

# Wombs for Rent: A Bioethical Analysis of Commercial Surrogacy in India

Neha D. Wadekar

*The practice of commercial surrogacy in India has developed into a profitable industry that operates within the free market. The surrogate mothers are generally impoverished, uneducated women from Indian villages, who engage in surrogacy for a variety of reasons. Because of the few government regulations on the surrogacy industry, the interests of the intended parents, the surrogacy clinics, and the brokers and agencies tend to be served before the interests of the surrogates themselves. An analysis of the practice through the lens of medical ethics examines if commercial surrogacy in India violates the four prima facie principles of non-maleficence, beneficence, autonomy, and justice. Upon this analysis, recommendations can be made as to how and if the commercial surrogacy in India should be changed or regulated in the future.*

## INTRODUCTION AND BACKGROUND

The practice of commercial surrogacy has grown into an international industry since 1978, when Drs. Robert Edwards and Patrick Steptoe facilitated the birth of Louisa Joy Brown, the first baby conceived through in vitro fertilization (IVF), in Oldham, England.<sup>1</sup> India has consistently been at the forefront of surrogacy technology during its 30-year existence, beginning with the birth of the world's second IVF baby, nicknamed Durga, in Kolkata, India just several months after Louisa Brown was born. Today, commercial surrogacy in India has become a profitable industry with an estimated value of \$445 million per year.<sup>2</sup>

Surrogacy is a last resort for infertile couples trying to conceive a child who is genetically related to them. Infertility is widely defined as the inability for a couple to become pregnant after one year of unprotected intercourse, and it can affect both men and women.<sup>3</sup> Worldwide, an estimated 40.2-120.6 million women aged 20-44, living in a married or consensual relationship, are unable to conceive after one year of trying. Of these women, only 12-90.4 million are likely to seek medical help.<sup>4</sup> The highest rates of infertility are reported in developing countries, due to untreated pelvic infections, sexually transmitted infections (STIs), hormonal imbalances, and traumatic complications with past childbirths.<sup>5</sup> Until the recent advent of artificial reproductive technologies (ARTs), the only available option for an infertile couple to have children was to adopt them.<sup>6</sup>

As both medicine and technology advanced throughout the 1980s and 1990s, various ARTs were invented to help couples identify and correct, or circumvent, the source of their infertility. Women's treatments included hormone injections and intrauterine insemination (IUI), while men could depend on artificial insemination (AI) and intracytoplasmic sperm injections (ICSI).

There are several different types of surrogacy. Traditional surrogacy utilizes an embryo conceived via IVF that is implanted back into the female within the intended couple. This article focuses on gestational surrogacy, the kind that

is practiced in India for profit. Gestational surrogacy is the most expensive and invasive infertility treatment, and is generally viewed as a final effort for infertile couples.<sup>7</sup> In gestational surrogacy, the embryo is conceived through in vitro fertilization (IVF), generally using the egg and sperm from a prospective couple, although donor eggs and sperm may also be used. The success rates of IVF vary greatly depending on factors such as age, cause of infertility, and weight. For example, in 2006, the U.S. had average IVF success rates of 39% in women under age thirty-five, 30% in women age thirty-five to thirty-seven, 21% in women age thirty-seven to forty, and 11% in women forty-one to forty-two.<sup>8</sup> If the IVF is successful, the egg is fertilized, and the resulting embryo is implanted into the womb of the surrogate mother, who carries the child to term and delivers on behalf of the intended parents. Commercial surrogacy, as opposed to altruistic surrogacy, occurs when the surrogate mother is compensated for her efforts, usually according to the guidelines of a previously decided agreement.<sup>9</sup>

Opinions concerning ARTs vary greatly between countries around the world. Gestational surrogacy ignites a particularly heated debate. Many countries, Australia, China, the Czech Republic, Denmark, France, Germany, Italy, Mexico, Spain, Switzerland, Taiwan, and Turkey, for example, have entirely banned surrogacy. In 1991, France defended its position by declaring, "the human body is not lent out, is not rented out, and is not sold."<sup>10</sup> Other countries such as Belgium, Finland, Guatemala, Greece, the Ukraine, and India have minimal regulations regarding surrogacy. In the United States, the legality of the practice varies by state. In India, the surrogacy industry exists in a liberal market economy, where private agencies run and manage the practice with little government interference.<sup>11</sup>

