in *The 'Who Am I?' Generation*, Our Sunday Visitor, March 23, 2014.

⁴² Elizabeth Marquardt, et al., *My Daddy's Name is Donor*, The Institute for American Values, (2010), p.5, viewed on September 1, 2016 at http://americanvalues.org/catalog/pdfs/Donor_FINAL.pdf, hereafter “2010 Marquardt Study.”

⁴³ 2010 Marquardt Study, first cited at n. 42 above, at pp. 7-14, and in more detail thereafter.

⁴⁴ Nearly half of “donor offspring” agree, “it bothers me that money was exchanged in order to conceive me.” About twice as many sperm “donor offspring” as adoptees and biological offspring agree, “It is wrong for people to provide their sperm or eggs for a fee to others who wish to have children.” Depending on what question is asked, about two-thirds of grown “donor offspring” support the right of offspring to have non-identifying information about the sperm “donor” biological father, to know his identity, to have the opportunity to form some kind of relationship with him, to know about the existence and number of half-siblings conceived with the same man's sperm, and to have the opportunity as children to form some kind of relationship with such half-siblings. Almost half of “donor

experience sadness or hurt because they lack a connection to their genetic fathers.⁴⁵ They have unique worries about their relationships with the families who raised them,⁴⁶ accidental incest,⁴⁷ divorce of the parents who raised them,⁴⁸ and their ability to express themselves to the adults who raised them or to the public.⁴⁹

Another study by Diane Beeson and others surveyed “donor-conceived offspring” registered with the non-profit US-based international Donor Sibling Registry (DSR). The authors note that DSR registration is voluntary and incomplete, and that, many, if not most, donor-conceived offspring (especially those born to heterosexual parents) are not told that they were conceived using donor gametes. They note that it is impossible to know whether or not DSR registrants are representative of all donor conceived offspring, or even of all such offspring with knowledge of their conception. After excluding a small number of offspring of egg-donation, the final sample consisted of 741 offspring of sperm donors: 458 (61.8%) of them offspring of heterosexual parents (OHETs) and 283 (38.2% offspring of lesbian parents (OLSBs). Respondents lived in the USA (80.5%) and eleven other countries (19.5%); they were 31% male and 69% female. Their reported ages ranged from 9 to over 40; 54.6% of those reporting their age were 18 or under and 47.4% were 19 or older. OLSBs were generally younger than OHETs, for example, 60% of OLSBs and 26% of OHETs were 15 years or younger. Over 93% of OHETs and 82% of OLSBs reported that they were conceived using anonymous sperm “donors” while 7% and 18% respectively reported that their parent(s) had used a known or willing-to-be-known donor. The authors studied disclosure patterns and responses as they varied with two aspects of family type: single or dual parent families and heterosexual or lesbian parent families.⁵⁰

offspring” have concerns about or serious objection to “donor” conception itself, even when parents tell their children the truth. 2010 Marquardt Study, first cited at n. 42 above, at pp. 7-14, and in more detail thereafter.

⁴⁵ Nearly half of “donor offspring” (compared with about one-fifth of adoptees) agree, “When I see friends with their biological fathers and mothers, it makes me feel sad.” Similarly, more than half of “donor offspring” (compared with less than a third of adoptees) agree, “It hurts when I hear other people talk about their genealogical background.” 2010 Marquardt Study, first cited at n. 42 above, at pp. 7-14, and in more detail thereafter.

⁴⁶ More than half of “donor offspring” agree, “I have worried that if I try to get more information about or have a relationship with my sperm donor, my mother and/or father who raised me would feel angry or hurt.” Almost half of “donor offspring” (compared with about one-quarter of adoptees and less than one-fifth of biological offspring) agree, “I worry that my mother [or my father] might have lied to me about important matters when I was growing up.” About twice as many “donor offspring” as biological offspring agree, “I feel I can depend on my friends more than my family.” 2010 Marquardt Study, first cited at n. 42 above, at pp. 7-14, and in more detail thereafter.

⁴⁷ Nearly half (46%) of “donor offspring” (compared with 17% of adoptees and 6% of biological offspring) agree, “When I am romantically attracted to someone I have worried that we could be unknowingly related.” Similar percentages (respectively, 43%, 16%, and 9%) agree, “I have feared having sexual relations unknowingly with someone I am related to.” 2010 Marquardt Study, first cited at n. 42 above, at pp. 7-14 and in more detail thereafter.

⁴⁸ About 27% of “donor offspring” (compared with 14% of adoptees and 25% of biological offspring) reported that their parents divorced before respondent was age 16. The authors state that the comparison between parents of “donor offspring” and the parents of adoptees is apt, because in both cases the parents would likely have turned to “donor” conception or adoption later in their marriages when marriages on average are more stable. 2010 Marquardt Study, first cited at n. 42 above, at pp. 7-14 and in more detail thereafter.

⁴⁹ More than half of “donor offspring” agree, “I have worried that if I try to get more information about or have a relationship with my sperm donor, my mother and/or the father who raised me would feel angry or hurt.” Those “donor offspring” who do not support the practice of “donor” conception are more than three times as likely to say they do not feel they can express their views in public. 2010 Marquardt Study, first cited at n. 42 above, at pp. 7-14 and in more detail thereafter.

⁵⁰ D. R. Beeson, et al., *Offspring searching for their sperm donors: how family type shapes the process*, Human Reproduction, Vol. 26, No. 9, 2011, pp. 2415-2424, hereafter “2011 Beeson Study.”.

Beeson found that OLSBs learned earlier than OHETs the nature of their donor conception, and that offspring in single-parent families learned it earlier than those in dual-parent families.⁵¹ Most OHETs and almost all OLSBs learned of their origins from a parent.⁵² About 25% of OHETs and 10% of OLSBs reported confusion upon learning the method of their conception; over 33% of OHETs in dual-parent households reported such initial confusion.⁵³ Usually, the older subjects were when they learned they were “donor-conceived,” the higher the percentage of them reported initial confusion. For example, among those who “always knew” or learned by age 10, about 5% to 20% reported such confusion, while among those who learned at age 11 to 18 or older, about 35% to 45% reported such confusion.⁵⁴ Confusion about donor conception diminished over time, but significant minorities, up to 11.3% among dual-parent OHETs, remained confused at the time of the surveys.⁵⁵

We acknowledge the limitations (chiefly self-selection of the subjects) of the Marquardt and Beeson studies for their own purposes. Furthermore, neither Marquardt nor Beeson reported any study of the impact of sperm vending compared with sperm donation. And, of course, neither Marquardt nor Beeson studied surrogacy.

Part 3B – Embryonic and Other Children Conceived by IVF for Surrogacy

IVF, including IVF for surrogate child-bearing, puts embryonic human beings at deadly risk. It uses sperm to fertilize eggs, thus creating embryonic human beings, and then implants one or more of those embryos into the uterus of a woman who will then carry the embryo as it grows into a fetus, or child. Because of the risks and difficulty of harvesting eggs, it is typical to collect and then to fertilize many at once in order to have a ready supply, first of eggs for fertilization, and then of embryos for implantation.⁵⁶

Some implanted embryos are aborted. In order to avoid the expense and complications of multiple pregnancies, IVF professionals now recommend that fewer embryos be implanted.⁵⁷ It is unclear how widespread is compliance with such recommendations. Of course, to the extent that fewer extra embryos are implanted, it is to be welcomed that fewer embryos are aborted. Yet some embryos created by IVF are still aborted after implantation, and some portion of those are aborted in the wombs of surrogate child-bearers. Although any trend to single embryo transfer means that fewer implanted embryos are deliberately destroyed, nonetheless, some still suffer that fate.

Some embryos are never implanted. We deplore the fate of embryonic human beings created by IVF, but never implanted. Most appear doomed to indefinite storage with risk of accidental

⁵¹ 2011 Beeson Study, cited at n. 50 above, at p. 2417.

⁵² 2011 Beeson Study, cited at n. 50 above, at p. 2417.

⁵³ 2011 Beeson Study, cited at n. 50 above, at p. 2418 and Table I.

⁵⁴ 2011 Beeson Study, cited at n. 50 above, at p. 2419 and Figure I.

⁵⁵ 2011 Beeson Study, cited at n. 50 above, at pp. 2418-2419 and Table II.

⁵⁶ At least three to six embryos created for possible use in IVF are aborted, discarded, or stored indefinitely for each embryo brought to birth by IVF. See n. 16 above.

⁵⁷ See, for example, T. Allen Merritt, et al., *National Perinatal Association Position Statement*, Neonatology Today, March 2014.

destruction through imperfect storage techniques, subjection to research with risk of death, or deliberate destruction.

Since the Task Force reported in 1998 about Assisted Reproductive Technologies (ART), new information has appeared about the risks to babies conceived by IVF. A study of 2.5 million Swedish infants born between 1982 and 2007 who were followed for an average of 10 years found a low but statistically significant increased risk of autism or mental retardation among infants born using IVF.⁵⁸ A 2013 review of 25 papers published from 1990 to 2012 found that children born after fertility treatment (mostly IVF) were at a 33% higher risk for all childhood cancers and up to a 400% higher risk for some such cancers, than those born without such fertility treatment.⁵⁹ A study of 2.8 million Danish infants born between 1964 and 2006, found that those born to women with fertility problems and fertility treatment (mostly IVF) had an 18% higher risk of childhood cancers and a 22% higher risk of young adult cancers than those born to women without such problems.⁶⁰ The cancer rates in the last two studies were low, but the increases were statistically significant. None of these three studies was able to tell whether the increased morbidities were caused by the fertility treatments or by factors related to the underlying fertility problems. But from the perspective of the afflicted child it is unlikely to matter which cause operated. We know of no reason why IVF for surrogacy would not result in the same risks associated with IVF overall.

Part 3C – Other Persons

Anonymous gamete “donation” for surrogacy puts the grandchildren of surrogacy at medical risk for genetic diseases through accidental incest. The repeated sale or donation of gametes by a single person may produce genetic half-siblings or siblings unknown to each other, and thus cause accidental incest. The children of such incest are at risk for genetic diseases. There is at least one reported case of twins separated at birth who did not learn until after their marriage to each other that they shared a common father.⁶¹ If it can happen to twins born to one woman, it can happen to half-siblings born to multiple surrogate child-bearers.

Transfer of newborn children from a surrogate child-bearer to intended parents could frighten the other older children of the child-bearer. There has been little research on the question whether children are frightened by their mothers' surrender of another child born for other parents. A UK CFR study has been cited for the hypothesis that most biological children did not have negative psychological impacts as a result of their mothers' being surrogate child-bearers; but that study had a small sample size, no control group and some selection bias. Even so, over 10% of the children cooperating with that study failed to report positive views of their mothers' surrogacy or of family life.⁶² The study method makes it hard to know what caused the absence of such

⁵⁸ Sven Sandin, et al., *Autism and Mental Retardation Among Offspring Born After In Vitro Fertilization*, Journal of the American Medical Association, 2013; 310(1): 75-84.

⁵⁹ Marie Hargreave, et al., *Fertility treatment and childhood cancer risk: a systematic meta-analysis*, Fertility and Sterility, Vol. 100, No. 1, July 2013, pp. 150-161.

⁶⁰ Marie Hargreave, et al., *Increased risk for cancer among offspring of women with fertility problems*, International Journal of Cancer, Vol. 133, No. 5, September 2013, pp. 1180-1186.

⁶¹ 2010 Marquardt Study, first cited at n. 40 above, at p. 35.

⁶² Vasanti Jadvia and S. Imrie, *Children of surrogate mothers: psychological well-being, family relationships and experiences of surrogacy*, Human Reproduction, Vol. 29, No. 1, 2014, pp. 90-96. The authors asked 34 UK

positive feelings. Until research determines that no harm is caused to such children by surrogacy, precaution suggests society should discourage it.

