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ARTICLE

Surrogacy and the Fiction of Medical Necessity

Teresa Baron

University of Nottingham, School of Humanities, University Park Campus, Nottingham, UK
Email: teresa.baron@nottingham.ac.uk

Abstract

A number of countries and states prohibit surrogacy except in cases of "medical necessity" or for those with specific medical conditions. Healthcare providers in some countries have similar policies restricting the provision of clinical assistance in surrogacy. This paper argues that surrogacy is never medically necessary in any ordinary understanding of this term. The author aims to show first that surrogacy per se is a socio-legal intervention and not a medical one and, second, that the intervention in question does not treat, prevent, or mitigate any actual or potential harm to health. Legal regulations and healthcare-provider policies of this kind therefore codify a fiction—one which both obscures the socio-legal motivations for surrogacy and inhibits critical examination of those motivations while mobilizing normative connotations of appeals to medical need. The persisting distinction, in law and in moral discourse, between "social" and "medical" surrogacy, is unjustified.

Keywords: Healthcare policies; legal regulations; medical necessity; surrogacy

Surrogacy as a Socio-Legal Intervention

Surrogacy is generally characterized as an arrangement in which a woman conceives and carries a child to term for another individual or couple to raise. There are two forms of surrogacy: "traditional" surrogacy, in which the gestational mother of the child uses her own egg and is therefore also a genetic parent; and gestational surrogacy, in which the egg is provided by either a commissioning parent or by a further donor. Conception always requires clinical assistance in the latter case, since it involves in vitro fertilization (IVF), but in the former case, it may be carried out at home using the "turkey baster method" or other means of nonclinical artificial insemination. In some countries (such as the United Kingdom, Netherlands, Belgium, and Australia) the gestational mother of the child is the legal parent at birth; her legal parental responsibility can only be terminated by a court order and transferred to the commissioning parents. In others (such as Greece, Georgia, and Ukraine), the commissioning parents are assigned legal rights and responsibilities over the child from birth by virtue of a pre-birth contract and court order.[1]

These details—and especially the differences in the legal nature of surrogacy between countries—serve to underline the first point of my argument, which is that *surrogacy* is not a medical intervention, but a socio-legal intervention, targeting parenthood (a socio-legal condition) rather than any physiological state or disposition. We may thus contrast surrogacy with processes such as IVF, artificial insemination, and obstetric assistance during childbirth. These latter procedures are medical (or clinical) interventions, acting upon the physiological dispositions of the patient. Any of those procedures might be used in the course of a surrogacy arrangement, but *surrogacy itself* is socio-legal in nature. It is concerned with the distribution of parental rights, status, and responsibilities. This is made clear in part by the ways in which surrogacy changes form depending on the laws and regulations of the relevant jurisdiction.

In the bluntest terms, surrogacy arrangements enable person A, who is unable to have a child (because they are single, or because they cannot have a child with their chosen partner person B), to have a child with person C, while also ensuring that person C does not become a social/legal parent. While surrogacy is often represented as a means of becoming a genetic parent, it is motivated by a desire for not only genetic parenthood but also *exclusive social parenthood*, whether alone or with one's chosen partner.[2,3] In most countries that permit surrogacy, this is achieved by allowing person C (the surrogate mother) to consent to termination of her presumptive parental rights and responsibilities, and attributing these rights and responsibilities to person A (and, when relevant, their partner B). In other countries, it is achieved by allowing pre-birth contracts to be drawn up that allocate these parental rights and responsibilities directly to the commissioning parent(s). It is these socio-legal phenomena that characterize surrogacy arrangements, regardless of the clinical or nonclinical means by which the child is conceived. The same child could be born to the same sets of people but be (for example) co-parented by all in a collective arrangement. The reason this would no longer be surrogacy is because of the difference in social and legal arrangements rather than because of the relevant clinical procedures or biological relationships involved.