## THE REALITY OF COMMERCIAL SURROGACY IN INDIA

Commercial surrogacy in India is part of a larger trend known as medical tourism, in which foreigners travel to India to receive different types of medical treatments, primarily cardiac care, joint replacement, or cosmetic surgery, for relatively low prices.<sup>12</sup> Commercial surrogacy has specifically been renamed reproductive outsourcing. India attracts crowds of medical tourists due to its English-speaking medical staff, its technologically advanced medical care, and its low costs. The few regulations and little government interference in the industry makes India a more hassle-free location for infertile couples seeking commercial surrogates than developed nations like England or the United States.

India legalized commercial surrogacy in 2002.<sup>13</sup> Currently, the Indian government has no official, enforceable laws to monitor or regulate the industry. In 2005, the Indian Council for Medical Research (ICMR) formulated guidelines for the surrogacy industry, but these suggestions focus on ensuring that the surrogacy process does not “tax the [intended] couple’s endurance physically, emotionally, or economically.”<sup>14</sup> Specific sections of the document are dedicated to ensuring the protection of the unused embryos, the children born of surrogacy, and the intended parents, but there is no such section for protection of the surrogate mothers. The regulations provide no means of enforcement. Because the surrogacy industry in India remains laxly regulated and decentralized, few files and no central registry exist to document the various outcomes of the procedures, the names and nationalities of the intended parents, or information about the surrogates. This poses a challenge in attempting to regulate commercial surrogacy, since estimated numbers and projections about the industry vary greatly.<sup>15</sup>

The dawn of the surrogacy industry in India is widely attributed to the work of one woman, Dr. Nanya Patel. In 2003, Dr. Patel orchestrated the surrogacy of a woman from Anand, Gujarat, a rural dairy community with a population of approximately 150,000 citizens. The woman wanted to serve as a surrogate mother for her infertile daughter who was living in the United Kingdom. With Dr. Patel’s help, the woman gave birth to her own grandchild as a gestational surrogate, and this event fueled a media frenzy. Dr. Patel was inundated with requests for surrogacy, and she decided to create a business. Dr. Patel currently runs the Akanksha Infertility Clinic in Anand, where forty-five local women serve as surrogates in rotation. At any given time, between twenty and thirty surrogate women are pregnant.<sup>16</sup>

The Akanksha Clinic serves as a typical example of the many surrogacy clinics in India. The clinic physicians, nurses, and brokers actively recruit women from the neighboring villages to serve as surrogates. The clinics generally follow a set of informal rules when selecting a surrogate: the woman should not be older than forty, should be medically fit with a healthy uterus, should be married with at least one child, and must have her husband’s consent. In reality, the majority of surrogates are poor, with a median family income of approximately 2,500 rupees (sixty dollars) per month.<sup>17</sup> While a few surrogates completed high school, most never graduated from middle school, and some illiterate surrogates can only sign

their consent forms with a thumbprint. The women work a variety of jobs ranging from housewives to farmers and tailors. Their husbands tend to be contract workers, farmers, or unemployed.<sup>18</sup>

The success of India’s thriving commercial surrogacy industry stands in stark contrast to the standard of healthcare that these surrogate women are accustomed to. The rural poor in India have fewer than four doctors for every 10,000 people. According to the 2005 Reproductive and Child Health Facility Survey, fewer than half of India’s primary health centers have a labor room or a laboratory, less than one-third stock essential drugs, and only one-fifth have a telephone connection. The growth of private health care in India has fueled the migration of skilled healthcare workers to urban centers or abroad, leaving the rural poor with few or no quality healthcare options.<sup>19</sup>

To ensure the safety of the fetus in the surrogate’s womb, many clinics require that the women spend the duration of their pregnancy living in a surrogacy hostel. Reporters and researchers are rarely allowed access to the clinics or the surrogates, so gathering information about the surrogates’ lives and attitudes has been difficult. Generally, the hostel rooms have eight to ten single beds fit into a small space. The women have little to occupy their time, as they cannot climb stairs or use the elevators without the nurses present. Their husbands are allowed to visit, but are forbidden to stay the night to ensure that the surrogates do not have any sexual relations during the pregnancy. Some clinics offer the surrogates activities to pass the time, such as English and computer lessons to help make the women better candidates for surrogacy again in the future by improving their communication skills.<sup>20</sup> The nurses monitor every moment of the surrogates’ daily lives for nine months, so the clinic directors can assure their clientele that their women are, as Dr. Patel explains, “free of vices like alcohol, smoking, and drugs.”<sup>21</sup>