Surrogacy can undermine the dignity of surrogate child-bearers. The Task Force has heard evidence that surrogacy, especially commercial surrogacy, undermines the dignity of the women who agree to bear children for others.⁶³ The European Parliament has asked its member states “to acknowledge the serious problem of surrogacy which constitutes an exploitation of the female body and her reproductive organs;” and has emphasized that “women and children are subject to the same forms of exploitation and both can be regarded as commodities on the international reproductive market, and that these new reproductive arrangements, such as surrogacy, augment the trafficking of women and children and illegal adoption across national borders.”⁶⁴ The Dutch National Rapporteur has warned against transnational human trafficking for the purpose of forced commercial surrogacy.⁶⁵

As an economic matter, one can easily argue that surrogates are exploited for their services. If one were to allocate all of the payment typically received by a gestational surrogate (say \$25,000 to \$30,000) to her services during pregnancy, and allocate none of it to her pre-pregnancy services or to her surrender of the child, and if one were to divide that payment by the number of hours in a typical 37 to 42 week pregnancy (6,216 to 7,056 hours), one would calculate a payment during pregnancy of about \$3.55 to \$4.85 per hour. That is less than the current federal minimum wage of \$7.25 per hour and far less than any of the current state minimum wages of at least \$9.00 per hour for various classes of workers in New York.

Surrender of children to intended parents disrupts the relationship between the carrier and the child. The Task Force received evidence that children bond *in utero* with the women who carry them, even if the carrier is a so-called “gestational” surrogate who has no genetic kinship with the child, and the disruption of that bond by post-natal surrender of the child to another person sometimes causes emotional pain to the woman and child.⁶⁶

surrogate mothers (that is, women who had born and surrendered a child to others) who had children over the age of 12 years whether their child wished to take part in their study. The surrogates had a total of 105 children, 60 of whom were aged over 12 years, and 44 of whom were living at home. Only 36 children, aged 12 to 25, seven of whom were no longer living at home, took part in the study. The authors acknowledge that their sample size was relatively small and not all children took part; it is unknown what would have been the responses of the children who did not take part. Over 85%, but not all, of those studied reported positive views of their mother's surrogacy and of family life. Over 10% of those responding failed to report a positive view of their mothers' surrogacy or of their family life. Because there was no control group, the authors did not compare the rate of positive views of family life in the study group with the rates of positive views by children of non-surrogates.

⁶³ Kathleen Sloan, *Abuses of Women's Human Rights in Third Party Reproduction*, presented to the Task Force on October 17, 2013. Jennifer Lahl, *Breeders: A Subclass of Women?*, a 2014 film produced by the Center for Bioethics and Culture Network.

⁶⁴ European Parliament, *Resolution on priorities and outline of a new EU policy framework to fight violence against women*, April 5, 2011, at #s 20-21.

⁶⁵ Bureau of the Dutch National Rapporteur on Trafficking in Human Beings, *Human Trafficking for the purpose of removal of organs and forced commercial surrogacy*, 2012.

⁶⁶ In her 2012 film, *Breeders: A Subclass of Women?*, cited at n. 49 above, Jennifer Lahl presented comments of Nancy Verrier who spoke about the bond of child-bearers and children that forms even without a genetic connection. The 2013 UK Study at Age 10, first cited at n. 30 above, acknowledges that the absence of a gestational connection between the children of surrogacy and the mothers who raise them may be more problematic for children than the absence of a genetic link.

Surrogacy risks disputes between the surrogate child-bearers and the intended parents over custody of the children. The Task Force has heard of disputes where surrogate child-bearers, who have promised to surrender the child to the intended parents, have changed their minds and refused to do so. We have been told that this happens less often with non-genetic than genetic surrogacy, but that it still happens. And some intended parents refuse to take custody of the children they have contracted for through surrogacy.⁶⁷ It is difficult to know the frequency of such disputes, but they do happen, apparently rarely.⁶⁸ Any such dispute has the potential to cause emotional harm to the adults involved, and - if it is prolonged - serious and lasting harm to the child whose home is rendered unstable during the dispute.

Part 3D – Unmeasured or Unmeasurable Harms Risked by Commercial Surrogacy

Some harms are inherent in surrogate child-bearing and are not necessarily measurable with present techniques. No matter how carefully it is done, surrogate child-bearing always deliberately divides, before conception, the roles of parenthood, namely: conception, gestation and child-rearing. We sympathize with the suffering of spouses who cannot have children, we value human life and the special nature of the transmission of life in marriage, and we accept every child as a blessing no matter how conceived. But we disapprove of surrogate child-bearing because it sets up – to the detriment of families and children – a division between the physical, psychological, social and moral elements of families.⁶⁹

In 1988, the Task Force found that surrogate parenting arrangements deliberately fracture the genetic, gestational and social relationships of children to their parents.⁷⁰ The current Task Force has heard arguments that surrogacy violates natural law with predictable undesirable consequences.⁷¹ We share these conclusions.

Surrogacy unnecessarily complicates before conception the family context in which children will seek their identities. A child needs an understanding of where he or she fits into family, society and – as some of us believe – all creation, in order to form a sense of purpose essential to

⁶⁷ A notorious Australian pedophile, who with his wife contracted with a surrogate to bear twins for them, accepted one and abandoned the other. Richard Ackland, *Surrogacy is still available to paedophiles. This must change – but how?*, The Guardian, August 14, 2014, and Thomas Fuller, *Thailand's Business in Paid Surrogates May be Foundering in a Moral Quagmire*, New York Times, August 26, 2014. A US TV personality, Sherri Shepherd, who with her husband contracted with a surrogate to bear a child for them using a third woman's egg, separated from him before the child was born and refused to consent to be declared the baby's mother; as the baby neared 1 year of age, a court declared Shepherd to be the mother and ordered her to pay support. See Pennsylvania Superior Court opinion in In re Baby S., (2015, PA Super.244 (November 23, 2015)).

⁶⁸ On November 20, 2014, California attorney Andrew Vorzimer orally told the Task Force that there have been about 67,000 surrogate deliveries in the US since 1979, and that his law firm is aware of about 80 US cases where the intended parents considered changing their minds about taking the child, and about 36 cases where the surrogate (25 genetic and 11 non-genetic) changed their mind about surrendering the child. Those disputes appear to us to occur at a low rate: $80/67,000 = 0.12\%$, $36/67,000 = 0.05\%$, and $(80 + 36 = 116)/67,000 = 0.17\%$.

⁶⁹ The Roman Catholic Church holds this view. See Congregation for the Doctrine of the Faith, *Donum Vitae* (The Gift of Life), 1987, English translation viewed on March 5, 2014 at www.vatican.va/roman_curia/congregations/cfaith/. But it is not necessary to be Catholic in order to hold this view.

⁷⁰ NYS TFL, *Surrogate Parenting*, 1988, pp. 119, 122 and 124.

⁷¹ Rev. Tadeusz Pacholczyk, Director of Education at the National Catholic Bioethics Center spoke to the Task Force on February 25, 2014.

individual and social health. Confusion about a child's place in a family or society sometimes leads to individual distress or to anti-social or asocial behavior.⁷² Unfortunately, some children of traditional conception, gestation, birth and child-rearing suffer such distress or behave in such ways. Fortunately, many children of surrogacy do not exhibit such distress or behavior. But children of surrogacy are at elevated risk for these harms.

The commercialization of gamete provision and child-bearing puts children at risk for instrumentalization and commodification. The 1988 Task Force report affirmed that society has an interest in shielding gestation and reproduction from commerce. Many members viewed surrogate parenting arrangements, including those for non-genetic or so-called “gestational” surrogacy, as indistinguishable from the sale of children. Some believed that, like pre-nuptial agreements, surrogate parenting contracts replace social relationships of care and trust with contractual relationships, and that such replacement is a change for the worse.⁷³

Recent research in behavioral economics offers analogies that might explain how commercial surrogacy changes the way that adults relate to children. Such research suggests that in many facets of communal life, people can be motivated by social rewards or economic incentives, and that sometimes the introduction of external monetary incentives undermines internal social motivation. For example, monetary rewards sometimes reduce the frequency of blood donation.⁷⁴ Introduction of fines for late parental pick-up of children at day-care centers was followed by increased frequency of tardiness.⁷⁵ And an offer of compensation reduced some communities’ popular support for siting of radioactive waste storage facilities in those communities.⁷⁶

A plausible explanation for these results is that some communally useful behaviors are motivated by internal social perceptions of ourselves and our relationships with others, and that monetary incentives do not reinforce such social motivations, but instead undermine them. The foregoing research suggests that the introduction of money into the processes of conception and gestation is likely to change the motivations of parents, perhaps in unexpected and undesirable ways. In fact, there is already anecdotal evidence that commercial surrogacy changes adult attitudes toward children. For example, a disappointed customer of a failed surrogacy broker said: “It’s like we paid money to buy a condo, they took the money and there was no condo.”⁷⁷

⁷² See 2010 Marquardt Study, first cited at n. 42 above, and 2011 Beeson Study, cited at n. 50 above.

⁷³ NYS TFL, Surrogate Parenting, at pages 117-118 and 122-123.

⁷⁴ Richard Titmuss, in *The Gift Relationship*, 1970, argued that monetary compensation for donating blood might crowd out the supply of blood donors. A Swedish study suggested that in some circumstances it is true. Carl Mellstrom and Magnus Johannesson, *Crowding Out in Blood Donation: Was Titmuss Right?*, Journal of European Economic Association, Vol. 6, No. 4, 2008, pp. 845-863.

⁷⁵ Introduction of fines for late pick-up of children at Israeli day-care centers was followed by doubling of the rate of tardiness; the more frequent lateness persisted after the fines were removed. Uri Gneezy and Aldo Rustichini, *A Fine Is A Price*, Journal of Legal Studies, Vol. XXIX, University of Chicago, January 2000.

⁷⁶ Swiss authorities twice surveyed residents of two communities proposed for the location of low level radioactive waste storage facilities, once without mention of monetary incentives, and again after offering money to residents if the facility was sited in their community. Pre-offer rates of support fell to half after the monetary offer. Bruno Frey, et al., *The Old Lady Visits Your Backyard: A Tale of Morals and Markets*, Journal of Political Economy, Vol. 104, No. 6, pp. 1297-1313, December 1996.

⁷⁷ Tamar Lewin, *A Surrogacy Agency That Delivered Heartache*, New York Times, July 27, 2014.

The offer of money changes how an action is perceived. Consider the Swiss waste storage case. When money was offered, people suspected that there were unpleasant features of the arrangement that the offer-maker thought must be offset by money. The offer changed the respondents' focus from how the facility might benefit the broader society, to how it might harm them in ways requiring compensation.

The foregoing research suggests that children who learn that money bought the gametes by which they were conceived or encouraged women to bear them, might plausibly wonder what was so distasteful about their conception or gestation that money was used to make it happen, and might doubt their own worth. And even though we do not know with scientific certainty how it happens, we do know that significant numbers of the adult children of anonymous commercial gamete providers report deleterious effects, and do so at rates higher than adopted children and children raised by their biological parents.⁷⁸ It is reasonable to hypothesize that many children born through commercial surrogacy will face struggles similar to those of children conceived by commercial gamete “donation.”

⁷⁸ See the blogs, film and research cited at Subpart 3A above.

Chapter 4 – ANALYSIS

We describe our selection and application of principles for, first factual, then ethical, analysis.