In many countries and states where surrogacy is legal, the practice is nonetheless permitted only in the case of putative "medical necessity" or due to "medical need." In the United States, for example, Louisiana state law requires that the intending mother's physician "submits a signed affidavit certifying that *in utero* embryo transfer with a gestational carrier is medically necessary to assist in reproduction."[4] Illinois similarly allows surrogacy only for intending parents who "have a medical need for the gestational surrogacy as evidenced by a qualified physician's affidavit."[5] In many other countries, while the term "medical necessity" is not always encoded directly into the relevant law or regulation, couples and individuals seeking surrogacy are required to demonstrate infertility and/or a biomedical reason making conception and/or childbirth dangerous for the prospective mother. For example, in Florida, Utah, Virginia, and Texas, intended parents must be unable to conceive naturally without the risk of health problems to the pregnant parent or the fetus.[6] In South Africa, intended parents must demonstrate that they "are not able to give birth to a child and that the condition is permanent and irreversible."[7] Greek law likewise requires medical documentation demonstrating that the commissioning mother cannot carry a child to term herself.[8]

I aim to show that describing surrogacy as medically necessary in any scenario departs significantly from our ordinary concept of medical necessity. I will then extend this point to argue that legal regulations restricting access to surrogacy only to those with specific medical conditions—whether or not by explicit appeal to "medical necessity"—are unjustified, given the nature of surrogacy as a social and not medical intervention.

Surrogacy, Health, and Medical Necessity

When we say that something is necessary (outside the context of a formal logic classroom), we generally have a practical imperative in mind. To say that *X* is necessary is therefore usually shorthand for saying that *X* is necessary for *Y*. That is, it is an appeal to the steps that are practically necessary to bring about our chosen outcome (e.g., *X* can be "brushing regularly" and *Y* can be "avoiding cavities"). So what stands in for *Y* when we say that something is medically necessary?

Numerous scholars have observed that there is not a clear consensus on the definition of "medical necessity."[9,10,11] However, use of the concept (particularly in the context of legal frameworks relating to healthcare access) is frequently justified "in terms of its ability to distinguish not only necessary from unnecessary care but also medical from cosmetic, experimental, elective, and even social or educational procedures, often in the name of ensuring that patients receive treatment that is appropriate and medically indicated while also controlling costs."[12] The exact bounds of medical necessity may be defined more or less strictly by different parties for different purposes. However, on ordinary, widely shared understandings of the term, a service, treatment, or procedure is *medically necessary* if it is:

1. A medical/clinical intervention—that is, acting upon the physiological dispositions of the patient
2. Required by a patient for the treatment (curative or preventive) of an actual or potential threat to the health of that patient

In other words, *X* is medically necessary if *X* is a medical intervention necessary to restore or maintain the health of the patient.[13]

We can distinguish physiological infertility (a property of individuals) from situational infertility (a property of couples) and childlessness (a property of individuals and couples). Physiological infertility is the inability to produce functional gametes.[14] Conditions that contraindicate fertilization, implantation, and/or gestation to term may often be referred to as *forms of infertility*, but for the sake of precision, we recognize these as causes of childlessness. Situational infertility is the inability of two people to conceive and bring a child to term together: They are "both capable of reproducing without assistance with any other individual, just not with each other."[15] Where couples (as opposed to individuals) are described as infertile, this may be because one or both people in the couple are physiologically infertile, or because they are, as a couple, situationally infertile. As Robert Sparrow notes, there are therefore many circumstances "in which fertile individuals are granted access to reproductive technologies to assist them in pursuit of their reproductive goals."[16]

However, we may note that neither surrogacy nor other forms of assisted reproduction (such as IVF) are *curative* even in the case of medical (physiological) infertility. These procedures circumvent the problem at hand, rather than cure infertility. To illustrate this argument, we may compare in vitro fertilization (IVF) here to a procedure treating a blocked fallopian tube. The latter procedure treats the dysfunction impeding conception, and that dysfunction would be properly understood as a departure from healthy functioning even if that person were not trying to conceive. IVF, on the other hand, is a means of creating a zygote from healthy gametes, which offers a "workaround" in the case of individuals who either are not able or do not wish to conceive via sexual intercourse. This applies whether this is a heterosexual couple struggling with infertility, a same-sex couple who need to use a donor gamete to conceive, or a commissioning parent and surrogate mother. Importantly, IVF (unlike the unblocking of fallopian tubes) is not a medical intervention that would be offered *outside* the context of a specific reproductive venture. It is therefore not indicated solely, or even primarily, by the medical condition of a specific patient, but by further social considerations.

