Elsevier required licence: © <2018>. This manuscript version is made available under the CC-BY-NC-ND 4.0 license http://creativecommons.org/licenses/by-nc-nd/4.0/

The Role of Professional Facilitators in Cross Border Assisted Reproduction

9/7/18

Jenni Millbank≈

Introduction

This research examines the roles of 23 professionals facilitating cross border reproduction, as part of a broader socio-legal study of the Australian experience of cross border assisted reproduction. We sought to understand how facilitators and service providers operate within a professional frame, examining their understandings of ethical limits on their roles within a largely unregulated and rapidly evolving international 'marketplace'.

Those who facilitate travel across international borders to pursue assisted reproduction are little understood (Inhorn and Gurtin, 2011, 668). Within the broader field of study of medical travel, most empirical studies have addressed facilitator websites (Cormany and Baloglu, 2011; Lee et al., 2014; Lunt and Carrera, 2011; Maguire et al., 2016; Mason and Wright, 2011; Penney et al., 2011; Sobo et al., 2011; Turner, 2012) or other promotional materials such as brochures (Crooks et al., 2011). A handful of studies have surveyed medical travel facilitator companies (Alleman et al., 2011; Peters and Sauer, 2011) or interviewed facilitators (Chee et al., 2017; Dalstrom, 2013; Holliday and Bell, 2015; Johnston et al., 2011; Lunt et al., 2014b, 2014a; Snyder et al., 2011; Speier, 2015, 2011). Perhaps unsurprisingly, researchers have found that facilitator companies emphasised the benefits of medical travel rather than the risks (Lee et al., 2014; Mason and Wright, 2011; Penney et al., 2011) and reported that facilitators did not consistently provide information about legal liability, regulatory oversight, emergency arrangements, or financial ties (Lunt and Carrera, 2011; Maguire et al., 2016). In general, researchers have analysed medical travel facilitators as *businesses*, often characterising them as a sub-set of tourism or mode of travel agency, or alternately analysing their operations as part of a system of *information flow*, and more recently with increasing

≈ Distinguished Professor of Law, UTS. Warm thanks to my colleagues Isabel Karpin and Anita Stuhmcke for all that was involved in collaborating on this project, to Norman O'Dowd and Rachel Carr for research assistance, and to the four journal reviewers for their detailed and thoughtful comments on this piece.

complexity, as dynamic *networks* (Lunt et al., 2014; Hanefeld et al., 2015) and international 'assemblages' (Chee et al., 2017).

In the smaller field of empirical research on facilitators and providers of internationalised assisted reproduction, feminist-oriented researchers have paid heightened attention to the relationships between providers and travellers. In foundational research on the facilitation of egg donation in the Czech Republic and Thailand, Amy Speier and Andrea Whittaker characterised the role of facilitators as one of 'intimate labour' (Whittaker and Speier, 2010; Speier, 2015; a characterisation echoed in Holliday and Bell's more recent analysis of those facilitating cosmetic surgery travel: 2015) in which small operations, run by those who are former patients themselves, provide both logistical and emotional support as an explicit dimension of their services. In the context of international surrogacy in India, Prabha Kotiswaran utilises the concept of 'relational work' drawn from economic sociology to characterise the role of doctors in clinics she observed negotiating the roles, emotions and expectations of intended parents and surrogates, and actively crafting meaning within those relationships (2013, 134).

Amy Speier states that, 'Intimate labour offers a way to understand how care, kinship work and economic transactions must be considered in tandem' (Speier, 2015, 27) and Whittaker and Speier have noted in their work that IVF brokers 'assert the primacy of affective relationships in their trade' (2010, 364). All of the professionals interviewed in the present research, to a greater or lesser degree, characterised their role as one of relational or intimate labour, overtly claiming the value of nurture and care in the provision of their services, and downplaying the commercial nature of the transaction or of their own motives.

Building on a feminist relational approach, rather than examining facilitators of fertility travel as a form of business or web-based marketplace, we sought to understand their roles within this frame of relational labour. This frame immediately prompts questions about to whom the facilitator owes allegiance or professional duties, most especially when the interests and needs of the relevant parties – patients seeking surrogacy or egg donation, reproductive contributors or 'assistors' providing eggs or surrogacy (Inhorn and Birenbaum-Carmeli, 2008), other professionals providing elements of the service 'assemblage' (Chee et al., 2017) – are

in actual or potential conflict. Thus, this analysis seeks to understand the operations of those facilitating or providing cross border reproductive services as a form of professional practice based within a web of commercial and personal relationships that form relational labour. We found that informal practice-based norms dominate current understandings of ethical conduct. These norms are largely implicit, and there appears to be little appetite to make them express, formal or binding; although it is suggested that there was some common ground among the interview cohort in terms of shared understandings of minimum standards of good practice.

Background

Relative to other Western Countries, IVF in Australia is liberal in access and somewhat affordable, with no limits on the number of cycles or age of women undertaking treatment, and substantial (although declining) public subsidies for treatment (Karpin and Millbank, 2014). However, surrogacy is highly regulated, with variable rules in different states for eligibility and approval processes, and strict post-birth consent based parentage transfer laws styled on the UK, which require court approval. Throughout Australia there are long-standing shortages of donor gametes; with long waiting lists for donor eggs, and much donor sperm obtained through importation (Millbank, 2015b). Both gamete donation and surrogacy take place within an overt framework of 'altruism' in which any payment beyond documented reasonable expenses is prohibited, and professional matching and intermediation is also prohibited (Karpin and Millbank, 2014).