Part 4A – Factual Analysis

We repeat that the current measurable evidence concerning the long-term harms of surrogacy, or the alleged lack thereof, is scanty, equivocal, sometimes biased, and often anecdotal. Those on all sides of the debate must be careful to evaluate with care what little evidence exists. Because the evidence is incomplete, one must make reasonable guesses about what is unmeasured. Rational extrapolations are sometimes needed, but they must be used with caution.

The absence of proof of harm is not proof of the absence of harm. Moreso, the current absence of proof of measurable harm is especially not proof of the absence of long-term harm.

In order to find that a cause contributes to an effect, one need not find that the cause always produces the effect or that no other cause ever produces the effect. We are thankful that surrogacy does not always result in measurable harm. And we acknowledge that an end to surrogacy would not end all the harms of which it is one cause. Yet we find that surrogacy creates a heightened risk of harms sufficient to justify a public policy to discourage it.

Scientific measurement always involves some error rate. And the ability to detect a pattern in reality depends on how regular or variable is the reality studied. So even without bias, scientific findings are less likely to be true: (1) the smaller the samples studied, (2) the smaller the effect sizes, (3) the greater the number and the lesser the selection of tested relationships, or (4) the greater the flexibility in designs, definitions, outcomes, and analytical modes.⁷⁹

Human biology and behavior are more variable than the subjects of hard sciences like inorganic chemistry or astrophysics. The descriptions of soft sciences like sociology and psychology are more flexible and their measurement tools are more imprecise than those of the hard sciences. There are reasons to be skeptical about research findings in the social or psychological fields, even when those findings are not biased, and especially when they are not replicated.

Peer review does not correct all false research findings. It lacks common standards for what it is or how it is done; it is subjective and inconsistent.⁸⁰ Moreover, it is often ineffective. Experimenters modified a paper accepted for publication by the British Medical Journal (BMJ) by introducing eight errors in study design, methodology, data analysis, and interpretation of results, and submitted it to 420 BMJ reviewers. None of the 221 reviewers who reported back caught all of the errors; on average they caught about two; and only 30% recommended that the

⁷⁹ John P. A. Ioannidis, *Why Most Published Research Findings Are False*, *PLOS Medicine*, 2005 Aug; 2(8): e124.

⁸⁰ Richard Smith, *Peer review: a flawed process at the heart of science and journals*, *Journal of the Royal Society of Medicine*, 2006 Apr; 99(4): 178-182.

intentionally flawed paper be rejected for publication.⁸¹ It has been said “If peer review is good at anything, it appears to be keeping unpopular ideas from being published.”⁸²

We find no credible studies showing that commercial, non-genetic “gestational” surrogacy risks no long-term harm to the children it produces, especially, but not only, when – as it often does in the US – it uses anonymous or commercially obtained gametes. As explained above, we specifically deny that the UK/CFR studies prove the absence of such risks.

The studies are all limited but:

- (1) Beeson found that a significant minority of sperm “donor” offspring reported confusion when they learned of their genetic origins;⁸³
- (2) Marquardt found that many (often about half) of the offspring of anonymous sperm “donors” had concerns about anonymous commercial gamete “donation” and/or accidental incest, felt sadness or hurt because they lacked a social connection to their genetic fathers, and worried about trust and stability in the families that raised them;⁸⁴
- (3) Marquardt found that sperm “donor” offspring are 1.5 to 2 times as likely as biological offspring to report problems with the law before age 25, mental health problems, or substance abuse problems;⁸⁵
- (4) both Beeson and Marquardt found that large portions of sperm “donor” offspring (up to one-quarter and one-half respectively) have concerns about expressing their feelings about “donor” conception to their social parents or the public; and
- (5) the 2013 UK/CFR Study at Age 10 found “The absence of a gestational connection to the [intended or social] mother may be more problematic [for the child] than the absence of a genetic link.”⁸⁶

Taken together, these studies suggest the following transitive logical possibility, or even probability. If (per the UK/CFR study) children of surrogacy might be worse off in some respects than some children of gamete donation, and if (per Marquardt) some children of gamete donation are worse off in some respects than children of natural conception, then it is plausible to posit that children of surrogacy might be worse off in some respects, and at higher rates, than children of natural conception.

Of course, this suggestion is not proven by any scientific study, nor – so far as we know – has it even been systematically studied. It certainly has not been proven false. And of course, before its truth or falsity could be proven, one would want to investigate the relative contributions of paid surrogacy, paid gamete “donation,” anonymous gamete “donation,” for both male and female gametes. We see no obvious reason to expect that offspring of paid surrogacy or paid egg “donation” would be entirely free of the problems associated with offspring of paid sperm “donation.” One would also want to follow the studied offspring long enough to know what are the long-term consequences of each form of surrogacy. We think it a plausible hypothesis worthy

⁸¹ Fiona Godlee, et al., *Effect on the Quality of Peer Review of Blinding Reviewers and Asking Them to Sign Their Reports*, *Journal of the American Medical Association*, 1998: 280(3): 237-240.

⁸² William A. Wilson, *Scientific Regress*, *First Things*, May 2016, pp. 37-42.

⁸³ 2011 Beeson Study, cited at n. 50 above.

⁸⁴ 2010 Marquardt Study, first cited at n. 42 above.

⁸⁵ 2010 Marquardt Study, first cited at n. 42 above.

⁸⁶ 2013 UK/CFR Study at Age 10, first cited at n. 32 above.

of investigation. Anecdotal reports from offspring of surrogacy reinforce our belief that this hypothesis could be proven true. Yet no one has systematically studied it.

A reasonable forecast emerges. Some, perhaps many, offspring of US commercial surrogacy will live to adulthood without reporting feelings of maladjustment (like confusion, shame, anger, depression or loss) or misbehaviors (like delinquency, or drug abuse). But some offspring of such surrogacy, especially, but not exclusively those created with one or more anonymous or commercially obtained gametes, will suffer such maladjustments and will engage in such misbehaviors. They will do so perhaps at rates comparable to those of adoptees or the offspring of anonymous sperm vendors, and probably at rates greater than those of children conceived and born naturally and raised by their genetic parents. Society will pay a social and fiscal cost for some of those maladjustments and misbehaviors. We are ready to connect those dots, even if others are not.

In addition to the measurable (but as yet unmeasured) long-term harms to which the children of commercial surrogacy are subjected by the adults who arrange for such surrogacy, there are also unmeasurable harms to such offspring. If the fact of commercial surrogate gestation is kept secret from the child, it disrespects the child and risks a bad reaction. If it is revealed to the child, it reveals facts which will cause some children to believe that they were bought and sold, or to wonder what was so distasteful about their gestation that a woman was paid to undertake it.

To the extent that surrogacy uses commercially obtained gametes (and we believe their use is widespread in the US), it risks reactions of confusion, shame, and anger among its offspring arising from their conception even before their gestation.

To the extent that surrogacy uses anonymous gametes (and we believe their use is widespread in the US), it risks: social, psychological or medical harm to children, including accidental incest; and genetic diseases harming the children of accidental incest who are the grandchildren of surrogacy by anonymous gamete “donation.”

In the US, surrogacy is virtually always practiced with IVF with the deliberate creation of more embryonic human beings than will be implanted, carried to term and raised after birth, thereby predictably leading to the indefinite storage, pre-implantation destruction, or post-implantation death by abortion of many of those embryonic or fetal human beings.

IVF, including IVF for surrogacy, is associated with higher rates of autism, mental retardation, childhood cancers, and young adult cancers. See Subpart 3B.

As surrogacy is often, but not always, practiced in the US, it risks:

- (1) the subjection of other children of the surrogate child-bearer to the fear that they too might be surrendered or otherwise abandoned by their mother;
- (2) undermining the dignity of women who are paid to bear and then surrender the child to another;
- (3) requiring the woman who carries the child to agree before birth, or even before implantation or conception, that she will surrender the child to others, regardless of the

mutual attachment she and the child may form during and immediately after pregnancy;
and
(4) child custody disputes between the intended parents and the surrogate child-bearer.

Not all of these risks have or will become real in every case, but they are possible in many cases and sometimes have become real.

Part 4B – Ethical Analysis

Our thinking has often originated with principles of Judeo-Christian thinking. Yet the following analysis is based on reasons, and expressed in terms, that can appeal to all rational persons of good will and open mind, even to non-religious persons. It is possible for those applying different principles to reach the same conclusions.

Subpart 4B1 – Motive and Method

The laudable intent to create and love a child is not enough to assess the morality of the means by which the child is to be created. Some have argued that a good end justifies even bad means to attain it. But this Machiavellian argument is not universally accepted; in fact it is widely despised.⁸⁷ No current Task Force member claims that every means to create a child is acceptable. For example, we daresay all members would discourage incest or statutory rape of minors (who though otherwise consenting to sexual intercourse are deemed by law to be too young to consent), even if the couple intend to love the resulting child. In assessing whether New York should continue to discourage surrogacy, one must assess not only its intended benefits, but also its likely risks, both those inherent in surrogacy no matter how it is done, and those that are contingent depending on how surrogacy is done.

A child of surrogacy has written: “It looks to me like I was bought and sold. ... My biological father and adoptive mother were very good to me and I know they loved me. I love them too very, very much. But they did some things that were inexcusable and made me feel horrible. ... Yes I am angry. Yes I feel cheated. Yes I feel that my parents and my mother did not take my feelings into consideration when they entered into this arrangement, but I feel that they are all good people just really misguided and did not stop to think of the ramifications. It's a shame and it sucks for me. ... It looks like you [the surrogates and the intended parents] are all good people with good intentions and a lot of love but all the good intentions and love in the world wont [*sic*] change the defenition [*sic*] of right and wrong. It won't change how the kids feel.”⁸⁸

⁸⁷ Although he did not say precisely that the end justifies the means, Niccolo Machiavelli is correctly associated with the substance of that saying. See *Of the Things for Which Men, and Especially Princes, Are Praised or Blamed, and In What Way Princes Must Keep Faith, The Prince*, ~1532, Chapters 15 and 18, English translation by The New American Library of World Literature, Inc. 1952. This is not the place to discuss different systems of ethics. It suffices to say that the adjective “Machiavellian” suggests expediency, deceit or cunning.

⁸⁸ Brian C., Son of a Surrogate blog, posted August 9, 2006, viewed on May 25, 2016 at <http://sonofasurrogate.tripod.com>.

The existence of a child, a fact to be celebrated, is not enough to assess the morality of the means by which the child was conceived. To tell a child of surrogacy “You should be glad to be here” can be perceived as disenfranchising the child's grief over family connections lost.⁸⁹

We do not judge the motives of most adults who enter into surrogacy arrangements. We certainly have no wish to stigmatize the children born of surrogacy; they had no say in how they were created. We are thankful that many children of surrogacy report no distress about their origins and appear to be well adjusted to their families and to society. But some significant number of children of surrogacy report feelings of confusion loss, anger or shame; and we have reason to think that some children of commercial surrogacy will suffer delinquency, depression or drug abuse at rates higher than those of the general population. Our sympathy with the motives of most adults who want to create children by surrogacy, does not outweigh our sympathy for the children who suffer because of it.

Subpart 4B2 – Autonomy, Beneficence and Justice

Surrogate child-bearing creates a tension between autonomy for adults and beneficence for children, which should - in justice - be resolved in favor of children. The 1979 Belmont Report identified three basic ethical principles accepted in our cultural tradition: (1) respect for persons, that is: (a) individuals should be treated as autonomous agents, and (b) persons with diminished autonomy are entitled to protection; (2) beneficence, that is, making efforts to secure persons' well-being by: (a) doing no harm, and (b) maximizing possible benefits and minimizing possible harms; and (3) justice, that is, the avoidance of unfair: (a) denial of benefit, or (b) imposition of burden.⁹⁰

There has been much debate about whether embryonic human beings are persons who are entitled to respect and, if so, what sort of respect. We conclude that they are entitled to respect as human persons, but acknowledge that not all Task Force members agree. Yet there can be little doubt that if embryonic human beings are persons, their personal autonomy is diminished compared with that of adults.