In the United States, surrogacy costs approximately \$80,000, including medical costs and surrogate fees. In India, the same procedure costs around \$12,000, usually paid to a medical tourism agency or a surrogacy broker. In the award-winning documentary *Made in India*, the filmmakers explore the distribution of this money, finding that between the agency and the clinic directors, the Indian surrogate women are left with a small percentage. While clinics claim to pay surrogates between \$5,000 and \$7,000, several of the surrogates who were interviewed in the documentary stated that they only received a portion of their money, sometimes as little as \$1,000.<sup>22</sup>

## A PRINCIPLED BIOETHICAL FRAMEWORK

The practice of commercial surrogacy in India raises complex moral and ethical questions. Experts from various fields of study have presented different ethical analyses and proposed numerous solutions to the practice. This paper addresses commercial surrogacy as it is currently practiced in India as a bioethical dilemma. As described by bioethicist Professor Ben Mepham, bioethical dilemmas initially appear unsolvable, and are often characterized by several features. Firstly, such dilemmas often have valid reasons for both supporting and opposing a particular course of action. Secondly, the ethical acceptability in determining a course of action to deal with

a bioethical dilemma depends heavily on scientific evidence, which may be complex, incomplete, and/or debatable. Finally, in such cases, a decision must be made by and for society as a whole, in which many individuals may oppose the opinion held by the majority of scientific experts.<sup>23</sup> The practice of commercial surrogacy in India fits all three criteria, and can therefore be defined as a bioethical dilemma.

The four *prima facie* principles of bioethics were developed by the medical ethicists Tom Beauchamp and James Childress in the United States, with the goal of helping doctors, nurses and healthcare workers deal with the ethical problems that they inevitably faced when treating their patients. Beauchamp and Childress built upon Oxford philosopher David Ross' suggestion, proposed in the 1930s, that ethical principles needed to be *prima facie*, or conditional, so that a stronger or more compelling principle could overcome a weaker one in a particular situation. Beauchamp and Childress believed that decisions in medical ethics should be handled on a case-by-case basis, by applying the *prima facie* principles to each situation.<sup>24</sup> The four principles of bioethics are:

1. Non-maleficence: to cause no harm.
2. Beneficence: to effect a cure.
3. Autonomy: to respect patients' independence.
4. Justice: to treat patients fairly and without discrimination.

These principles are intended to provide a general guide to dealing with bioethical issues that transcends the boundaries of culture, nationality, religion, and other existing ethical frameworks. Because they are conditional, the principles are characterized by a need for balance, which allows multiple important factors to weigh into the final chosen course of action. In the case of commercial surrogacy, many different stakeholders must be taken into account: the intended parents, the child, the healthcare workers, the brokers and agencies, and the surrogate mother herself. In some cases, a complex issue such as commercial surrogacy may create a double effect in which an action that may have unforeseen harmful effects to one set of stakeholders may simultaneously cause many beneficial effects to another set of stakeholders.<sup>25</sup> According to the criteria of the double effect, a practice having foreseen harmful effects that are inseparable from the good effect is justifiable if the following is true:

- That the nature of the act is itself good, or at least morally neutral.
- That the agent intends the good effect and not the bad either as a means to the good or as an end itself.
- That the good effect outweighs the bad effect in circumstances sufficiently grave to justify causing the bad effect and the agent exercises due diligence to minimize the harm.<sup>26</sup>

## APPLYING THE BIOETHICAL PRINCIPLES TO COMMERCIAL SURROGACY IN INDIA

### Non-maleficence

The biomedical principle of non-maleficence is based on the 4th century Hippocratic oath. It states that to "cause no

**“Despite the risks involved, surrogates have no one to hold accountable should something go wrong.”**

harm” includes not to kill, not to cause pain, not to incapacitate and not to deprive of goods. In the United States this principle is considered fundamental and absolute. However commercial surrogacy in India has the potential to cause both physical and psychological harm to the surrogate and the fetus. If surrogacy were illegal, the mother would never take this risk; no potential fetus would be at risk. However, the commercial surrogacy industry in India ignores this fundamental risk by its very existence.