Australian women travel abroad to undertake egg donation not because of 'push' factors such as legal restrictions, but rather due to the 'pull' of 'bioavailability' (Cohen, 2005): that is, to access donor eggs more quickly, and with a wider range of choice, than they are able to within Australia (Rodino et al., 2014, 1425; Millbank, 2015b). Common destinations for Australians seeking egg donation at the time of writing are South Africa, Greece, Spain and the USA.

Australian women and men who travel overseas to undertake surrogacy do so for a range of 'push' and 'pull' reasons including: local legislative barriers to access in some states (such as the exclusion of gay men from regulated surrogacy in some states), perceptions of unavailability or complexity of domestic surrogacy, the desire to access professional intermediation and matching services, the desire for (the appearance of) legal certainty

87 around parentage and surrogacy obligations, and the belief that overseas providers are
88 successful and accessible (Everingham et al., 2014; Rodino et al., 2014, 1425, 1426; Jackson
89 et al., 2017). When gay men undertake surrogacy, or when a female intended parent is unable
90 to contribute her own eggs, overseas surrogacy arrangements also include the use of egg
91 donation services. Common destinations for Australians in the 2000s seeking surrogacy were
92 India and Thailand; following regulatory crack-downs operators migrated across to Nepal and
93 Cambodia, respectively, as well as Mexico, before these jurisdictions, too, were shut down
94 (Jackson et al., 2017, 24; Everingham et al., 2014). Canada, the USA, Ukraine and Kenya
95 remain common destinations at the time of writing.

96

97 **Methods and materials**

98 The broader study examined the experiences of Australians who travel, both internationally
99 and within Australia, to undertake assisted reproduction. Semi-structured interviews took
100 place between June 2015 and June 2018 with a total of 93 interviews conducted. Interviews
101 were transcribed, anonymised, and entered into NVivo software to enable thematic coding
102 and analysis.

103

104 The total cohort comprised 66 interviews with patients[i] and 27 with professionals. Among the
105 patient group were 37 interviews with people who had travelled overseas. Countries travelled
106 to were: India, Thailand, Nepal, Mexico, Spain, South Africa, Greece, Canada, and the USA.
107 Ten participants travelled to more than one country in different attempts. Several
108 participants also undertook treatment with more than one provider in a given country in
109 subsequent pregnancy attempts. Twenty patient interviews involved participants who had
110 undertaken one or more surrogacy arrangements overseas (seven gay men, twelve women
111 and one man and woman interviewed as a couple). Seventeen interviewees involved patients
112 who travelled to undertake egg or embryo donation in order to try to achieve a pregnancy
113 themselves (16 women and one man and woman interviewed as a couple). Among
114 interviewees, 30 had children born as a result of CBRC[ii] and a further four participants were
115 pregnant at the time of interview.

116 Among the professional cohort were four professionals who only worked facilitating
117 treatment within Australia. Thus there were 23 interviews conducted with professionals
118 involved in CBRC; 12 by telephone and 11 in person. Interviews were semi-structured and
119 took between 40 and 90 minutes. Recruitment was targeted at services named by patient
120 interviewees in the study, as well as by members of on-line message boards examined in the
121 study, as those which they or others known to them had utilised. A number of other providers
122 were identified through their placement of advertising or sponsorship, or personal
123 appearance, at fertility 'roadshows' (Jackson et al., 2017) held within Australia and directed
124 primarily to Australian clients. Those services were also approached via email and, in a small
125 number of cases, in person at the relevant events. No provider declined to participate, but
126 four providers did not respond to requests. This targeted recruitment process reflected the
127 aim of the study which was to identify services utilised by Australians and, indeed, most
128 services reported a substantial proportion of Australian clientele.

129 Among the 23 professionals interviewed there were 11 women and 12 men. Eight were based
130 within Australia, while the rest were located in the USA (6), the UK, Canada and Greece (2
131 each), and Thailand, South Africa and Israel (1 each). Interviewees reported that they had
132 been in practice in their current occupation for between 1 and 20+ years, with an average of
133 12 years and a median practice duration of 9 years. Interviewees located abroad estimated
134 that between 20 per cent to 80 per cent of their international clientele were Australian. The
135 interviewees are grouped into three categories in this analysis: medical professionals, lawyers
136 and facilitators. However, as will be seen there was some overlap in the roles performed
137 between the legal and facilitator groups, as well as considerable variation in the roles
138 performed within those groupings. In semi-structured interviews, providers' views were
139 sought on what they 'value add' to their clients' experience, how conflicts of interest arise,
140 whether they reject clients, their views on unethical or improper practice and what role, if
141 any, regulation should play in improving or safeguarding their field from unscrupulous
142 players, particularly in the trans-national context.

143 The major limitation of our methodology lies in the self-selecting nature of those who
144 participated, in that they typically saw themselves as 'good' market players, and they had a
145 strong interest in showing a positive face of their operation to Australian researchers. In
146 addition, the dynamic and fast changing marketplace in cross border reproductive care (CBRC)

means that an overview of any operation or operator is very much a point in time snapshot. Moreover, it was not always clear if particular operators had commercial links with other providers or facilitators, such that purportedly distinct or arm-length arrangements could in fact be covertly enmeshed. Finally, the tightly knit networks of players and markets meant that interviewees were markedly reluctant to specify other providers whom they believed were operating unethically, possibly because such information might come back to harm their own business.

This next section outlines the main characteristics of, and divisions between, the professional groups. The major focus of this piece is upon those who fall outside the bounds of traditional professional disciplines (such as medicine and law) and whose ethical frame and sense of professional obligation is therefore less externally imposed and, I suggest, more individually shaped through their experience and practise.