Without doubt, children are human beings and natural persons, and their autonomy is diminished compared with that of adults. By federal law, children born in the United States and subject to its jurisdiction are citizens.⁹¹ Legal purposes aside, there is widespread agreement that children are persons for moral purposes and they deserve our respect.⁹² We believe that in case of conflict, the Belmont principle of respect for persons supports more protection for the best interests or rights of vulnerable children than for the desires of autonomous adults.

⁸⁹ Jessica Kern in *Jennifer Lahl interviews Jessican Kern*, April 18, 2015, viewed on May 25, 2016 at www.cbc-network.org/2015/04/a-product-of-surrogacy-interview-video/.

⁹⁰ The Belmont Report; Ethical Principles and Guidelines for the Protection of Human Subjects of Research, The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979, at pp. 22-28. Although the Belmont Report applied these principles to human subject research, their broad cultural acceptance makes them relevant to analyses of other moral issues, including surrogate child-bearing.

⁹¹ U.S. Constitution, Amendment 14, §1; and 8 U.S.C., §1401.

⁹² See, for example, the sources cited in Part 1.

The principle of beneficence obliges adults and governments to avoid harm to persons, but particularly to vulnerable children who cannot otherwise protect themselves.⁹³

For the reasons set forth in Part 3, we are convinced that it is often a benefit for a child to be raised by the same adults who provided the gametes with which the child was conceived and who carried the child to birth. We are also convinced that it is often a burden on a child for the functions of parenting to be deliberately separated before conception. We conclude that, to avoid unfair denial of benefits and unfair imposition of burdens – that is, as a matter of justice – New York State should discourage families from seeking children by surrogate child-bearing.

Even utilitarian libertarians understand that individual autonomy is not boundless. It may be limited by society or government in order to prevent harm to others.⁹⁴

There is no legal or moral right to government help to acquire a child by surrogacy. Any claimed freedom to invoke state enforcement of surrogacy contracts is tantamount to a claim that there is a right to have a child by surrogacy, that society has no interest in family formation sufficient to justify state intervention to discourage surrogacy, and/or that adult desire for a child is enough to justify creation of a child by surrogacy despite the child's best interests based on beneficence and justice. But there is no such right.

Moreover, even democratic governments, including New York State, limit the freedom of their citizens for the broader good. In order to improve our communal lives together, governments have legitimately limited their citizens' freedom to contract, even if the parties are otherwise competent by age and mental capacity to do so. In addition to the area of surrogacy, New York has done so in other fields in order to protect the contracting parties from one another,⁹⁵ to protect non-parties,⁹⁶ and to discourage certain disfavored activities.⁹⁷ It has made void the purported waiver of certain rights, for the protection of both individuals and society.⁹⁸ The remedies New York has chosen to discourage surrogacy are neither unique nor unreasonable.

⁹³ The Belmont Report, op. cit.

⁹⁴ See, for example, John Stuart Mill, *On Liberty*, 1859, reprinted by Prometheus Books, 1986, at p. 16.

⁹⁵ New York General Obligations Law (GOL) makes certain contracts void and unenforceable, even if the parties are otherwise competent to enter them. Examples follow: (1) contracts where an employee agrees either to join a company union or not to join a labor organization – GOL §5-301; (2) contracts exempting from liability for negligence various contractors, such as: (a) lessors of real property – GOL §5-321, and (b) operators of pools, gymnasiums or places of public amusement – GOL §5-326; and (3) consumer credit contracts where a consumer waives a reciprocal right to recover attorneys' fees for breach – GOL §5-327.

⁹⁶ New York voids any restrictive covenant in a contract, mortgage, lease or deed affecting real property that limits the sale, lease, use or occupancy of real property because of race, creed, color, national origin or ancestry – GOL §5-321. Limits on the power of a husband and wife to contract to alter or dissolve their marriage or to relieve either of his or her liability to support the other (GOL §5-311) appear to be for the benefit of the adult parties to the marriage, but perhaps also for the protection of their children.

⁹⁷ All contracts for money or property wagered on unlawful bets are void – GOL §5-401 to §5-423. This appears to apply whether it is a bookie or a bettor seeking to collect an illegal gambling debt.

⁹⁸ An agreement purporting to waive a data subject's rights under the Personal Privacy Protection Law, for example, the subject's right of access to a state agency's record pertaining to the subject, is void as against state policy. Public Officers Law, §98. The New York State Court of Appeals has held that a sentencing court must comply with the command of Criminal Procedure Law, §720.20(1) that, where a defendant is eligible to be treated as a youthful offender, the court must determine whether he or she is to be so treated, even where the defendant has purported to waive that right. *People v. Reece Rudolph*, 21 NY 3d 499 (2013). The State has made the right to be considered for

Subpart 4B3 – Precautionary Principles

Those who propose societal endorsement of a dramatic departure from long-held and nearly universal norms for the creation of families have, pursuant to a precautionary principle, the burden to persuade society that the change has no significant risks. There are many formulations of precautionary principles, including “Better safe than sorry,” “Look before you leap,” and “An ounce of prevention is worth a pound of cure.” The Hippocratic Oath and the Belmont Report enjoin, respectively, physicians and policy-makers to “Do no harm.”

Precautionary principles have been adopted in the context of the environment,⁹⁹ human health,¹⁰⁰ and food supply.¹⁰¹ There are strong and weak versions of precautionary principles. Strong precaution requires a safe choice even when the risk is small or unlikely, the evidence is speculative, and the cost of safety is high. Weak precaution allows, but might not require, a safe choice if the damage would otherwise be serious or irreversible, and then only if the action is reasonable in proportion to the risk.

New York State has used a precautionary approach to public policy-making. In December 2014, the state Department of Health recommended that high-volume hydraulic fracturing (“HVHF” or “fracking”), a technique for oil and gas extraction, should not proceed in New York. The acting commissioner said: “I have considered all of the data and find significant questions and risks to public health which as of yet are unanswered. I think it would be reckless to proceed in New York until more authoritative research is done. I asked myself, ‘would I let my family live in a community with fracking?’ The answer is no. I therefore cannot recommend anyone else’s family to live in such a community either.”¹⁰² He said there was insufficient evidence to affirm the safety of fracking, and “We cannot afford to make a mistake. The potential risks are too great. In fact, they are not even fully known.”¹⁰³ As a result, the state Department of Environmental Conservation has undertaken to prohibit fracking in New York State,¹⁰⁴ rather than to permit it subject to regulation.

youthful offender status non-waivable, not just for the benefit of the defendant, but also for the good of society, which has an interest in the social development of young persons despite their otherwise criminal acts.

⁹⁹ “In order to protect the environment, the precautionary approach shall be widely applied by States according to their capabilities. Where there are threats of serious or irreversible damage, lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent environmental degradation.” *Rio Declaration on Environment and Development*, *United Nations Environment Programme*, 1992, Principle 15.

¹⁰⁰ “When an activity raises threats of harm to human health or the environment, precautionary measures should be taken even if some cause and effect relationships are not fully established scientifically.” Science and Environmental Health Network, *Wingspread Statement on the Precautionary Principle*, 1998.

¹⁰¹ “Lack of scientific certainty due to insufficient relevant scientific information ... shall not prevent the Party of import, in order to avoid or minimize such potential adverse effects, from taking a decision, as appropriate, with regard to the import of the living modified organism in question. *Cartagena Protocol on Biosafety*, [United Nations] *Convention on Biological Diversity*, 2000, Article 11, §8.

¹⁰² Acting Commissioner of Health, Howard A. Zucker, *New York State Department of Health Completes Review of High-volume Hydraulic Fracturing*, New York State Health Department website, December 17, 2014, viewed on April 3, 2015 at http://www.health.ny.gov/press/releases/2014/2014-12-17_fracking_report.htm.

¹⁰³ Thomas Kaplan, Citing Health Risks, Cuomo Bans Fracking in New York State, *New York Times*, December 17, 2014.

¹⁰⁴ New York State Department of Environmental Conservation, *Final Supplemental Generic Environmental Impact Statement on the Oil, Gas and Solution Mining Regulatory Program [for HVHF]*, June 2015.

We take no position here on HVHF. We simply note that in a field where NYS saw that the potential risks of an activity proposed to be permitted and regulated were both serious and not fully known, NYS deemed it appropriate to apply a precautionary principle and to ban the activity, rather than to regulate it.

Surrogacy, like other issues of public health, is appropriately subject to a precautionary principle. We note its great risks, not fully known, and the insufficiency of evidence to affirm its safety, especially for the long-term adjustment of offspring of surrogacy. We would discourage it rather than explicitly permit and enforce it subject to regulation. The psycho-social health of children, parents and families is important enough, the heightened risk of harm to children of surrogacy appears irreversibly serious enough, and the refusal to enforce commercial surrogacy arrangements is proportionately reasonable enough, that even a weak precautionary principle would justify extreme caution before departing from New York's policy of discouraging surrogacy. Of course, a strong precautionary principle would even more surely justify such caution before experimenting with the welfare of children.

Based on published studies, including the UK/CFR studies, we do not know the extent of commercial, non-genetic surrogacy's long-term psycho-social risks for its offspring. This alone should spur caution about permitting, let alone even enforcing, contracts for such surrogacy. To this knowledge we add the reports of a few such offspring, the analogous reports of many more offspring of commercial or anonymous gamete donation, and the statistical knowledge of the enhanced risks of autism, mental retardation and cancer for the offspring of IVF, including IVF for surrogacy, and the risks of accidental incest or custody disputes. This additional knowledge gives New York no reason to relax its vigilance. Precaution requires us to continue the ban on commercial surrogacy of all kinds, and the refusal to enforce contracts for surrogacy.

Subpart 4B4 – Surrogacy and Adoption

Society has an interest in encouraging the creation of families by means that either avoid unnecessary problems or mitigate pre-existing problems. It is rational for New York to discourage surrogate child-bearing, and instead to encourage the creation of families by other means, including adoption. It is fair for society to ask whether the desire of adults to create “their own” children through surrogate parenting is more worthy of state facilitation than satisfaction of the need of numerous children to find stable homes through adoption.¹⁰⁵

Adoption is a process that responds to the needs of children already born who, for whatever reason, now need parental support from someone other than two genetic parents one of whom bore the child. By contrast, surrogate child-bearing by its very nature divides parental functions

¹⁰⁵ During the twelve months ended September 30, 2013, there were 2,184 New York foster children adopted. US Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Children's Bureau (CB), *Adoption of Children with Public Child Welfare Agency Involvement by State FY 2004-FY2013*. On September 30, 2013, there were 5,843 New York foster children awaiting adoption. US HHS, ACF, CB, *Children in Public Foster Care on September 30th of Each Year Who Are Waiting to be Adopted FY 2004-FY2013*. Both viewed on April 14, 2015 at <https://www.acf.hhs.gov/programs/cb>. There were additional New York children who were never in foster care, either adopted or waiting adoption, but their numbers are unknown to the minority.

among three, four or more adults, usually does so before the child is conceived and always before the child is born, and then separates the child from at least one of those adults.¹⁰⁶

Adoptees sometimes suffer from the knowledge that their biological parents surrendered them, confusion about who is or is not a member of their family, or from unfulfilled curiosity about the identity, character, personality or genetic history of those parents.¹⁰⁷ They are more likely than children raised by their biological parents to have problems with the law, mental health problems, or struggles with substance abuse.¹⁰⁸ But these problems occur almost or even more frequently among anonymous sperm “donor” offspring.¹⁰⁹ and we fear they will be at least as frequent among children of surrogacy once they become old enough to exhibit such behaviors and independent enough to report frankly.