Gestational surrogacy is a complex medical process that can cause a great deal of potential physical harm. Since the surrogate is not genetically related to the baby, her body must be prepared for artificial pregnancy. The embryo transfer itself is not very complicated, but the process of preparing the surrogate for that transfer and the weeks after, require a great deal of medical attention. Birth-control pills and hormone shots are required to control and suppress the surrogate's natural ovulation cycle, after which estrogen shots are given to help build her uterine lining. After the embryo is transferred, daily progesterone injections are administered until the surrogate's body finally believes and realizes that she is pregnant and begins to sustain the pregnancy. The side effects of all these medications can include hot flashes, mood swings, headaches, bloating, spotting, uterine cramping, breast fullness, light-headedness, and vaginal irritation.<sup>27</sup>

Despite the risks involved, the surrogates have no one to hold accountable should something go wrong. As one surrogate told researcher Amrita Pande during an interview, “we were told that if anything happens to the child, it's not our responsibility but if anything happens to me, we can't hold anyone responsible.”<sup>28</sup> There is no one accountable for the surrogate's welfare- not the brokers, nor the doctors, nor the intended parents. In India, should the doctor make a mistake so the surrogate is injured or even dies from the procedure, the surrogate's family cannot hold the doctor liable. The fact that there is nothing the surrogate can do in the case that she is harmed creates conditions in which the surrogacy industry in India could potentially take unnecessary shortcuts and risk the surrogate's health without fear of legal repercussions.

The surrogate faces more than physical harm. She also may be harmed psychologically through the process of gestational surrogacy. Removing a newborn child from its birth mother is inherently psychologically harmful. Some in the field of commercial surrogacy claim that the bond between

causes the surrogates in developing countries.<sup>30</sup>

Surrogate mothers also face high levels of social stigma and ostracism in India. This social stigma may be due to several contributing factors. Surrogacy is a practice that involves the bodies of poor women, which in India's socially conservative culture, is cause enough for disparagement. The surrogate mothers are treated as disposable objects, and the surrogacy industry highlights the "unnatural" aspects of pregnancy and reproduction. In addition, many Indians associate surrogacy with paid sex-work, and this comparison to prostitution further stigmatizes the surrogate women.<sup>31</sup>

Surrogate mothers face another type of potential psychological harm that stems from their social position as inferior and powerless within the complex of gestational surrogacy. Surrogate mothers typically engage in commercial surrogacy for three reasons. Some surrogates may have primarily altruistic motives. That is, a woman may feel compelled to become a commercial surrogate for a paying couple out of her pure desire to help them, and she takes the pay as an unimportant added benefit. Some women become commercial surrogates due to immediate financial pressures that the pay of surrogacy can alleviate. Finally, some women may not want to become surrogates but may do so as a result of external pressures. In Pande's interviews with forty-two surrogate mothers as well as surrounding family members, friends, and clinic workers, she found that the women often cited their own children as their primary reason for becoming commercial surrogates. Their wishes to send their children to school or pay for a good wedding would only be possible with the money they earned from their reproductive labor. Any and all of these reasons for engaging in commercial surrogacy in India, if viewed under the biomedical principles, commercial surrogacy in India may apply undue pressure on the women to consent.

### **Beneficence**

Beneficence, or promoting the well being of others, is widely interpreted to mean acting in the best interest of the patient. It considers the opposite of malfeasance. In the case of commercial surrogacy in India, the patient is the surrogate mother undergoing treatment. The intended parents can be considered the client. In examining beneficence in the overall practice of commercial surrogacy, the client appears to benefit.<sup>32</sup> The surrogate mother undergoes a risk that she need not encounter at all, in exchange for her fee. Therefore, the question that needs further examination is whether benefits for the surrogate mother are promoted and awarded equal consideration throughout the surrogacy process.