I. Professional groups and characteristics

Four of the interviewees were medical professionals providing IVF services, all of whom were male. Their role in generating cross border reproduction was largely through marketing their expertise in egg donation and/or surrogacy to Australian clients (often directly, e.g. through participating in webinars or travelling fertility ‘roadshows’), drawing upon their experience, success rates, professional standing, personal charisma and access to a ready supply of reproductive contributors as ‘pull’ factors. The medical practitioners understood themselves to be a distinct profession in which their role was to ‘treat patients’, whether domestic or international, rather than as a source of egg donation or surrogacy services *per se*. However, two of the doctors’ medical practices directly recruited egg donors, and one directly recruited surrogates; the remainder dealt with surrogates or egg donors via one or more agencies that they worked with regularly. Two of the doctors had originally trained and worked in Australia, and all of them reported strong professional links and referral channels with Australian medical professionals.

Eleven interviewees were lawyers, of whom five were women. The services that they provided, and their conception of their role, varied widely. Five fit squarely within the commonly understood role of an independent legal professional; that is, they operated specialist practices providing legal advice on contracts, parentage and immigration issues for

clients who had engaged with a wide range of agencies and countries in undertaking surrogacy. However, for more than half of the lawyers their roles were far less clear. Two lawyers worked directly and exclusively for surrogacy or CBRC agencies as in-house counsel or as a one-step removed 'independent' lawyer working in a close association with the agency. Two lawyers owned and managed major surrogacy agencies (and related egg donation agencies) and also maintained related legal practices, and two other lawyers had an independent specialist legal practice plus a smaller side-business facilitating CBRC and/or surrogacy arrangements. All of the lawyers understood their legal role as jurisdictionally bounded; that is, they gave advice only on the law of their jurisdiction of practice. Because of the dual or multiple nature of legal regimes operative in CBRC this meant that it was common for lawyers to report that they repeatedly paired up with, and cross-referred to, other lawyers in relevant jurisdictions.

The remaining eight interviewees could broadly be characterised as 'agents' facilitating CBRC. Six of these interviewees were women who were directly involved in brokering arrangements between reproductive contributors and recipients, while the two men undertook more removed facilitation work through organising referral pathways. Of the men, Travis worked exclusively for a single foreign entity, channelling clientele to them as a direct agent located in Australia being paid a form of commission, while Alec's role was as an information clearing house, funded mostly by CBRC providers, marketing surrogacy and associated egg donation services to Australians and also providing specific advice services to intended parents. Neither man was himself involved directly in facilitating the individual arrangements that ensued.

In contrast, the six female facilitators provided or matched egg donors and/or surrogates with patients and intended parents as hands-on brokers of reproductive arrangements. These six women all ran their own businesses, mostly as sole start-ups that had grown to a cottage industry or small business incorporated as a private company with between four and six employees. In contrast the largest professional agency in the study was a major surrogacy provider with more than a dozen full time employees.

Notably, matching or brokering work also encompassed a variety of direct and supply chain conduct: some interviewees ran agencies in which they recruited, screened and selected egg donors and/or surrogates, while others recruited, screened and selected surrogates but drew

207 upon another agency or agencies to provide donor eggs. Even among surrogacy agents there
208 were very different levels of service provided, reflecting both commercial scale and
209 jurisdictional legal restraints. For example, Robyn ran a large US-based surrogacy agency
210 which provided very extensive screening and direct matching services; in contrast to Ruth's
211 small home-based surrogacy agency in Canada where it was unlawful to be paid a fee to
212 directly match parents and surrogates and she instead ran a closed website where previously
213 screened parties self-matched and then were provided with support services. Both large and
214 small agencies offered a variety of other practical support to patients beyond the
215 reproductive arrangement, often providing a range of 'concierge' services such as arranging
216 travel and accommodation and referring or linking clients with local IVF providers and lawyers
217 in order to facilitate treatment, legal parentage and travel documentation. Significantly, a
218 range of such services was also provided to reproductive contributors, including assistance in
219 travelling to medical appointments, taking injections, peer support groups and counselling.

220 The facilitators came from diverse professional and educational backgrounds. Two facilitators
221 had some training in counselling or social work, without having attained a formal tertiary
222 qualification, while others had trained in and previously worked in teaching, accounting,
223 embryology and health research.

224 A striking commonality among the eight heterogeneous facilitators was that all volunteered
225 that they had personal experience of assisted reproduction, both as patients and as
226 reproductive contributors. This reflects other qualitative research in the field which has found
227 that facilitators are frequently former patients whose business models and professional
228 practices were strongly informed by their own experiences and connections overseas (e.g.
229 Speier, 2015; Lunt et al., 2015; Holliday and Bell, 2015; see also Alleman et al., 2011). In our
230 study, three interviewees had children as intended parents through surrogacy prior to
231 becoming surrogacy facilitators; two facilitators volunteered that they had come into the field
232 having previously experienced infertility, two interviewees were repeat egg donors prior to
233 founding egg donation agencies (one had also recently been a surrogate) and one was a
234 former surrogate before founding her own surrogacy agency. In contrast only two of the 11
235 lawyers were parents through surrogacy, and none among the medical or legal group
236 volunteered that they had been reproductive contributors.

237 Unlike doctors and lawyers, the heterogeneous facilitator group did not have a shared
238 training, discipline or professional membership to constrain their conduct or shape their
239 ethical decision making. The unifying factor for the facilitator group was that they had created
240 their business through experience, and had an embodied claim to expertise, this strongly
241 informed their understanding of their collective identity as 'lay experts' (Speier, 2011, 595)
242 and of ethical standards. For this reason, the facilitator group is the major focus of this paper
243 but I also pay heightened attention to the 'hybrid lawyers' who owned agencies or performed
244 faciliatory roles in addition to their legal role, because of the ambiguous professional and
245 ethical boundaries that this engendered.