Yet adoption is importantly different from third party reproduction like gamete “donation” or surrogate child-bearing. Adoption finds parents for children who need families. But surrogacy creates children for adults who want, but do not need, them. The similarities between the struggles of adoptees and those of offspring of third-party reproduction should prompt caution about using surrogacy to deliberately and unnecessarily take from children before they are born the chance to grow up with their biological parents.

Children of surrogacy are in some ways worse off than children of adoption. Both adoptees and the offspring of third-party reproduction, including by surrogate child-bearing, can take comfort from knowing that they were wanted by the parents who raised them. But both risk the pain of thinking that at least one of the parents who made and bore them apparently did not want them. The children of adoption can dream that their biological parents might have struggled with the decision to give up their child. But the children of third-party reproduction, particularly commercial third-party reproduction, struggle with the knowledge that their biological and/or gestational parents sold what was needed to make the child, and often have no further contact with that child.¹¹⁰

The hurdles of adoption law are meant to protect children. Adoption can be expensive, time-consuming and frustrating for those seeking to adopt a child.¹¹¹ But child welfare should outweigh adult frustration.

¹⁰⁶ “Of course there will always be children who are raised under sub-optimal circumstances. We can’t control for every tragedy and every irresponsible parental choice. Nevertheless, we can insist that our laws and customs with respect to family formation should be ordered primarily towards the good of children and not the desires of adults.” Rachel Lu, *The Perils of Surrogacy*, *The Human Life Review*, Summer 2014, p. 45.

¹⁰⁷ 2010 Marquardt Study, first cited at n. 42 above, at pp. 7-14.

¹⁰⁸ 2010 Marquardt Study, first cited at n. 42 above, at pp. 7-9 and 115.

¹⁰⁹ 2010 Marquardt Study, first cited at n. 42 above, at pp. 14, 71-72 and 115.

¹¹⁰ 2010 Marquardt Study, first cited at n. 42 above, at pp. 71-72.

¹¹¹ At least one of the demographic groups of intended parents for whom surrogacy advocates claim adoption is too expensive, namely, male-male married couples, in fact is better positioned than most couples to bear the costs of adoption. A recent Internal Revenue Service analysis of the adjusted gross income (AGI) of married couples filing joint tax returns in 2014 shows: opposite-sex couples reported AGI averaging \$113,115; female-female couples reported AGI averaging \$123,995; and male-male couples reported AGI averaging \$175,590. Male-male-joint returns that included deductions for at least one dependent child reported AGI averaging \$274,855. See, IRS Office of Tax Analysis, Working Paper 108, August 2016.

Subpart 4B5 – Prohibition and Regulation

Since all fair-minded observers must admit, and all current Task Force members acknowledge, that commercial surrogate child-bearing arrangements pose some risks to the adults who enter them and to the children who result from them, one must address the claim that the proposed regulation and enforcement of some surrogacy contracts will cause less harm than the current policy of banning all commercial surrogacy and refusing to enforce surrogacy contracts. There are at least four reasons to believe that the current policy is less harmful.

First, although some surrogates still bear children for New Yorkers, the current New York policy is working to discourage much surrogacy. The 1988 Task Force report, acknowledged that a policy of discouragement would not eliminate all surrogacy in New York, but predicted that such a policy would “significantly” or “greatly” reduce it.¹¹² Of course, the effectiveness of that policy should not be judged by whether surrogacy has decreased since the enactment of the policy in 1992, but instead by whether surrogacy now occurs less frequently than it would have without the policy. This cannot be experimentally measured. To the extent there are any statistics, surrogacy under present New York policy remains rare.¹¹³ Proponents of surrogacy complain that the current policy makes surrogacy so difficult in New York that those contemplating it either leave the state or abandon their efforts to find a surrogate child-bearer.¹¹⁴ We conclude that New York's policy of discouragement is working, and that a change in policy risks an undesirable increase in the incidence of surrogacy.

Second, some of the harms of surrogacy are inherent in the arrangement and cannot be regulated away. No matter how carefully surrogacy is arranged, and even if there is no post-natal custody dispute, surrogacy always deliberately divides the functions of parenthood among more than two adults. It thus risks confusing children's identity and sense of place in their own families, and undermining society's notion of the family. No matter how carefully done, commercial surrogacy is tantamount to baby-selling and so undermines the intrinsic value of children both in their own eyes and in the eyes of society.

We think commercial surrogacy is tantamount to the purchase and sale of babies. When a surrogacy contract provides that a lower fee is paid to the surrogate when the child is stillborn than when he or she is born alive, or when it provides that some fees otherwise due are withheld until the surrogate surrenders the child to the intended parents, it is hard for an objective observer

¹¹² NY TFL, Surrogate Parenting, 1988, at pp. v, 129 and 139.

¹¹³ The American Society for Reproductive Medicine has reported to Task Force staff that the number of “gestational babies” born live to non-genetic surrogates in the US during each of eleven years from 2004 to 2014 ranges from 738 to 2,236. If those national numbers are even close to accurate, then the number of such babies intended to be raised by parents in New York is probably much lower, and the number of such babies born in New York is certainly much lower than the national figures. According to the US Census Bureau, New York has about 19.8 million (6.2%) of the country's 309 million people. <http://quickfacts.census.gov/qfd/states/36000.html>. If we apply that 6.2% to the 2,236 “gestational” babies born nationwide in 2014, we get about 139 such babies born in 2014 to be raised in New York. Because commercial surrogacy is banned in New York, its share might be lower than 6.2%. But even if New York's share of such babies is as high as 10%, we get only about 224 such babies, a low number.

¹¹⁴ All invited witnesses who testified at a New York State Legislative Public Forum on the Child-Parent Security Act, held on April 1, 2014, opposed New York's present policy, but they at least implicitly, and often explicitly, acknowledged that it is working to discourage some New Yorkers from entering surrogacy arrangements.

to say that all of the payments are for the surrogate's services during pregnancy and that no money is paid for the surrender of a live child.¹¹⁵ Perhaps more importantly, it gives the children of surrogacy grounds to think they were bought and sold.¹¹⁶

Third, regulation is unlikely even to try to reduce some of the contingent harms of surrogacy. Three such harms come to mind: (1) creation of more embryonic human beings than will be brought to birth or natural miscarriage; (2) commercial gamete procurement; and (3) anonymous gamete “donation.” Present IVF practice, including IVF for surrogate child-bearing, entails creation of more embryonic human beings than are likely to be implanted in the surrogate and brought to birth, thus intentionally creating human beings who are likely to be stored indefinitely, subjected to harmful research, destroyed without implantation, or killed by post-implantation abortion, so-called “fetal reduction.” Commercial gamete “donation” inflicts on some offspring a sense of confusion, shame or anger arising from the exchange of money used to conceive or gestate them. Anonymous gamete “donation,” including for surrogacy, often leaves the identity of the gamete “donor” unknown to the child so conceived and even to the intended parents of that child, thus risking the harms of procreation with anonymous gametes. Because New York State now tolerates these consequences of IVF and commercial or anonymous gamete “donation,” and because the majority does not sufficiently appreciate the risks to children so conceived, no foreseeable regulation of surrogacy will eliminate, or even substantially reduce, these risks that we find unacceptable.

Fourth, although it might reduce some of the contingent harms of surrogacy, even well-intentioned regulation is likely to be ineffective, arbitrary and/or intrusive. There is an inherent tension between protecting the best interests of children and providing government assistance to help adults become parents regardless of their circumstances. To the extent a regulation better protects children, it will impinge on adults' privacy and state-enforced access to parenthood. To the extent it respects adult autonomy, it will often risk harm to children. And however it might balance those competing concerns, it will – at least at the margins – be arbitrary. We believe this is likely for any foreseeable regulation. We will illustrate it in our discussion at Part 6 of the regulation proposed by the majority.

New York should not – by endorsing surrogacy – encourage even a marginal increase in IVF and its attendant risks for embryonic human beings. We acknowledge, with dismay, that New York has accepted IVF and its predictable consequences for embryos, and we acknowledge that surrogacy contributes only a minor portion of the women who will carry an IVF embryo. Nonetheless, we believe that New York should go no further down that road by encouraging any form of surrogacy through state enforcement of surrogacy contracts.

New York should continue to discourage surrogate child-bearing which often uses anonymous or commercially obtained gametes. This would protect children pursuant to a precautionary principle.

¹¹⁵ Robert Blank and Janna C. Merrick, Human Reproduction, Emerging Technologies, and Conflicting Rights, Congressional Quarterly, Inc., 1995, at p. 110.

¹¹⁶ Brian C., Son of a Surrogate blog, first cited at n. 88 above.

Chapter 5 – WHY REVISIT SURROGACY?

The majority cites three post-1988 developments in support of revisiting surrogacy: (1) a shift away from genetic “traditional” surrogacy and the growing practice of non-genetic “gestational” surrogacy; (2) changing perceptions of parenthood and family which do not conform to “the rigid heterosexual nuclear family model;” and (3) a revolution in marriage equality marked by the 2011 enactment of New York State's Marriage Equality Act and the 2015 United States Supreme Court decision in *Obergefell v. Hodges*. The majority claims “Equity must be a driving principle if all families are to enjoy the opportunity to welcome children into their family.”

The first two “developments” actually pre-date the Task Force's 1988 report, and in any event are not enough to warrant a change in the 1988 conclusions. The third is new, but also insufficient to justify a new result.

Non-genetic “gestational” surrogacy existed before the Task Force issued its 1988 report. That report explicitly addressed it, urging New York to discourage both genetic and non-genetic surrogacy, mentioning non-genetic or “gestational” surrogacy at least half a dozen times.¹¹⁷ Even a post-1988 increase in the frequency or proportion of non-genetic surrogacy does not change the applicability of the 1988 report's unanimous, well-supported, and still valid conclusions on the subject. Indeed, non-genetic surrogacy was widely practiced for decades outside New York while this Task Force did not return to the subject.

Most of the 1988 arguments concerning “traditional” genetic surrogacy remain relevant to “gestational” non-genetic surrogacy. The only 1988 arguments against genetic surrogacy that non-genetic surrogacy avoids are those based on the genetic relationship of the “traditional” surrogate with the child. To the extent that a genetic relationship is the sole cause of the child-bearer's distress upon surrender of the child, such distress would be absent from non-genetic surrogacy. However, the Task Force has received evidence that child-bearers and children bond through the experience of gestation even without a genetic connection and such bonds are disrupted by the surrender of the child after birth.¹¹⁸ Moreover, any risks in genetic surrogacy to the well-being of the child-bearer's husband and her pre-existing children arising from bearing and surrendering a child for and to another, also exist in non-genetic surrogacy with little or no diminishment. Most importantly, the harms inherent in all paid surrogacy – deliberate pre-conception division of the functions of parenthood among more than two adults, and commercialization tantamount to baby-selling – pose risks for society, families, women and the children born of surrogacy, whether genetic or non-genetic. What is more, non-genetic surrogacy has problems of its own.

Non-genetic surrogacy aggravates or creates harms in ways that genetic surrogacy does not and so should be discouraged for those additional reasons. Genetic surrogacy usually divides the functions of parenthood among up to three to four adults, namely: (1) a child-bearer who is also the genetic mother; (2) an intended mother who has no genetic or gestational link to the child;

¹¹⁷ NYS TFL, Surrogate Parenting, 1988, pp. v, 23-24, 31, 47, 103, 125 and 139

¹¹⁸ In her 2014 film, *Breeders: A Subclass of Women?*, Jennifer Lahl presented the remarks of psychotherapist Nancy Verrier who spoke about the emotional bond of child-bearers and children that forms even without a genetic connection. See also 2013 UK Study at Age 10, first cited at n. 30 above.

and (3) either: (a) one man who is both the genetic and intended father, or (b) two men, one to “donate” sperm and the other to raise the child.