Ethicists have attempted to answer the question of what benefits commercial surrogacy can provide to a poor Indian woman. Casey Humbyrd argues that in order to rule that commercial surrogacy is harmful to the surrogate mothers, the psychological harm of surrogacy must outweigh psychological harm of poverty.<sup>33</sup> Jennifer Parks lists the following ways in which surrogacy benefits the surrogate mothers: it provides economic relief, it provides the resultant effect of being able to care for their families, it ensures their freedom to use their bodies as they see fit, their freedom of choice, and

their freedom to contact.<sup>34</sup> These defenses highlight the positive aspects of commercial surrogacy that promote the well-being of the surrogate women involved.

Numerous anecdotes exist that emphasize the benefits of commercial surrogacy to surrogate women. Marie Claire, a popular women's fashion and lifestyle magazine published an article that told the story of Najima Vohra, who earned \$5,500 for being a surrogate mother. Her current job, helping her husband collect scrap metal, pays \$1.20-\$1.45 per day. With her money, Vohra plans to purchase a brick house to replace her family's mud house that washes away each year during the monsoons. She also will invest in her husband's business and pay for her daughter's education.<sup>35</sup> Stories like Vohra's imply that surrogacy is a quick fix: an easy way for poor women in developing countries to make a great deal of money to help their families.

Surrogates sometimes receive more than just monetary benefits from their participation in the surrogacy industry. Another surrogate mother featured in Marie Claire is Rubina Mondal, who traveled from Kolkata to a surrogacy clinic in Gujarat because her young son had a hole in his heart and surrogacy was the only way for her to make enough money in time to pay for his surgery. The client involved was an American woman named Karen, who called Rubina weekly for updates throughout the pregnancy. Karen and her husband purchased an apartment for Rubina and her family, and gave them money for groceries, and send the, clothing. In the last weeks, Karen moved in with Rubina for support, and was by her side during the delivery. Rubina plans to attend Karen's son's first birthday party in the United States. In some cases, like Rubina's, the surrogates can form lasting and beneficial relationships with the clients.<sup>36</sup>

A number of surrogacy hostels provide English and computer lessons to the resident surrogate mothers. These lessons can prove to be valuable for the women later in life, after their temporary employment as surrogate mothers ends. The surrogacy clinics also teach the women a great deal about maternal health, since most of these women had such poor quality healthcare before becoming surrogates.<sup>37</sup>

### **Autonomy**

Autonomy is the right of an individual to self-determination. In the context of commercial surrogacy, this "right" is defined in numerous ways. The medical field defines autonomy in more complex terms as, "self-determination that is free from both controlling interferences by others and personal limitations preventing meaningful choice (such as inadequate understanding or faulty reasoning). Having the capacity to act with autonomy does not guarantee that a person will actually do so with full understanding and without external controlling influences."<sup>38</sup> This definition calls into question many different aspects of the commercial surrogacy that is practiced in India, and whether the surrogates' autonomy is truly respected and preserved.

#### *Before pregnancy*

Proponents of commercial surrogacy argue that the freedom to procreate and the freedom to contract are the most

important aspects of a surrogate mother's autonomy. As long as these rights are not violated, the surrogate's autonomy is preserved.<sup>39</sup> However, in the case of commercial surrogacy in India, the right to procreate and the right to contract are not always upheld to their intended standards. Philosopher and ethicist Elizabeth Anderson argues that the interest protected by the right to procreate is that of being able to create and sustain a family life with some integrity. Although commercial surrogacy in India helps to create one family life, it potentially can destroy another.<sup>40</sup> After her nine-month job is over, the Indian surrogate mother could potentially return to a disgruntled husband, neglected children, and a society riddled with stigma towards surrogates and the practice of surrogacy. In addition, the freedom to contract that is, in theory, intended to preserve the autonomy of Indian surrogate women, is constrained in reality. The surrogacy contracts "command the surrogate mother to conform her emotions to the interest of the other parties to the contract." In addition, the contracts restrict the surrogates' behavior and make demands upon the surrogates' emotions. Because surrogacy in India currently operates within a *laissez-faire* system, surrogacy arrangements tend to favor the healthcare providers, surrogacy agencies, and intended parents at the expense of the surrogates and their communities.<sup>41</sup> Surrogate women have little to no voice throughout the process, not even in drawing up the contract, and the practice of commercial surrogacy consequentially infringes upon their autonomy.