246 II. What is the role of the facilitator, and what value do they provide

247 Krawiec suggests that in third party assisted reproduction generally, most intended parents,
248 surrogates, and gamete donors are in need of some form of professional intermediation
249 because they are 'not repeat players' and as such they interact with 'severe information
250 disparities' (Krawiec, 2009, 236). Elsewhere, I and others have argued that high quality
251 professional intermediaries may be helpful in third party assisted reproduction, for instance
252 if they assist in negotiating expectations, matching personalities and needs, providing
253 information, support and counselling, or monitoring and ensuring quality (Krawiec, 2009, 234;
254 Millbank, 2015a).

255 Analysing the ways in which facilitators spoke of what they do, and how this is of value to
256 their clientele, revealed a number of themes: specialist knowledge, quality control, and
257 support services. Within all of these, but most especially in the area of 'support', was the
258 claim that the agent provided something unique and valuable to the client, unavailable from
259 other providers and necessary to a positive experience and/or outcome. While the specialist
260 knowledge claims were framed as forms of expertise, the quality control and support claims
261 were much more deeply imbued with the language of intimacy and affect.

262 *Specialist knowledge and 'navigation'* were stressed by arms-length facilitators such as Alec
263 and Travis, as well as by lawyer/facilitators Mark and Justine and lawyer/agency owner Talia.
264 Alec was at pains to characterise his role as neither an advisor nor a facilitator in potentially
265 unlawful commercial surrogacy arrangements; 'really it's not a legal service, it's really one
266 parent giving advice to another parent' (Alec, information facilitator). Likewise, Travis

267 described himself as a 'local communication piece' or 'client manager' for a large multi-
268 national surrogacy provider. Travis explained that he is not facilitating commercial surrogacy
269 because he 'doesn't sign the contracts', adding, 'I'm just the person that is a channel of
270 information back and forth.' Travis said that the value he provides is that when engaging in
271 surrogacy abroad, 'you're jumping in with no parachute':

> 272 'I felt if I can be that peace of mind for people, also chase up the other end and be that
> 273 advocate…to make sure [the company] is doing what they say they're doing and...to
> 274 make sure [the clients] understand the process…'

275 Mark is a lawyer with a 'project management company' for surrogacy that offers a fixed fee
276 'complete package service' in which he acts as middleman linking intended parents to
277 overseas IVF clinics and surrogacy and egg donation agencies. Mark also has a 'legal side'
278 undertaking immigration and parentage work for another fixed fee. Mark reported that his
279 service has a 'value add' in representing the interests of Australian clients to overseas
280 agencies because they are often not at arms-length from the lawyers they utilise, and also
281 through his repeat work with the agencies in garnering better services for his clients, because
282 otherwise an intended parent 'on their own is just another little fish.'

283 Lawyer and agency owner Talia stressed the benefits of her 'complete service' covering both
284 'legal and logistical services of surrogacy abroad.' Talia's surrogacy agency based in Israel
285 directly runs a surrogacy provider in Ukraine as well as a series of supply chain arrangements
286 in other countries; the 'organisational' elements of surrogacy she manages include the
287 movement of doctors, egg donors, embryos and gametes across international borders.

> 288 'I'm not a doctor, I'm not doing the IVF myself. I'm not a shipper, I'm not flying the
> 289 embryos myself. But it's choosing the right partners and struggling to protect the
> 290 rights of the clients.'

291 In contrast, as discussed below, the six female facilitators directly negotiating reproductive
292 relationships focused much more upon quality control and support services as their
293 contribution. These claims were based much more squarely within the relational frame and
294 expressed as the provision of *care* or as caregiving labour.

295 *Quality control*

296 In keeping with the broader literature on medical travel facilitators, there was very little focus
297 on formal accreditation or objective safety measures when asserting 'quality' (e.g. Penney et
298 al., 2011; Snyder et al., 2011); rather it rested upon facilitators having personal knowledge of
299 a service and the personnel there. Three facilitators volunteered that they only worked with
300 clinicians who adhered to the voluntary professional standards for reproductive medicine in
301 their respective country, although none appeared to have knowledge of the more stringent
302 approach of Australian clinical guidelines concerning IVF compared to the country of
303 treatment (Millbank, 2015b).

304 Among the six female facilitators was a strong thread of having personally developed what
305 they regarded as a positive working model of their service (whether surrogacy or egg
306 donation), accompanied by close working relationships with particular clinical sites and
307 providers. All stressed that they invested care and resources into an intensive screening and
308 matching model which they regarded as responsible for high 'success rates': meaning the
309 satisfaction of both parties in the arrangements that they brokered, over and above the
310 completion of the arrangement without dispute. All six facilitators stressed that they sought
311 clinicians whom they regarded as trustworthy, safe and clinically competent. For most this
312 involved long-term reciprocal referral arrangements wherein they worked repeatedly with
313 the same clinicians or clinics. For Paige this involved annual visits to the clinics that she worked
314 with abroad, and a year-long process of evaluation before she would 'take-on' a new clinical
315 provider.

316 In Robyn's words,

317 'There are some doctors that I don't accept referrals from, there are just some doctors
318 that – I don't care, you can give me 100 clients, I don't like that doctor, I don't trust
319 that doctor, I'm not working with that doctor….When you've been in the field long
320 enough you pretty much know where most of the skeletons are. Whereas an
321 international couple might not know about the skeletons so we just simply say "I'm
322 really sorry we don't work with your doctor. He's got other agencies he or she can
323 refer you to."'

324 Within a web of professional and commercial relationships was a sense of personal
325 responsibility for their supply chain (Snyder et al., 2011), in that facilitators would not work
326 with clinical providers or other professionals who had treated their own clients or
327 reproductive contributors badly in the past. Saffy, who runs an egg donation agency said,

328 ‘we choose our clinics quite carefully, and we have stopped working with a doctor
329 because we didn’t like how he treated – not even on a medical level – how he treated
330 one of our donors. We’re quite on the ball with how we support our donors to make
331 sure they’re completely happy…I didn’t like how he spoke to her.’