Non-genetic surrogacy typically divides those functions among three to five adults, namely: (1) a child-bearer who is neither the genetic nor intended mother; (2) either: (a) one woman who is both the genetic and intended mother, or (b) two women, one to “donate” an egg and the other to raise the child; and (3) either: (a) one man who is both the genetic and intended father, or (b) two men, one to “donate” sperm and the other to raise the child. If female mitochondrial DNA transfer becomes both legal and feasible, non-genetic surrogacy could divide parental functions among up to six adults.

The pre-conception parental fracture inherent in all surrogacy with attendant risks for society, families, women and children can be aggravated in non-genetic surrogacy by dividing parenthood among even more adults. And a recent study acknowledges that the absence of a gestational connection between the children of non-genetic surrogacy and the mothers who raise them may be more problematic for children than the absence of a genetic link.¹¹⁹

Families that do not conform to the “heterosexual nuclear family model” (“rigid” or otherwise) are not new. Non-conforming families, that is, those other than two opposite-sex adults raising one or more children that they conceived together and bore, also pre-date the 1988 report. The sexual revolution, the rise in divorce, and the rise in never-married single-parent families all began before the Task Force was created and continued for decades after 1988 without the Task Force returning to surrogacy.

The third and final ground cited for revisiting the 1988 conclusions regarding surrogacy is, in fact, a new development since 1988, namely: the 2011 legalization of same-sex marriage statewide by New York State and nationwide in 2015 by the US Supreme Court. This legal development has been followed by claims that “marriage equity” requires the state government to assist married couples to get children by enforcing contracts for commercial non-genetic “gestational” surrogate child-bearing, or even that some broader notion of equity requires the state to enforce such contracts for adults other than married couples.

Of course, equity on this issue could be achieved by banning commercial surrogacy and refusing to enforce contracts for any adults, couples or singles, no matter their sexual attractions or behavior, married or not. Equity achieved this way would not sacrifice children on an altar of false equity.

The reasons to discourage surrogate child-bearing for opposite-sex couples have no less validity for same-sex couples or for single persons who want to be parents.

In New York, same-sex couples share many of the rights and privileges of opposite-sex couples. No matter what family arrangements we prefer for ourselves or others, all compassionate people acknowledge the joy of loving adults united with a wanted child and wish only good things for all such families. After all, they are our relatives, friends, and neighbors. Those good wishes apply whether the parents are single or a couple, whether married or not, and whether same-sex

¹¹⁹ 2013 UK Study at Age 10, first cited at n. 32 above.

or opposite-sex. Such good wishes apply whether the family was created by natural conception, adoption, ART or even surrogate child-bearing. We acknowledge too the disappointment, even the heartbreak, of adults who want to love a child but cannot create a family.

However, because we see heightened risks for the children conceived for surrogacy, we believe society should discourage that method of family creation.

Same-sex couples have no more moral or legal right to a child than opposite-sex couples have. No matter what other rights positive human law may give same-sex couples, it is a natural fact of life that they – like infertile or sterile opposite-sex couples – cannot by themselves create a child. They – like opposite sex couples – have a right to try to create a family by means society deems licit, including by adoption or – to the dismay of some of us - by IVF. Of course, adoption does not guarantee to a couple a child genetically related to either of them. And simple IVF does not work for same-sex male couples because they lack both eggs and wombs.

Lesbians, gays, bisexuals and transgender (LGBT) persons speak with many voices; some have expressed misgivings about families created by surrogate child-bearing. For example, two gay men, Italian fashion designers Domenico Dolce and Stefano Gabbana are reported to have criticized IVF and surrogacy, saying “No chemical offsprings [*sic*] and rented uterus: life has a natural flow, there are things that should not be changed,” and “I am gay, I cannot have a child. I guess you cannot have everything in life. Life has a natural course, some things cannot be changed. One is the family.”¹²⁰ An American professor, Robert Oscar Lopez, who describes himself as a queer bisexual son of a lesbian, and now a father to a child whom he is raising with his wife, agrees that surrogate child-bearing for same-sex couples is harmful to children.¹²¹

A leading New York LGBT advocacy group, Empire State Pride Agenda (ESPA), recently disbanded, announcing that its policy priorities had been accomplished. Of course, some LGBT persons believe that surrogate child-bearing ought to be made easier for them. But the leadership of ESPA apparently believed that state enforcement of surrogate child-bearing contracts is not important enough to continue its advocacy on the issue.¹²²

One can sympathize with the frustration of same-sex male couples who want a child genetically related to one of them, but cannot create one by themselves. But their wants, like those of infertile opposite-sex couples, do not justify government enforcement of surrogacy contracts. If,

¹²⁰ Terry Marocco, *Figli e famiglia, la verita di Dolce e Gabbana*, *Panorama Magazine*, March 16, 2015 viewed on April 7, 2015 at <http://www.panorama.it/news/cronaca/dolce-gabbana-lunica-famiglia-quella-tradizionale/>. See two English translations of the original Italian remarks by Victoria Ward, *Sir Elton John boycotts Dolce & Gabbana after row over same-sex families*, *The Telegraph*, March 15, 2015, and by Leigh Weingus, *Dolce & Gabbana Face Outrage After Controversial Comments About Gay Families*, *Huffington Post*, March 15, 2015, updated March 16, 2015, both viewed on April 7, 2015 at <http://www.telegraph.co.uk/news/celebritynews/11473198/Sir-Elton-John-calls-for-Dolce-and-Gabbana-boycott-after-row-over-same-sex-families.html> and http://www.huffingtonpost.com/2015/03/15/dolce-and-gabbana-gay-families_n_6872710.html, respectively.

¹²¹ Robert Oscar Lopez, *Truth, Metaphor, and Race in the Marriage Debate*, *The Public Discourse*, February 11, 2013, viewed on April 7, 2015 at <http://www.thepublicdiscourse.com/2013/02/7871>; and *Synthetic Children, First Things*, March 18, 2015, viewed on March 22, 2015 at <http://www.firstthings.com/web-exclusives/2015/03/synthetic-children>.

¹²² Jesse McKinley, *Empire State Pride Agenda to Disband, Citing Fulfillment of Its Mission*, *New York Times*, December 12, 2015.

as we have argued throughout this minority report, in order to protect children it is good public policy to discourage surrogate child-bearing for opposite-sex couples, then it is no less good to discourage it for same-sex couples.

Chapter 6 – COMMENTS ON THE MAJORITY'S PROPOSED REGULATION

An attempt to regulate surrogacy as the majority recommends is likely to result in surrogacy on terms that even the majority does not favor. The majority proposes to treat six kinds of surrogacy in three different ways. It would enlist state power of enforcement and pre-birth judicial validation of parental rights for only one kind of surrogacy, and then only if it meets (or substantially meets) over thirty terms that the majority favors. Those terms appear primarily designed to protect the adult participants, and only secondarily and incompletely to protect children. The majority conditions its recommendation that New York permit and regulate some forms of commercial surrogacy upon compliance with all (or substantially all) thirty terms. The majority does not explain which terms are essential and which inessential to its recommendation. We believe it is unrealistic to expect the state legislature and bureaucracy to implement all of the majority's terms.

The majority proposes a complex regulatory scheme that would treat six kinds of surrogacy in three different ways. It proposes that the Domestic Relations Law should continue to ban contracts for compensated “traditional” or genetic surrogacy, and contracts for compensated “gestational” or non-genetic surrogacy that do not comply with the majority's proposed terms. It proposes that state law continue to permit, but refuse to enforce, contracts for uncompensated surrogacy, both genetic and non-genetic. It proposes to permit and, for the first time, to enforce certain contracts for compensated, non-genetic surrogacy that comply with the thirty terms, and to let a judge determine parental rights before implantation. It proposes that existing state law should continue to permit state courts to approve post-natal adoptions by the intended parents of the children of surrogacy. This chart illustrates the overall scheme.

	<u>Uncompensated</u>	<u>Compensated</u>
<u>“Traditional” Genetic Surrogacy</u>	Permitted Unenforced Post-Birth Adoption	Banned and Fined Unenforced Post-Birth Adoption
<u>“Gestational” Non-Genetic Non-Compliant Surrogacy</u>	Permitted Unenforced Post-Birth Adoption	Banned and Fined Unenforced Post-Birth Adoption
<u>“Gestational” Non-Genetic Compliant Surrogacy</u>	Permitted Unenforced? * Post-Birth Adoption	Permitted Enforced Pre-Implantation Order or Post-Birth Adoption

* We do not know whether or not the majority would enforce contracts for uncompensated, but otherwise compliant, non-genetic surrogacy. We guess that, because majority might deem the amount of compensation (namely: zero) to be unreasonable, it might not enforce them.

The proposed regulation would favor compensated, “gestational,” non-genetic, surrogacy so long as it complies with all (or substantially all) thirty-some terms. It is only in that sort of surrogacy that New York would determine parental rights before birth and enforce the child-bearer's promise to surrender the child.

The majority proposes that the parties to a compliant compensated contract for non-genetic surrogacy could seek a pre-implantation order from a New York state court that would establish the intended parents' rights to the child of the proposed surrogacy. Those pre-implantation rights would be subject to rescission during the pregnancy or after the birth only upon clear and convincing proof of exceptional circumstances. The exceptions are not defined.

The majority proposes over thirty terms for a compensated contract for non-genetic surrogacy, compliance with which would make it eligible for state enforcement. The terms would govern the eligibility of the parties, the provisions of the contract, and the qualifications of any broker.

The majority wants intended parents to meet four (sometimes five) conditions, namely:

- (1) they must be legal residents of New York State for at least six months before the order is sought;
- (2) they must be at least 21 years old;
- (3) they must undergo a mental health screening to determine if they are prepared to be parents, if they are entering the contract for valid motives, and what they would expect for the child if one or both of them were to die or if they were to separate;
- (4) they, and anyone over age 18 residing in the home where the child will be raised, must undergo a background check to determine if there is a history of crimes that would disqualify any of them to reside with the child; and
- (5) if the intended parents are providing any of the gametes, they should undergo blood and STD testing as a physician deems appropriate.

The majority does not say what motives or crimes might be disqualifying.

The majority wants the surrogate child-bearer to meet six conditions, namely:

- (1) she must be a legal resident of New York State for at least six months before the order is sought;
- (2) she must be at least 21 years old;
- (3) she must have given birth previously to at least one child;
- (4) she must undergo a medical screening by a physician to determine if she is physically capable of sustaining an uncomplicated, successful pregnancy;
- (5) she must undergo a mental health screening to determine if she is psychologically prepared for surrogacy, pregnancy and surrender of the child upon birth; and
- (6) she must undergo a credit and background check to determine if she is under financial duress or if she has engaged in criminal or other activity that would make her a poor candidate for surrogacy.