## **“The contract allows the surrogate no time to change her mind or object to handing over the infant.”**

The key points of the medical definition of autonomy ask whether surrogate women in India are free *from both controlling interferences by others and personal limitations preventing meaningful choice*. In the surrogacy industry in India, many external controlling forces exert influence upon the surrogate women. For example, most of the surrogate women are poor, uneducated, and lower caste, and are made to feel vastly inferior to surrogacy doctors, clinic workers, and the intended parents. As a result, the surrogates follow instructions and commands with few questions or complaints, because they presume that the doctors and clinic workers know best. Living within India's traditional patriarchal society, the surrogate women lack control over their own finances and the money they are able to earn, which could further contribute to feelings of inferiority. Everyone around them has the monetary control, from the intended couple that determines the fee, to the clinic directors who distribute and control their pay, to their husbands at home who take their money.<sup>42</sup>

The poverty and desperation the surrogate women and their families face calls into question whether the surrogates make autonomous decisions to engage in the practice in the first place. In many clinics, the doctors, nurses, and clinic staff who benefit monetarily from the practice of surrogacy actively travel into the impoverished surrounding communities to recruit young women to become surrogates. Some surrogates report that they enter into commercial surrogacy contracts due to pressure from their husbands or in-laws who need money.<sup>43</sup> It is important to note why and how these women decided to become surrogates in the first place. Desperate poverty, clinic recruitment, and familial pressure are all factors that influence and coerce women into becoming surrogates, and infringe upon their ability to make autonomous, informed decisions.

### *During and after pregnancy*

The surrogate mothers must forgo their autonomy throughout the surrogacy process. After a woman presents herself to a surrogacy clinic as a candidate, the clinic screens her and either approves or denies her application. If selected, the surrogate waits to be matched with an intended couple. The surrogate has no say in who the intended parents are. Many clinics do not permit the intended parents and the surrogate mother to meet, in circumstances similar to a closed adoption.<sup>44</sup> The women must sign a binding consent form that lists the procedures they will undergo and the amount of compensation they will receive. The forms are generally written in English, a language most surrogates cannot read or understand. The clinic workers and nurses translate what they deem to be the most important points for the surrogate, and she signs away her reproductive rights.<sup>45</sup> As currently practiced, commercial surrogacy in India has the potential to occur without the autonomous and informed consent of the surrogate mother. After the delivery, the surrogate mother, or a nurse, hands the newborn over to the intended parents. The contract allows the surrogate no time to change her mind or object to handing over the infant. Given their average family income, it can be presumed that most surrogates do not have the means to seek legal council, and therefore have no opportunity to contest the terms of the surrogacy contract.

### **Justice**

Justice, perhaps the most difficult medical principle to define, is the concept of fairness and equality in the distribution of scarce health resources and the decision of who will receive what treatment. For both medical interventions and research, justice occurs when the burdens and risks are spread equally to all parties involved. When examining justice from the surrogate's point of view, it is important that the principles of medical ethics not be violated during the process of commercial surrogacy in India.

One source of injustice that affects the surrogate woman in India is the international double standard regarding the practice of commercial surrogacy. Most developed nations have banned commercial surrogacy on the basis that it violates women's ethical rights. As France states, "the human body cannot be lent out, rented out, or sold." Does a French woman's body deserve this protection more than the body of

an Indian woman? Is the Indian woman's right to live under the protection of the principles of medical ethics any less than the right of any other woman?

Even within the practice of commercial surrogacy a hierarchy exists and injustice abounds. With the creation of in vitro fertilization, it became possible for a woman from a developing nation to have a baby intended to grow up in a developed nation. The practice abounded. According to Amrita Pande, "In gestational surrogacy, the parents no longer care about the surrogates genes. Not surprisingly, gestational surrogacy allowed the surrogacy market to go global. It was now possible for a South Korean couple sitting in Los Angeles to hire a surrogate from a little village in western India to have a child for them."<sup>46</sup> In India, even within the practice of commercial surrogacy, women of higher caste receive better wages for the same work than women from lower castes, further emphasizing the social inequalities that exist in the population.<sup>47</sup>