Let us consider the case of women whose mental and/or physical health is threatened by pregnancy and/or childbirth. Here, it seems much clearer that the *avoidance* of pregnancy and/or childbirth is medically necessary (and that therefore either contraceptives, abstinence, or termination of existing pregnancy may be medically indicated) than that the outsourcing of pregnancy through surrogacy is medically necessary for the safeguarding of that individual's health. Surrogacy is not *medically* indicated as either a curative or a preventive treatment for the health risks in question. It is more accurately described as *practically* necessary in order to achieve an independently established social goal: having a genetically related child, of whom one is the exclusive social and legal parent, while avoiding these health risks. The desire for genetic offspring may be felt incredibly deeply by some individuals but does not amount to a medical need in any reasonable sense. If distress caused by childlessness becomes extreme to the point of being diagnosed as pathological, it seems highly implausible that the provision of a child would be suggested by any clinician as an appropriate treatment pathway, any more than arranged marriage would be suggested as an appropriate medical treatment for depression caused by extreme loneliness.

We can further undermine the plausibility of claims of medical necessity in surrogacy by using plain language to describe a standard surrogacy arrangement. Consider the following example:

> *Anne and Brian deeply want a child of their own, but they cannot conceive one together. It is medically necessary for Brian to impregnate Claudia so that Anne and Brian can raise the child together.*

The use of blunt terminology here does two things. Firstly, it makes clearer the social relationships here, removing us from the familiar terminology of surrogacy, donation, and assisted reproduction and the connotations carried by this terminology. Secondly, it makes the appeal to medical necessity sound peculiar; it is apparent that what is at stake can only be described as practical necessity *given* certain socio-legal aims. We can compare the above example with another:

> *Josie deeply wants to be able to run a four-minute mile, but her legs are not strong enough. It is medically necessary for her to be given robotic legs.*

This analogy may help illustrate the implausibility of appeals to medical necessity when the motivation underpinning the relevant practical imperative is nonmedical—whether that is a desire to run faster or to be provided with exclusive legal parenthood of a biologically related child without finding a new partner or sharing childrearing with a further biological parent. Neither practical imperative is motivated by the cure or prevention of some medically pathological state. This is the case *even if* there are medical or biological reasons for which surrogacy or robotic legs would be practically necessary for the individual or couple's desires to be met.

Restoring Fertility

There is, of course, a further debate in the philosophy of biology and medicine over how we should define health and disease—for example, whether disease should be understood as a departure from statistically normal contributions to survival and reproduction, or whether disease is a normative concept containing some appeal to harm or diminishing welfare.[17,18] Lennart Nordenfelt, for example, defines an individual's health as "his or her second-order ability to realize vital goals given standard or otherwise reasonable circumstances."[19] Vital goals are characterized as those whose achievement contributes to the long-term minimal happiness of that person—for example, to become an academic philosopher or to visit Europe. Unreasonable circumstances are those under which environmental factors—like sexist hiring practices or the outbreak of war—prevent someone from achieving their vital goals, without that person being unhealthy. On a Nordenfeltian account, then, a childless couple whose vital goals include parenthood might be considered unhealthy; it could then be argued that IVF is medically necessary for them to restore their health.[20] However, accounts of health that characterize the inability to achieve one's important goals as matters of ill-health depart sufficiently from ordinary understandings of medical necessity, that any law referring to "medical necessity" based on such a notion of health would need to independently define and motivate this approach.