The majority wants contracts to meet nineteen conditions, namely:

- (1) the compensation to be paid to the surrogate must be reasonable in the judgment of the court;

- (2) the contract must provide, if the surrogate has not already provided, for health insurance covering her medical expenses for the duration of the pregnancy plus some weeks;
- (3) it must provide, at no expense to her, for life insurance and disability insurance to pay her family in the event of her death or disability during the surrogacy;
- (4) it must require the intended parents to carry life insurance, without specific minimum coverage, to care for the child and pay legal and other expenses to determine custody and guardianship of the child;
- (5) it must provide for separate and independent legal counsel licensed in New York, paid by the intended parents, to represent those parents and the surrogate during both the contract negotiations and any subsequent dispute;
- (6) it must provide that any physician screening or treating the surrogate or delivering the child must be licensed in New York, knowledgeable about surrogacy, and not have cared for the intended parents;
- (7) it must provide that the obstetrics provider(s) be chosen, not by the surrogate alone, but by the surrogate and the intended parents;
- (8) it must choose New York law to resolve any dispute;
- (9) it should provide that the intended parents agree to accept custody of any children born from the surrogacy, regardless of sex, number, prematurity, physical or psychological health;
- (10) it must permit either the intended parents or the surrogate to terminate the contract if the surrogate is not pregnant;
- (11) it must set forth how all the parties (not just the surrogate) agree they (not she alone) would address the “reduction” of the number of embryos or fetuses, the termination of the pregnancy, or medical decisions regarding the pregnancy;
- (12) it cannot require the surrogate to travel to another state or country for any purpose, including childbirth;
- (13) it cannot require specific performance;
- (14) it should provide for an escrow agent to hold and disburse funds to be paid to the surrogate;
- (15) it cannot permit the intended parents to recover money damages for breach of contract in excess of the amount already paid to the surrogate;
- (16) it should provide that the death of one or both intended parents does not void the contract after the surrogate becomes pregnant;
- (17) it must require the intended parents to name a guardian for the child in the event that they both die after the surrogate becomes pregnant;
- (18) it should not permit any divorce of the intended parents to void the contract; and
- (19) it must make funds available for counseling or mediation in the event of any dispute among the parties.

The majority wants brokers to meet six conditions, namely:

- (1) the broker must be registered in New York;
- (2) the broker must be licensed in New York (there is no existing process for New York licensure of such brokers; it would have to be created) and must pay a registration fee;
- (3) the broker must carry liability insurance of at least \$1 million;

- (4) any loans made by the broker to intended parents must comply with reasonable terms, including interest rates and reserve requirements, to be set by New York;
- (5) the broker must be subject to minimum disclosure and restrictions against false or misleading advertising; and
- (6) the broker must report to the state the number of surrogacy contracts arranged, the number of births that result, and adverse events, both legal and medical. It is not explained how the broker is to learn the number of births or adverse events.

Most of the conditions that the majority proposes to require for judicial approval of a surrogacy contract are designed to protect the intended parents and the surrogate, but not the child of surrogacy. All six requirements for brokers, nine to thirteen of sixteen for the contract terms, three of six for the surrogate, and one of six for the intended parents offer no protection for the child. We acknowledge that the majority proposes some protections for the child. The minimum age for intended parents and surrogate, the mental health screenings for those adults, contingent blood tests for the intended parents, and the requirement that the surrogate previously deliver a child, are designed to make it more likely that the surrogate will surrender the child of surrogacy to the intended parents and so avoid a custody dispute that might harm the child. The minimum age, required mental health screening and criminal background check for the intended parents are designed to provide some minimum standards for the maturity and capacity of the intended parents to provide a safe home for the child. The requirement that the intended parents carry life insurance and name a guardian for the child in the event of their deaths is meant to provide some security to the child. But most of the proposed requirements are oriented toward the adults, not the child.

Insofar as the proposed requirements are oriented toward the needs of the child, they try to protect against rare risks, but not the risks that are inherent in all surrogacy or in surrogacy as it is commonly practiced. The proposed regulation provides substantial protection against the possibilities that the adults will engage in a protracted child custody dispute, that the home of the intended parents will include an adult with a criminal record that jeopardizes the child's safety, or that a stranger will become the guardian of the child upon the intended parents' death. These are rare risks.¹²³ In our view, the proposal is insufficiently concerned about the risks to the children of surrogacy that arise even when there is no custody dispute, even when the intended parents offer a safe home to the child, and even when they live until the child's maturity.

The majority fails to propose regulatory terms that would better protect children.

The proposal omits to minimize the risk that intended parents will die before their children reach maturity. It omits: (1) to specify a maximum age for intended parents, or (2) to require intended parents to undergo a medical screening to determine if they have a life-threatening illness that

¹²³ "The Center for Surrogate Parenting reported in 1993 that there had been approximately 4,000 surrogate births since the late 1970s and that only 11 of them had given rise to custody litigation." Robert Blank and Janna C. Merrick, *Human Reproduction, Emerging Technologies, and Conflicting Rights*, 1995, *Congressional Quarterly, Inc.*, at p. 110. We calculate the rate of such disputes to be under 0.3%. See also, November 20, 2014 remarks of Andrew Vorzimer, first cited at n. 66 above, indicating that the rate of dispute may have declined to under 0.2%.

might kill them before the child matures beyond infancy. Children of natural conception¹²⁴ and adoption¹²⁵ are better protected against such risk.

To explain its first omission, the majority claims that “ART and IVF do not suggest age limits for their services.” But we are not surprised that the multi-billion dollar ART and IVF industries omit any upper age limits for their customers. The majority offers no explanation for its second omission. We doubt that the majority bases its conclusion that intended parents by surrogacy need not be subject to medical screening on the fact that parents by unaided sexual intercourse are not subject to such medical screening. We doubt it because, although parents by unaided intercourse are not subject to either mental health screenings or criminal background checks, nonetheless the majority would require such screenings and checks for intended parents by surrogacy. If mental screenings and criminal checks are appropriate, then why not medical screenings too?

Concern for children should prompt an upper age limit and/or medical screening for the life expectancy of intended parents who seek state approval of their chosen desire to employ a surrogate child-bearer. Reluctance to do so illustrates the pitfalls of embarking on state enforcement of some contractual arrangements for family creation by complex and artificial means.

The proposal omits to require investigation of the physical environment in which the child will live. It fails to require any visit to the intended parents' home to assess any risks or to make suggestions for improved safety. Adopted children are better protected.¹²⁶

The proposal would not require that gamete donor/vendors be known or disclosed to intended parents, much less to children.

The proposal would permit any adult resident of New York to seek state enforcement of a surrogacy contract for any reason. Most of the adults now seeking surrogate child-bearing are same-sex couples or infertile opposite sex couples. But there are some single adults and fertile couples who seek it, some for what any objective observer must call non-medical or even frivolous reasons.¹²⁷ which bode ill for their understanding of and commitment to good parenting. The majority's regulation does not exclude such persons.

¹²⁴ “[B]iology does some real work in 'suggesting' promising family structures. ... [A]t least it favors the young and healthy, thus increasing the likelihood that parents will have life and energy enough to see their offspring to adulthood.” Rachel Lu, *The Perils of Surrogacy*, *The Human Life Review*, Summer, 2014, at p.41.

¹²⁵ New York State has health requirements for prospective adoptive parents. They “shall be in such physical condition that it is reasonable to expect him/her to live to the child's maturity and to have the energy and other abilities needed to fulfill the parental responsibilities.” A recent report of a physical examination, including a tuberculosis screening, must be filed. See, Office of Children and Family Services regulations concerning adoption study criteria, at 18 NYCRR, §421.16(c)(1) and (2).

¹²⁶ New York State requires at least one visit to the prospective adoptive parents' home. See, Office of Children and Family Services regulations concerning adoption study process, at 18 NYCRR, §421.15(a). The home visit allows the investigator to observe and make suggestions about smoke detectors, fire extinguishers, unsecured pharmaceuticals, or unsecured firearms. Marie Dolfi, LCSW, Adoption: Where Do I Start, Adoptive Families of the Capital Region workshop at Colonie Town Library, attended by the author on April 7, 2015.

¹²⁷ Women seeking surrogacy for so-called social, rather than medical, reasons have included a photographer who did not want to disrupt her business, a physician who could not “afford” to be pregnant, a socialite who did not want

Some parenthood that begins for superficial reasons or no reason turns out well. But it must be feared that women who think they do not have time for pregnancy are less likely to devote the time and attention needed for post-natal parenthood.

Most single parents work very hard at parenthood and many successfully raise well adjusted children. However, children of single-parent families face some difficulties and risk some undesirable outcomes at rates higher than those in two-parent families do. Single-parent families are generally poorer than two-parent families.¹²⁸ Even when one controls for income level, the children in single-parent families, compared with those in two-parent families, have higher rates of delinquent or criminal behavior.¹²⁹ Children living with one parent have lower educational achievement,¹³⁰ and poorer physical and mental health,¹³¹ than children living with two parents.

to get fat, and an amateur runner who had an upcoming marathon. Sarah Elizabeth Richards, *Birth Rights: Inside the Social Surrogacy Debate*, Elle Magazine, April 17, 2014. However a reader might appraise the seriousness or frivolity of the reasons offered in these four examples, each reader can foresee surrogacy motivated by a frivolous or even abhorrent reason.

¹²⁸ The U.S. Census Bureau figures for 2016 show that children under 18 living with one parent only are, compared with children under 18 living with both parents, more than three times as likely to be in families that live in poverty (37.6% to 11.7%), receive food stamps (41.5% to 11.8%), and receive public assistance (7.3% to 1.4%). By these three measures, children living with fathers only (21.7% - 22.3% - 2.3%) are less often poor than those living with mothers only (40.4% - 44.9% - 8.1%), but even those living with fathers only are more often poor than those living with both parents, whether married or not (11.7% - 11.8% - 1.4%). U.S. Census Bureau, *Table C8 Poverty Status, Food Stamp Receipt, and Public Assistance for Children Under 18 Years by Selected Characteristics: 2016, Current Population Survey, 2016 Annual Survey and Economic Supplement*, viewed July 30, 2017.

¹²⁹ Areas with higher percentages of single-parent households also have higher rates of violent crime; the relationship is so strong that controlling for family configuration erases the relationship between race and crime and between low income and crime. Daniel Patrick Moynihan, *Defining Deviancy Down*, The American Scholar, Vol. 62, No. 1 (Winter, 1993), pp. 17-30, at p. 24, citing Smith and Jarjoura. Boys in stepfamilies or single-mother families at age 10 were more than twice as likely to be arrested by age 14 as children with two biological parents in residence; the association is clear even after controlling for other variables, including socioeconomic status. Chris Coughlin and Samuel Vuchinich, *Family Experience in Preadolescence and the development of Male Delinquency*, Journal of Marriage and Family, Vol. 58, No. 2 (May, 1996), pp. 491-501, at p. 498. Adolescents are at higher risk for delinquency if: (a) they live in a single-parent family, or (b) if they attend school where a higher proportion of adolescents live with only one parent, or (c) both. Amy L. Anderson, *Individual and contextual influences on delinquency: the role of the single-parent family*, Journal of Criminal Justice 30 (2002), pp.575-587.

¹³⁰ Among U.S. states, there is a high correlation between the percentage of eighth graders living in two-parent families and the average mathematics proficiency. Moynihan, *op. cit.*, at p. 23. U.S. children under age 18 living with single mothers or with mothers and step fathers were more likely than those living with both biological parents to have repeated a grade of school, or to have been expelled. Deborah A. Dawson, *Family Structure and Children's Health and Well-Being: Data from the 1988 National Health Interview Survey on Child Health*, Journal of Marriage and Family, Vol. 53, No. 3 (Aug., 1991), pp. 573-584, esp. Table 4, at p. 578. Children who live in single-parent families tend to perform more poorly on standardized tests, and are less likely to complete high school or to attend college. Suet-Ling Pong, *Family Structure, School Context, and Eighth-Grade Math and Reading Achievement*, Journal of Marriage and Family, Vol. 59, No. 3 (Aug., 1997), pp. 734-746.