## CONCLUSION

In the future, commercial surrogacy in India can take one of four paths. It can continue to exist in a loosely regulated environment, in which case the surrogate women are the most likely to be exploited and denied the basic medical ethical principles. The Indian government can pass laws to regulate the industry, requiring a central registry of surrogate women and intended parents, creating minimum payments for surrogates, and creating agencies to inspect and help maintain a quality standard of care. Furthermore, this regulation should also provide protection and non-binding clauses for the surrogate mothers, in case they suffer during the surrogacy process, either physically or mentally. India could follow in the footsteps of countries such as England by making gestational surrogacy legal, but only in altruistic cases. In these circumstances, the coercion of money would be removed from the practice, but surrogacy technology would still be utilized. Finally, India could implement a ban on commercial surrogacy.

Despite its economic advantages, I believe that commercial surrogacy inherently violates the bioethical principles to which Indian surrogate women should be entitled. In a country such as India, with a free market economy, and combination of public and private healthcare sectors, a moderate or regulated version of surrogacy would be difficult to achieve. I believe that it is crucial to preserve the rights and dignities of these Indian women, and that commercial surrogacy in India must be banned in order to end the potential exploitation that is occurring.

## REFERENCES

1. Mundy, Liza. *Everything Conceivable*. Anchor Books, (New York: 2008) p. 7.
2. Palattiyil, G. et al. "Globalization and cross-border reproductive services: Ethical implications of surrogacy in India for social work." *International Social Work*, (2010 v.53) p. 687.
3. U.S. Department of Health and Human Services, Office on Women's Health.
4. Palattiyil, G. et al. "Globalization and cross-border reproductive

- services: Ethical implications of surrogacy in India for social work." *International Social Work*, (2010 v.53) p. 688.
5. Pande, Amrita. "Commercial Surrogacy in India: Manufacturing a Perfect Mother-Worker." *Signs: Journal of Women in Culture and Society*, (2010 v.35 no.4) p. 972.
6. Mundy, Liza. *Everything Conceivable*. Anchor Books, (New York: 2008) p. 48.
7. Ibid.
8. U.S Department of Health and Human Services, Office on Women's Health.
9. Humbyrd, Casey. "Fair Trade International Surrogacy." *Developing World Bioethics*, (2009: v.9 no.3) p. 112.
10. Chang, Mina. "Wombs for rent: India's commercial surrogacy." *Entrepreneur*, *Harvard International Review*, (2009).
11. Pande, Amrita. "Commercial Surrogacy in India: Manufacturing a Perfect Mother-Worker." *Signs: Journal of Women in Culture and Society*, (2010 v.35 no.4) p. 969.
12. Haworth, Abigail. "Surrogate Mothers: Wombs for Rent." *Marie Claire*, (2009).
13. Gentleman, Amelia. "India Nurtures Business of Surrogate Motherhood." *NYTimes*, (March 10, 2008).
14. "Statement of Specific Principles for Assisted Reproductive Technologies." *Indian Council of Medical Research*.
15. "Statement of Specific Principles for Assisted Reproductive Technologies." *Indian Council of Medical Research*.

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## The Drug-Resistant Bacteria in Supermarkets

By Emily Clark

A study published today in the journal *Clinical Infectious Diseases* raises cause for some alarm about the state of food safety and agriculture in the US. 47% of the meat and poultry samples that researchers tested from supermarkets contained *Staphylococcus aureus* bacteria, and more than half of these were resistant to at least three classes of antibiotic. Staph bacteria can cause skin infections and food poisoning, and pose a danger if meat is not cooked properly or if there is cross-contamination in the kitchen. However the exact risk that this finding poses to consumers is not fully clear yet. These bacteria aren't one of the three drug-resistant organisms that the government looks for in retail supplies of meat, and so researchers suggest that it probably should be better tracked. The FDA is the branch of authority responsible for making sure that US consumers are safe from dangerous food products. Still another concern raised is that the widespread use of antibiotics in livestock ends up causing antibiotic resistance in humans, and there is evidence that the source of these bacteria were from the animals themselves. Therefore in the long run, this may be a question not just of food quality standards but also of agricultural practices more generally.

### Reference

Barclay, Eliza. "1 in 4 Supermarket Meat Samples Tainted with Drug-Resistant Bacteria." *Shots: NPR's Health Blog*.