In their recent discussion of in vitro gametogenesis (IVG), Lauren Notini et al. defend a contrary view. They argue that, on theories of health and disease such as Christopher Boorse's biostatistical theory, the provision of IVG (creation of artificial gametes) "can be deemed therapeutic […] as its aim is to provide or restore fertility, an aspect of 'normal' functioning."[21] According to the biostatistical theory, disease is a departure from statistically normal contributions to survival and reproduction; Notini et al. seem to presuppose that *not* having a genetically related child constitutes such a departure. IVG could therefore be considered medically therapeutic in treating or preventing that state. (The same argument could be made of surrogacy.) They illustrate their argument with the example of Bill, who is asexual, and while he has a strong desire for genetically related children, "he has a strong desire to not share this genetic relationship with his future children with another person—that is, he has a strong desire to pursue solo reproduction."[22] According to these authors:

> It is clear that Bill's asexuality is in some sense an abnormal function under Boorse's account of health. It is not contributing to his survival or reproduction. The use of IVG to help Bill have genetically related children could be seen as restoring a natural function (reproduction) and therefore could be provided for medical, rather than social, reasons.[23]

However, there are several problems here. Firstly, insofar as having a genetically related child is the outcome of (or comprises) reproduction, simply *not having* a genetically related child cannot itself be a departure from statistically normal contributions to reproduction. Put another way: We can reasonably call this such a departure only to the extent that we can also reasonably say that death is a departure from statistically normal contributions to survival. This seems, if nothing else, rather silly. Notini et al. may also find that they accidentally commit to calling every childless individual diseased (including those who are voluntarily childless and perfectly happy with that state), which is certainly something to avoid.

The second problem is that, as I argued in Section "Surrogacy, health, and medical necessity," neither IVG, IVF, surrogacy, nor other forms of assisted reproduction *restore* fertility in the medical sense. Rather, they circumvent infertility, just as moving objects closer or increasing font size may circumvent the effects of short-sightedness without actually curing myopia.[24] We may also note that *even if* collaborative reproduction did restore "normal functioning" in terms of biological reproduction, the aspects of surrogacy and gamete donation that allow for exclusive parenthood by the commissioning parent(s) remain a purely socio-legal intervention. As Donna Dickenson observes (somewhat wryly), "Few if any commissioning couples will want to sign a contract that does not definitely mean they get to keep the baby."[25] The biological imperative to pass on genes to the next generation falls short of motivating surrogacy.

There is a further point to be made here, arising when we give closer attention to some of the language chosen by Notini et al.: "IVG […] therefore could be provided for medical, rather than social, reasons." This statement performs the same dual function as legal restrictions that restrict access to surrogacy to those for whom it is purportedly "medically necessary." This is to draw a line between supposedly acceptable and non-acceptable motivations for surrogacy, while simultaneously obscuring the fundamentally social motivations for surrogacy and tapping into the moral connotations associated with appeals to medical necessity. The appeal to medical necessity occludes some of the ethical concerns that might otherwise be raised regarding surrogacy, since for something to be positioned as medically necessary is generally for it to be beyond certain kinds of moral scrutiny.[26] At the same time, the artificial distinction between medical and social reasons for surrogacy, utilized when defending the former, presupposes that ethical concerns can be raised against the latter.

Social Versus Medical Surrogacy

I have argued here that surrogacy can (at most) be described as practically necessary given independently established socio-legal goals or desires. While medical necessity may be defined more or less strictly, it seems straightforwardly unreasonable to redefine the concept so as to capture the nonmedical desires (as opposed to needs) of healthy individuals. The single man or male couple who wishes to have a child (genetically related to one of them) through surrogacy is expressing an entirely nonmedical wish: The couple wishes to reproduce with a woman who will have no parental rights or responsibilities regarding the child. Importantly, however, this *is exactly the same wish* expressed by heterosexual couples seeking surrogacy.

Giulia Cavaliere and Cesár Palacios-González raise a similar point with regard to the regulation of mitochondrial DNA (mtDNA) donation, which in some countries is restricted to couples with "medical need"—by this is meant those couples who have a mitochondrial disease and wish to have a genetically related child without passing this disease down to them. This rule precludes couples without this purported medical need from using the technology—for example, lesbian couples who could use mtDNA donation to produce a child genetically related to both mothers. This kind of case would be classed as a social use of mtDNA, rather than a case of medical need. Cavaliere and Palacios-González argue, however, that these technologies "are not therapeutic because they do not cure anyone; they just bring into existence a new organism."[27] All of those prospective parents seeking to use mtDNA donation have exactly the same aim, regardless of whether their reason for considering the technique is down to social or biomedical facts: "They aim to bring a particular kind of individual into existence: healthy people who are genetically related to their parents."[28]