332 Both Paige and Lisa reported that they had stopped working with clinics because the clinic
333 had practices that were risky to both donors (hyperstimulation) and recipient women
334 (multiple embryo transfer).

335 *Support services and relational labour*

336 Many facilitators characterised their role as ‘helping’ infertile people or as a form of *helping*
337 *profession*; indeed, more than one described themselves a ‘kind of counsellor’.

338 ‘Usually I like to tell people that I sell – I find beautiful women around the world to
339 help infertile couples that can’t have a baby. I’m an agent. I’m not – sometimes I act
340 as the matchmaker, but normally couples – I follow their lead…’ (Paige, egg donor
341 agency)

342 ‘I help people have babies. So, I help infertile couples to find an egg donor and then
343 support them emotionally through the process... I’m basically helping people to find a
344 suitable egg donor and then helping facilitate the donor’s appointments – basically
345 being a middleman between the clinic and the couple.’ (Saffy, egg donor agency)

346 ‘I am a consultant and a lot of times I just tell people I do infertility counselling,
347 because primarily what I’m doing on the phone all day is listening to many intended
348 parents and their journeys and their stories and their loss, and what decision is best
349 for them…’ (Ruth, surrogacy agency)

350 Within these claims was a consistent claim to emotional investment, personal presence, and
351 care. Saffy explained her role in shorthand as ‘handholding’, stressing this emotional link as a
352 vital part of the chain between patients and clinicians:

353 ‘The clinics are obviously far too busy to sit and do handholding…that’s where we step
354 in. We do handholding. I let people cry on my shoulder. I take phone calls at four in
355 the morning, if somebody’s period has started and it’s not supposed to…we’re in a
356 very, very emotional industry [and we help it] run a little bit smoother, for the benefit
357 of everybody, including the clinics because the doctor and nurses have more than
358 enough on their hands without somebody saying, ‘Oh I’m not going to be a good Mum’
359 or ‘Does the donor have curly hair – I’ve just woken up and thought it is just wavy or
360 is it actually curly?’ Little things that play on people’s minds, when you’ve got quite a
361 stressful choice and situation.’

362 The relational nature of the labour of facilitators was particularly inflected with the idioms of
363 intimacy for the six women who directly broker arrangements between reproductive

providers and egg recipients and intended parents. In these relationships the facilitator was personally present and claimed an investment in the emotional well-being of parties that she, and her team, were responsible for.

Among the six female facilitators who arranged reproductive relationships, all characterised their role as one of managing the relationship, mediating information and 'matchmaking'. Indeed, it was notable how often the language of romance seeped into interviews. Ruth said that, 'You always have to see surrogacy relationships as they're no different than romantic relationships, in the sense that you have to have certain etiquette with things.' Ruth explained for example that she would 'gently broach' topics if there appeared to be trouble brewing between a surrogate and intended parents but 'it's like your best friend going to your spouse if you're upset with your spouse.' Similarly, Paige described recipient couples as 'in love' with their donor, and the donor with them.

Paige explained that she assiduously fostered the relationship between donors and recipients through a structured exchange of notes and gifts; for example, a letter of appreciation from the recipients to the donor at the time when she is injecting hormones, 'It makes this couple real. She is no longer just giving eggs to a clinic', and a gift basket to her when she is recovering from egg retrieval. Paige, Saffy and Robyn all mediated contact with handwritten cards and gifts as a customary part of their practice, encouraging gifts which came from the recipients' cultural or country background and 'made them real' for reproductive contributors. Robyn also encouraged surrogates to take their own children shopping for a small baby present for the intended parents, in order to engage them in the relationship.

Interestingly, Paige also noted that her role in mediating communication was to 'protect' young and self-sacrificing donors by keeping them apart from recipients.

> 'She's this young innocent woman for the most part. Until she's at least 35 and no longer donating I feel I need to keep their direct contact separate.'

Paige went on to relate the story of a past donor from her service who had been approached directly by recipients (when they had seen her at the clinic abroad where they were all undergoing treatment) and persuaded to donate for them again without any payment, moreover at a cheaper and less safe clinic. In this anecdote, Paige downplayed her role as a

393 service provider to the clients and instead emphasised her ethical responsibility to 'protect'
394 the egg donor from those who might take advantage of her.

395 Just as they stressed their emotional investment in their work and the well-being of both their
396 clients and the women who form their supply chain, facilitators downplayed the commercial
397 aspects of their operations. Both Alec and Ruth went to some pains to stress that they had
398 provided free advice to others seeking surrogacy for a considerable period of time before
399 commercialising because, in Ruth's words, 'I just couldn't manage working in a family and
400 running it for free…' Likewise Mali, Paige and Robyn all volunteered that they asked only a
401 'fair' price for their services, and that they were not wealthy or motivated by money.

402

403 The marketplace in which facilitators were operating is one in which there were few, if any,
404 formal professional or ethical codes of practice in operation (recollecting that three stated
405 that they abided by local peer regulation in the form of ART guidance, and noting that four
406 facilitators had signed onto a US-based voluntary code of practice for egg donation and
407 surrogacy services).[iii] Yet in international treatment even more than domestic third party
408 reproduction, there is the potential for serious power disparities between intended parents
409 and reproductive contributors, as well as informational disparities between intended parents
410 and 'repeat players' in service provision. Particularly given that facilitators saw themselves as
411 'taking care' of their reproductive contributors *and* patients at the same time as the patients
412 were the paying clients, we sought to elucidate professionals' sense of ethical codes by
413 examining their views on conflicts of interest and client refusal.