¹³¹ Children who live with their own two married parents have better physical health on average than do children in other family forms, including single-parent families. W. Bradford Wilcox, et al., *Why Marriage Matters: Twenty-Six Conclusions from the Social Sciences*, Second Edition, Institute for American Values, 2005, at p.23, citing Ronald Angel and Jacqueline Woroby, 1988, *Single Motherhood and Children's Health*, Journal of Health and Social Behavior 29:38-52, and Jane Mauldon, 1990, *The Effects of Marital Disruption on Children's Health*, Demography 27: 431-446. On average, having an unmarried mother is associated with an approximately 50% increase in the risk of infant mortality; even after controlling for age, race and education, children born to unwed mothers generally have higher rates of infant mortality. Wilcox, et. al., *op. cit.*, at p. 24. Teens in single-mother families have higher

Although the mechanisms of cause and effect are complex and debatable, the associations are clear. Society and government pay a fiscal, as well as a social, cost for the poverty, delinquency, crime, illness and injury associated disproportionately with single-parent families.

We acknowledge that some two-parent families face the same difficulties and outcomes described above, and we are thankful that not all single-parent families face them. New York State should and does provide prudent assistance (for example, with nutrition and medical care) to both two-parent and single-parent poor families created without state collaboration; it has no compassionate alternative. But, because of the higher risk of these difficulties and poor outcomes in families headed by single persons. New York should not encourage single persons to become parents in the first place by enforcing their contracts to hire a surrogate child-bearer.

The proposal relies on a mental health screening to assess, or perhaps to allow the reviewing court to assess, whether intended parents are entering the arrangement for valid reasons. But it does not define what would be valid or invalid reasons, and it believes that the judge should have no discretion to disapprove a contract that meets all the majority's requirements. There is little point to such mental health screening if the proposed regulation does not provide guidance for the reviewing court, and in fact denies to the court any discretion of its own to act on warning signs revealed by the screening. In these respects, the proposed regulation abdicates responsibility to assess the motives and qualifications of intended parents who seek the state's approval of their contract for surrogate child-bearing and surrender of a child to them, and thus inadequately protects children.

The majority conditions its recommendation that New York permit and regulate some forms of commercial surrogacy upon compliance with all its proposed conditions, including the politically doubtful condition that New York create, staff and fund a new regulatory program to license surrogacy brokers. We might wish that, if the State refuses to commit resources to the regulation of brokers, it would respect the majority's preference for an all-or-nothing approach, and so refuse to permit and enforce any contracts for surrogate child-bearing. But it is more realistic to fear that New York, like California, would permit new forms of surrogacy without regulating brokers or without some other protections that the majority deems essential to its overall recommendation. Once state government begins to consider a legislative and regulatory scheme as complex as that proposed by the majority, we are likely to get surrogacy with many, even most, of its risks, including unregulated brokers, but without all the protections the majority wants.

Although it might reduce some of the contingent harms of surrogacy, even well-intentioned regulation is likely to be ineffective, arbitrary or intrusive. See Part 4B.

rates of abuse of alcohol, marijuana, or tobacco than teens living with their married parents. Wilcox, et. al., op. cit., at p. 24. Compared to children living with both biological parents, U.S. children living with a divorced mother experienced an increased risk of accidental injury, and those living with a single mother were at increased risk of asthma. Dawson, *ibid.*, Table 3 at p. 577. Even after adjustments for socioeconomic status and parents' addiction or mental disease, Swedish children in single-parent households had increased risks compared with those in two-parent households for psychiatric disease in childhood, suicide attempt, alcohol-related disease and narcotics-related disease. Gunilla Ringback Weitof, et al., *Mortality, severe morbidity, and injury in children living with single parents in Sweden: a population-based study*, *Lancet*, 2003; 361, pp. 289-95.

The majority's description of non-genetic surrogacy often stresses the comparative ease with which non-genetic surrogates might surrender the children they have carried, and predicts that disputes between intended parents and surrogates seeking custody of such children will be rarer with non-genetic surrogates than with genetic surrogates. Both the majority and the minority deplore the harm to children caused by such custody disputes. The majority's proposed regulation appears designed first to minimize the frequency and duration of custody disputes between the adult parties to surrogacy contracts, second to protect the medical and financial interests of surrogate child-bearers, and only third to address the needs of the children of surrogacy. The proposed regulation fails to address the harms inflicted on the children of surrogacy even when there is no custody dispute, and even when the child is well cared for by the intended parents.

We believe that the majority both overemphasizes the frequency of custody disputes and also fails sufficiently to appreciate the risks to children of surrogacy even when there are no such disputes. Thus, by permitting surrogacy and trying by regulation to minimize a relatively rare consequence of it (no more than scores of custody disputes nationwide), while failing to address adequately the other more frequent harms to children (potentially hundreds or even thousands of cases of psychological loss or maladjustment as children mature), the majority's proposal would do more harm than good. No regulation that permits surrogacy can address adequately the harms to children that are either inherent in all surrogate child-bearing or common in permitted forms of such surrogacy.

If New York policy-makers are convinced, as we are convinced, that surrogacy risks unacceptable harm, they can rationally decide to discourage it even if the policy will not eliminate it, and even if other states permit it. New York has done so with other practices it deems harmful that are permitted in other states. For example, New York continues to forbid prostitution even though some New Yorkers go to other jurisdictions to participate in it legally and others engage in it clandestinely in New York. If New York policy-makers believe that surrogate child-bearing is - on balance - harmful to New Yorkers, then New York should continue to discourage it, even if other states permit it. The experience of such other states and countries gives little support to the view that surrogacy is harmless. While some participants seem to emerge unscathed, there are numerous examples of intended parents, surrogate child-bearers, and – most of all – children who have suffered harm, both harms arising from the way it was done, and harms inherent in surrogacy no matter how it was done.

In 1988, the Task Force rejected the option of upholding surrogacy contracts under regulatory models, because that would put the state's imprimatur on such arrangements and use legislative and judicial authority to uphold the contracts, thus enmeshing the state in the problems of the practice.¹³² The proposed regulation illustrates some of the problems in which it would enmesh the State.

¹³² NYS TFL, Surrogate Parenting, 1988, at pp. v and 126.

In 1988, the Task Force believed that enactment of its proposals for invalidating surrogate parenting contracts and prohibiting fees for surrogates and brokers would significantly reduce, but not eliminate surrogacy in New York State.¹³³ We agree and approve.

¹³³ NYS TFL, Surrogate Parenting, 1988, at pp. v, 129 and 139.

CONCLUSIONS

Both genetic and non-genetic surrogate child-bearing - no matter how carefully done - inherently undermine families and can often confuse children. They do so by deliberately and unnecessarily dividing before birth or even conception, the functions of parenthood, namely: the conception, gestation and rearing of children.

Surrogate child-bearing – depending on how it is done – contingently risks additional harms, especially to embryonic human beings and children. It can do so by: (1) deliberately creating more embryonic human beings than will be implanted, carried to term and raised after birth, thereby predictably leading to the indefinite storage, pre-implantation destruction, or post-implantation death by abortion of those embryonic human beings; (2) obscuring the identity of one or more of the gamete providers, thereby causing social, psychological or medical harm to children, including accidental incest, and possible genetic disease in grandchildren of such providers; (3) subjecting children born by commercial gamete “donation” or commercial surrogacy arrangements to the risk of psycho-social harm (see Part 3A) arising from the knowledge or belief that they were bought and sold; (4) subjecting other children of the surrogate child-bearer to the fear that they too might be surrendered by their mother; (5) undermining the dignity of women who are paid to bear the child of another; (6) requiring the woman who carries the child to agree before birth that she will surrender the child to others, regardless of the attachment she and the child may form with each other during and immediately after pregnancy; and (7) risking disputes between the intended parents and the woman who bears the child. Not all of these risks will become real in every case, but they have become real in some cases and are possible in many cases.

Surrogate child-bearing may well be desirable to some adults, even intensely so. But it, indeed parenting of any kind, is not necessary to adult flourishing. Although we can glimpse some of commercial surrogacy's long-term and other harms, they are not carefully studied and they are not fully known. Precaution compels us to urge the continued prohibition and non-enforcement of contracts for commercial surrogacy of any kind.

New York State enforcement and regulation of contracts for surrogate child-bearing would endorse and encourage such surrogacy and so, despite the intent to reduce harm, would do more harm than good.

New York State should continue to: (1) discourage the practice of surrogate child-bearing; (2) refuse to enforce contracts to bear and surrender a child, (3) prohibit compensation in connection with surrogate parenting contracts or arranging for such contracts, and (4) penalize by monetary fines those who enter or broker such contracts for paid surrogacy.

For over twenty years, New York's policy to discourage surrogacy has not gone so far as to criminalize or otherwise prohibit such arrangements when they are non-commercial and undisputed. While some believe that this policy goes too far (and others, not far enough), we all believe that this position strikes a reasonable balance between discouraging inherently risky surrogacy and invoking criminal penalties against a controversial and risky practice that some New Yorkers nonetheless believe to be justified.

New Yorkers who, despite state barriers to surrogacy, nonetheless arrange for women to bear children for them, already have reasonable ways to adopt those children, without resort to a new scheme for pre-natal determination of parental rights. New York law permits adoption by the intended parents in such circumstances.¹³⁴ Not all the typical time and expense of adoption is necessary for the post-natal adoption of a child of surrogacy. While some believe such adoption is too complex, time-consuming and expensive, we believe that it is a reasonable option for adults who – despite the policy to discourage surrogacy – nonetheless arrange for children to be born with the help of a surrogate child-bearer.

We acknowledge that most of our Task Force colleagues disagree with us about what policy New York ought to follow regarding non-genetic or so-called “gestational” surrogacy. Of course, on this topic, it is difficult to balance the competing values of autonomy for adults, beneficence for children, and justice for all. Reasonable minds differ.

Surrogacy provokes not only reasonable debates, but also engages the emotions and political-cultural views of virtually all the debaters. We attribute good will to all our Task Force colleagues throughout our discussions of surrogacy. We in the minority hope that we have not let our own emotions or our politics get the better of our reason. Readers of the report can judge for themselves whether or not we have succeeded.

However, we must rebut the majority's “particularly strong objection” to five passages in the minority report which the majority believes are “unfounded and unnecessarily provocative and do not advance this important debate.” We think those characterizations are unreasonable.

The different terms used by the majority and the minority are both politically charged; our terms are descriptive, rather than euphemistic, and we explain the reasons why we (and sometimes others) prefer our terms. Without minimizing the desire of many adults to have children, we do say that adults, including same sex couples, do not “need” to have children, including children by surrogacy, and we cite some self-identified LGBTQ persons who agree, sometimes for reasons unique to LGBTQ persons. We do not equate the dangers of surrogacy with the dangers of fracking, but we do argue that the precautionary principles by which New York State has approached its decision to prohibit – rather than regulate – fracking are the same sort of principles by which it ought to approach surrogacy. We do argue that the children of surrogacy are in some ways worse off than the children of adoption and we explain why, citing some sources who agree. Finally, while we do argue that New York should not encourage single persons (or indeed any other persons) to become parents in the first place by enforcing their contracts to hire a surrogate child-bearer, the reasons are not so simple as the majority has described them. While it is true that single-parent families are generally poorer than two-parent families, we have also cited research showing that even when controlling for income level, the children in single-parent families, compared with those in two-parent families have higher rates of delinquent or criminal behavior, lower educational achievement, and poorer physical and mental health. These are not outcomes to be encouraged, even inadvertently, by state policy.

¹³⁴ New York Domestic Relations Law, Article 7.

The minority report may be persuasive or not; readers will decide for themselves. But the five passages to which the majority objects, and indeed the entire report, are founded on stated reasons and cited authorities. We admit that they are controversial, but not unnecessarily so; rather, they are meant to provoke thought. Readers will decide if they advance this important debate.