A key presupposition that underpins legal distinctions between social and medical surrogacy is that certain kinds of socio-legal procreative venture are legitimate when people engage in them solely or primarily *because of* some biomedical fact (e.g., clinical infertility) but not when people engage in them solely or primarily *because of* social or economic facts. It may be that this presupposition reflects a kind of sympathy or a view that those who seek out surrogacy due to infertility have lost an opportunity that they "rightfully" should have had. Alternatively, it may reflect a concern that engaging in surrogacy for (putatively) social rather than (putatively) medical reasons is a moral failure of some kind. A paradigmatic example of this attitude is encapsulated by the derisive language used by journalist Jenny Kleeman to describe surrogacy services offered by one Californian clinic:

> Now, a growing number of women are coming to Sahakian for "social" surrogacy: they want to have babies that are biologically their own, but don't want to carry them. There is no medical reason for them to use a surrogate; they just choose not to be pregnant, so they conceive babies through IVF and then hire another woman to gestate and give birth to their baby. It is the ultimate in outsourced labour.[29]

However, as demonstrated above, the same socio-legal goals motivate *surrogacy* regardless of the number, sex, or physical condition of the intending parents. If it is morally permissible to commission someone to produce a child for you while withdrawing their own parental rights and responsibilities, then that would seem to be the case regardless of whether an individual is clinically infertile, has a fear of pregnancy, or simply does not want to lose their figure. If, on the other hand, we find ethical problems in the socio-legal aims motivating surrogacy, then we have clear reason to acknowledge and examine these explicitly. We cannot use a fiction of medical necessity to mask those ethical problems; neither can we use this language to justify exceptions for people whom we think are "more deserving" prospective parents.

This is the key consideration that precludes our solving this problem by simply expanding the definition of medical necessity to include interventions that are *practically* necessary to achieve nonmedical aims because of biomedical facts. Given our widespread ordinary understanding of medical necessity (and its normative connotations), allowing the concept to be stretched in this way would obscure both the practical imperative and the nonmedical aims in question, and potentially inhibit critical examination and moral scrutiny of surrogacy more broadly. The arguments put forward in this article apply not only to restrictions on the basis of "medical necessity" but likewise to weaker formulations, such as "medical advisability." I maintain that even where it is indeed medically advisable (or necessary) for a woman to avoid pregnancy and childbearing for the sake of her own current or future health, the motivations for any individual or couple pursuing a surrogacy arrangement are socio-legal and not medical. They should be recognized as such across the board.

Conclusions

In light of our normal understanding of the concept of medical necessity, I have argued that surrogacy (and other forms of assisted reproduction) can only ever be *practically* necessary given specific socio-legal aims. It is these socio-legal aims that should be subject to ethical scrutiny (particularly in the context of a project of legal reform, as applies to a number of countries currently reviewing surrogacy regulations). National laws and healthcare-provider policies that restrict surrogacy to those for whom this is "medically necessary" codify the fiction that surrogacy can *ever* be medically necessary. Simultaneously, they mobilize normative ideals associated with the notion of medical necessity that imply an unjustified distinction between (supposedly) legitimate and illegitimate reasons for seeking surrogacy. The same unjustified distinction underpins healthcare-provider policies that allow assistance in surrogacy only to individuals or couples with specific identifiable medical conditions such as clinical infertility.