414

415 **III. Ethical duties and limits**

416 In order to explore in a concrete way participant's views about the role of regulation we
417 asked: 'Do you see any conflict of interest in your role? Are there any clients you have turned
418 away, and if so, why? Are there any other providers you have concerns about?' This allowed
419 us to explore specific examples before turning to the more abstract question of: 'Do you think
420 that there should be some regulation of your industry?' Interviewees were markedly reluctant
421 to acknowledge that they experienced conflicts of interest in their own role, but many

expressed concerns about the sharp practice of other players, or had a 'horror story' to tell. Many professionals were concerned to reduce or avoid such bad practice in the future, but were cautious about whether external regulation could provide the appropriate framework to do so.

Conflict of interest

Conflicts of interest may arise when professionals undertake multiple roles, when professional's engagement with other actors in arrangements is not arms-length, and when professionals are engaged with both reproductive consumers and contributors. Because of the open-ended nature of the question, respondents were able to focus upon any aspect of their role.

Facilitators Robyn, Paige, Lisa and lawyer/facilitator Mark were all strongly critical of agents and lawyers having merged roles and responsibilities or not operating at arms-length, and Robyn extended this criticism to doctors in another jurisdiction:

> 'I don't think that an owner of an agency should also be the attorney or the psychologist or own their own egg donation program or be a doctor. I think there needs to be a separation of professionals… Many of the cases that have gone wrong in America, when you analyse those cases it's because there was one person that was doing several things. It's what went wrong in India. The reason why surrogacy in India failed in my opinion is because a surrogate mum didn't have access to a counsellor and one doctor controlled everything.' (Robyn)

In contrast, none of the professionals who themselves undertook multiple roles volunteered that this gave rise to any conflict of interest. Two lawyers who also ran facilitation agencies explained that they had done so to deal with client demand that was placing a strain upon their legal practice.

According to Mark

> 'even though I was offering my legal services to people, people were calling upon me for a lot more, that wasn't just related to legal advice. It was more emotional support [and practical advice]… So we then decided that, look, all this work we're doing – because I offered my services for the entire duration, and I found it was just making no commercial sense. Because I was on tap – I never refused someone's call…So people had me on-call and they were using it.'

Likewise, Justine launched a separate entity,

> ‘because we had so many parents who were coming to us for legal advice and booking an hour long meeting and staying four hours. Because actually what they wanted to do was use the experience that we’ve gained from all the other clients we’ve helped about the practicalities and the risks and the costs and the different jurisdictions and how things worked and who to talk to and how to do it safely and ethically and so on. So we found that we just had this pool of practical knowledge and we needed to find a way of being able to help people.’

Three lawyers had attempted to hive off their facilitation work through setting up a distinct legal entity to undertake it – either in company form or in the name of a spouse who was also involved – thus clearly indicating an understanding that such work could be in conflict with some aspects of their obligations as a legal professional. (Similarly, facilitator Alec utilised the insider knowledge that he gained from his non-profit entity to provide specialist advice as a paid agent.) Interestingly, however, all spoke of cross-referring clients between the services and of themselves as operating across both services in a manner that was beneficial to clients because of the specialist knowledge that each ‘arm’ could bring to the other – rather than identifying this as potentially impacting upon the independence of advice.

Most interviewees emphasised the importance of close working relationships between professionals in the field in terms of ensuring quality control for clients, and again did not identify this as a source of potential conflict, i.e. if the closeness of such relationships impaired the independence of their advice or that of the other professionals. For example, lawyer/facilitator Justine reported that she has been ‘very fierce’ about ‘protecting our independence and our ability to advise our clients completely dispassionately’ and so did not have ‘official arrangements’ with any particular overseas surrogacy agencies or clinics. However, she also acknowledged that there were ‘really specialist and experienced’ agencies and attorneys with whom they worked repeatedly and cross-referred. Facilitator Saffy reported a co-operative working relationship with another egg donation agency (which was in a commercial sense her biggest competitor) in that they would warn each other about unreliable donors and also cross-refer clients whose particular needs they were unable to meet. Saffy characterised this as client-centred behaviour in that she and her competitor, whose ethical standards she respected, were together ensuring that client needs were met.

In a similar vein, lawyer Joan who worked providing advice to both intended parents and reproductive contributors on different matters, described herself as closely connected to a network of other lawyers who acted in surrogacy and egg donation arrangements. Joan

explained as 'lawyer screening' her decision not to act for certain people, within a co-operative commercial network in which professional rules such as lawyer-client privilege were properly observed. In a situation in which she was acting for a party whom she believed would break the agreement (such as an egg donor who was proving unreliable) or other 'fundamental problem',

> 'the lawyers that I work closely with, we have a code because we can't disclose what the privileged conversation was. So the code is I'd call the other lawyer and say 'I can't continue on this matter'. Then that lawyer would say to the parents 'you can't have that surrogate' or 'you can't have that donor. We don't need to know why because Joan won't do it.''

For those whose income was drawn from particular service providers, commercial conflicts of interest were starker. For example, Alec saw his role as 'informing consumers about best practice and making sure they're not getting ripped off and keeping agencies honest' but acknowledged that an income model which drew significantly upon 'sponsorship' from CBRC providers meant that 'we tend to have to chuck sponsors out quite regularly because we've found out they're doing something that isn't working legally for people.' Travis, who was paid by one particular surrogacy agency, explained that his role was 'advocat[ing] for the client as much as possible, but I guess I'm technically working for [the company].' This finding reflects that of Snyder et al's study of Canadian medical travel facilitators, who described their role strongly as one of advocating for patients ('from an ethical standpoint, my responsibility to the patient is … I really am that patient's physician one-step removed': 2011, 532) at the same time that they were paid primarily by service providers.