Notes

1. Baron T. *The Philosopher's Guide to Parenthood: Storks, Surrogates and Stereotype*. Cambridge: Cambridge University Press; 2023:116–22.
2. Some critics of surrogacy have objected in particular to the requirement that one's reproductive collaborator "disappear" from the social picture. See, for example, Ekman KE. *Being and Being Bought: Prostitution, Surrogacy and the Split Self*. North Melbourne, Victoria: Spinifex Press; 2013.
3. Groenhout RE. *Care Ethics and Social Structures in Medicine*. New York and London: Routledge; 2019.
4. Louisiana Act No. 494, 2016 Regular Session.
5. Illinois Gestational Surrogacy Act s. 20(b.1).
6. Finklestein A, McDougall S, Kintominas A, Olsen A. *Surrogacy Law and Policy in the U.S.: A National Conversation Informed by Global Lawmaking.* Sexuality & Gender Law Clinic, Columbia Law School; 2016 May:55–63.
7. See note 6, Finklestein et al. 2016, at 87–8.
8. Amoiridis C, Akritidou A. *Surrogacy Proceedings in Greece after the Implementation of Law 4272/2014.* Aspects of Greek Civil Law, Amoiridis Law Services, 2016 July:154.
9. Kerrigan Cl, Dale Collins E, Kim HM. Reduction mammaplasty: Defining medical necessity. *Medical Decision Making* 2002;**22**(3):208–17.
10. Caulfield TA. Wishful thinking: Defining "medically necessary" in Canada. *Health Law Journal* 1996;**4**:63–85.
11. Caulfield T, Zarzeczny A. Defining "medical necessity" in an age of personalised medicine: A view from Canada: Insights & perspectives. *BioEssays* 2014;**36**:813–17.
12. Skinner S. Defining medical necessity under the patient protection and affordable care act. *Public Administration Review* 2013;**73**(s1):S49–59, 49.
13. Here, "health" is understood as some acceptable baseline condition, rather than the maximal level of enhancement that could possibly be achieved. On this understanding, for example, surgery to remove cataracts would be medically necessary, but not laser eye surgery giving the patient completely perfect vision.
14. Mclean SAM, Mason JK. *Legal and Ethical Aspects of Healthcare*. Cambridge: Cambridge University Press; 2003:99.
15. Notini L, Gyngell C, Savulescu J. Drawing the line on in vitro gametogenesis. *Bioethics* 2019;1–12, 4.
16. Sparrow R, Is It "Every man's right to have babies if he wants them"?: Male pregnancy and the limits of reproductive liberty. *Kennedy Institute of Ethics Journal* 2008;**18**(3):275–99, 284.
17. See, for example, Kingma E. What is it to be healthy? *Analysis* 2017;**67**(294): 128–33.
18. Boorse C. Health as a theoretical concept. *Philosophy of Science* 1977;**44**(4): 542–73.
19. Nordenfelt L. On the notion of health as ability, *Scandinavian Journal of Occupational Therapy* 2014;**21**(supp. 1):48–52.
20. Many thanks to Ian Dunkle for raising this point.
21. See note 19, Notini et al. 2019, at 4.
22. See note 19, Notini et al. 2019, at 5.
23. See note 19, Notini et al. 2019, at 5.
24. While not curing myopia as laser eye surgery would, the prescription of glasses or contact lenses may be seen as a medical intervention on the common-sense understanding of this concept, as glasses/contact lenses act on the physiological dispositions of the patient. It is interesting to note that 1–3 rounds of IVF will be covered on the NHS, but glasses and contact lenses are not; if taken at face value this would seem to imply that babies are essential to health while eyesight is an eccentric luxury.
25. Dickenson D. *Property in the Body: Feminist Perspectives*. Cambridge: Cambridge University Press; 2017:69.
26. Consider, for example, the old strategy of legitimizing women's access to contraceptives by appeal to medical necessity (e.g., referring to the use of hormonal contraceptives in reducing menstrual pain or

curing hormonal acne), when simple appeal to women's autonomy was considered insufficient justification.

27. Cavaliere G, Palacios-González C. Lesbian motherhood and mitochondrial replacement techniques: Reproductive freedom and genetic kinship. *Journal of Medical Ethics*. 2018 Dec;**44**(12): 838.
28. See note 27, Cavaliere and Palacios-González 2018, at 840.
29. Kleeman J. "Having a child doesn't fit into these women's schedule": Is this the future of surrogacy? *The Guardian* 2019 May 25, sec. Life and style; available at https://www.theguardian.com/lifeandstyle/2019/may/25/having-a-child-doesnt-fit-womens-schedule-the-future-of-surrogacy (last accessed 5 April 2023).

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