The lawyers all frankly acknowledged that the bulk, or entirety, of their clientele was made up of reproductive 'consumers' not reproductive contributors, because they are the paying customers. As lawyer David says 'its necessarily the case that our practice [is] reflective of the market, that most of those clients are intended parents, not surrogates.' As long as a surrogate had her own legal advice, distinct from that provided to the intended parents, the lawyers interviewed were content that there was no conflict. Only one medical professional volunteered a sense of conflict in that he was making decisions for intended parents that were not necessarily in the best interests of the surrogate, noting that the high rate of caesarean births in surrogacy could be seen as an unnecessary operation for the surrogate and represented a 'compromise with morality sometimes' (George, doctor).

In contrast, those involved directly in brokering and matching services acknowledged the division of loyalties that arose when working with reproductive consumers and contributors. To varying degrees, all six female facilitators argued that although the intended parents or recipient woman was their *client*, they did not overlook the interests of the surrogate or egg donor. Indeed some argued that they went out of their way to 'protect' the women who are reproductive contributors:

> 'The intended parents are my only client, because they sign a contract with me. But I am the protector of my surrogate mums. … So my job is to be as fair between both parties as I possibly can, otherwise I'm going out of business.' (Robyn)

Robyn also said that she when she recruited the surrogates she had made a 'verbal promise' about levels of reimbursement of costs and payment, and so felt obligated to fulfil that promise, even though the actual contract was made between the intended parents and surrogate and she was not herself party to the contract.

Paige argued that that her primary responsibility is to the donors:

> 'first and foremost my responsibility is for – as a company – is to the donor. We're absolutely not going to jeopardise the health or safety or wellbeing of a young woman for the fertility of someone else…Most of our couples understand that. They understand that they're second in this whole procedure.'

Paige, Robyn, Saffy, Lisa and Ruth all provided strong support services to surrogates and donors; they had separate and specialised personnel for dealing with intended parents and recipients, with clearly delineated roles for counsellors and support workers. Paige noted that it is very important for a donor to have 'her own advocate', and for intended parents too, so there is 'not the same person trying to juggle both of them.' It was common for donor support workers and surrogate support workers in these agencies to be former donors/surrogates themselves. For example, Ruth's five surrogate support workers were all former surrogates because she regarded it as vital for surrogates to speak to someone 'who has been through it and understands.' She noted that, 'It's very hard for a surrogate to get all of her support from the intended parents. I think it's essential that they have peer support…'

While reproductive consumers are clients, the success and reputation of the agency with those who are reproductive providers was a very significant part of the working model of the industry. All of those involved in brokering reproductive arrangements, whether in surrogacy

550 or egg donation, utilised a word of mouth chain recruitment system in which former egg
551 donors or surrogates sent them new contributors. As Robyn put it, the parents are her clients,
552 'but without surrogate mums I don't exist in this world'. The value of the *reputational capital*
553 (Krawiec, 2009, 236) that brokers amassed not just among clientele but throughout their
554 network of reproductive contributors, should not be underestimated. I suggest that this
555 capital was jealously guarded by those who held it, and that a number of interviewees saw it
556 as acting as an important form of quality control in the market.

557 *Client refusal*

558 More than one interviewee frankly acknowledged that they had never turned away a client;
559 however, this was said to be because their referral system had already filtered out
560 problematic clients, and all interviewees reported that they would deny service in certain
561 circumstances. There were very few articulated or 'hard and fast rules' about exclusion of
562 clients, it was more a question of what didn't 'feel right' (facilitator Paige).

563 Most facilitators and some lawyers required as a condition of their services that clients
564 undertake a criminal record check, or a personal reference check if this was not possible
565 because of the country of origin of the parents. Two reported that they had refused to work
566 with a client who disclosed criminal convictions for child pornography or sexual violence,
567 while one noted that he had accepted a client with a criminal record for another form of
568 criminal offence that he did not regard as 'incompatible with good parenting.' Two agents
569 and one lawyer acknowledged that the background checking for intended parents was far less
570 rigorous than that undertaken on surrogates.

571 Interviewees from all professional groups reported declining a client couple where the
572 relationship between the intended parent couple was 'rocky' or appeared to be a sham. For
573 the medical professionals and facilitators this was because they did not believe that the
574 couple would successfully complete the surrogacy arrangement; for the legal professional it
575 gave rise to a professional conflict as he was acting for both parties in the couple and believed
576 that their interests were in conflict.

577 No one reported that they declined service to same-sex couples; although some reported that
578 they undertook extra investigation when the client for surrogacy was a single man.

579 A few doctors and facilitators said that they were not 'comfortable with' or refused to act for
580 'older' clients, even if there was no age limit in the relevant jurisdiction relating to the
581 provision of IVF. For Alec this meant those over 50; for Talia it was over 60. Alec was also not
582 'comfortable' with surrogacy for those who already had children but were seeking more,
583 giving the example of those with age related infertility in second marriages seeking more
584 children: 'Well look, so there's a sense among many of us that you should prioritise surrogacy
585 for people who are childless.' Conversely, Paige reported 'ignoring' requests from a gay male
586 couple seeking surrogacy whom she regarded as too young (under 25).

587 Two facilitators and one lawyer reported refusing clients whom they believed had
588 approached surrogacy in an overtly commodifying manner (such as seeking multiple
589 simultaneous surrogates, suggesting that they would choose 'the best' baby, or offering to
590 buy babies for adoption).

591 Several interviewees stressed that it was not for them to 'make value judgments' (facilitator
592 Alec), 'impart my personal belief system upon the clients' (lawyer Nigel) or 'to decide who
593 can have a child and who cannot have a child' (Lucas, doctor). This prevailing view was that it
594 was for clients themselves to judge their own suitability to parent and that professionals were
595 neither equipped nor inclined to do so.

596 However, there was a minority who saw themselves as 'gate-keepers'. Paige acknowledged
597 that, 'I am the one that judges if they are going to be good parents or not, because that is
598 what I am looking for.' Four interviewees stressed that they would only accept clients who
599 agree to what they regard as an ethical or workable model for surrogacy or egg donation. For
600 those facilitators, their commitment to their model of 'successful' or 'good' practice required
601 a commitment to relationality in the process; that is for intended parents to be willing to form
602 a relationship with the surrogate before and during the pregnancy and/or for egg donors to
603 be identifiable at a later point to donor conceived children. This was not so much a judgment
604 on parental suitability as it was a commitment to what they believed was a successful model
605 of practice in their field.

606 Taken together, it appeared that the interviewees largely saw their mission as assisting the
607 alleviation of infertility (defined as both medical and social infertility inclusive of gay men),
608 working from a presumption of fitness of intended parents that could be rebutted by clear

609 evidence of past harm to children or by strong indications of current relationship, or
610 emotional, instability. Within that frame, eligibility requirements or background checks for
611 intended parents were limited, and client refusal was uncommon. As will be seen below,
612 interviewees were generally more concerned about the unethical practice of other market
613 players than they were about the suitability of their clients.

614 *Unethical providers*

615 All of the facilitators, and many of the lawyers, acknowledged that the unregulated nature of
616 cross border reproduction meant that unqualified and unethical players were rife. Alec noted,
617 'It is the wild west in surrogacy still… Any Joe Blow can open up a surrogacy agency…'.

618 Several interviewees reported that their clients had paid thousands of dollars to other
619 agencies or facilitators who had then shut up shop and disappeared. As lawyer David put it
620 there are 'plenty of sharks in the water.' Lawyer/facilitator Mark said, 'if you're looking for
621 crooks, this is the industry to find them in. There are so many people out there who are out
622 to make a quick buck.'

623 Alec, Mark, Talia and Bob were all strongly critical of agencies which 'sold' clients into
624 countries where they did not actually have staff on the ground. Alec characterised these
625 agencies as 'outsourcing' the crucial elements of recruitment and 'just taking a cut at the
626 start.' Mark volunteered as one 'shocker' a person

> 627 'with about 20 different domain names …and he basically is a channel to different
> 628 agencies. So he just like takes commission and passes you onto someone but doesn't
> 629 – you never hear from him or see him again…you have people who are setting up their
> 630 little business from home, and saying, 'hey we can be a surrogacy agency'. All they
> 631 really are is really an introduction agency to another agency.'

632 When serious problems arose, such as regulatory shutdowns in India or Thailand, or natural
633 disasters such as in Nepal, arms-length agencies who were not located within the relevant
634 country were seen as more likely to cut and run: for example, Alec named one agency who,
635 'once Thailand closed down they said oh well you're on your own now everybody, you can
636 get babies out on your own.'

Several interviewees, particularly lawyers such as Frank, Joan, Mark, and Talia, were very critical of both facilitators and lawyers who 'set up shop' with little or no experience. Frank reported,

> 'operators around town who jumped on the surrogacy bandwagon and they include medium to large sized law firms who obviously have the marketing budget to get their name out there, but I just think their clients are probably getting an inferior service and inferior advice.'

Talia noted that in Ukraine there were women who 'today she opened an agency because yesterday she was a donor and she thinks she knows what to do.' In Bob's words, 'anybody can call themselves an agency.' Bob expressed concern that former parents through surrogacy and former surrogates, who set up agencies when they lack legal background or social work skills, don't understand the law and don't do proper screening. In contrast, facilitator Saffy stressed that her faith that 'we're all on the same ethical road' in her field was precisely because in her jurisdiction,

> 'Most of the agencies have been started by women who have either undergone the IVF process themselves, or been egg donors. So we've all had experience in the field…'

Examples of specific conduct which interviewees regarded as unethical practice by other agencies or providers included: Utilising surrogates who have not yet had their own children; not carefully matching surrogate's and intended parent's views on pregnancy termination; not requiring intended parents to be present at the birth (and not informing the surrogate that they intended to be absent); advertising for egg donors in 'low income' areas; paying egg donors excessive sums; utilising the same egg donors more than a certain number of times; performing multiple embryo transfers (more than two at a time); not ensuring that intended parents and children are genetically related before issuing documentation relied upon for legal parentage; and not refunding payment to egg recipients when an egg donor withdrew from donation.

Overwhelmingly, participants understood their own ethical duty to be limited to service denial; only two professionals, both lawyers, referred to a situation where they had 'blacklisted' a provider or taken other active steps such as alerting other professionals to a situation which they regarded as improper. In general, the approach was very much one of 'live and let live', in which undesirable clients or unethical providers were quietly withdrawn

668 from (or indeed in the case of one medical professional, referred to each other when he did
669 not wish to engage with them) but not confronted; the market was trusted to 'find its own
670 level'. Saffy noted that in her view agencies 'who don't run ethically don't last long, because
671 the clinics won't refer people to them.'

672 Interestingly, Alec and Talia turned the question to the conduct of the local Australian fertility
673 industry, rather than CBRC providers. In Alec's view, 'profit driven' Australian fertility clinics
674 behave unethically when undertaking multiple unsuccessful IVF cycles for couples who have
675 very low likelihood of success, without suggesting egg donation or surrogacy. He argued that
676 such treatment was 'medically negligent'. Talia regarded it as unethical and a human rights
677 breach for Australian clinics to refuse to transfer patients' own gametes or embryos out of
678 their service and/or out of the country (in circumstances where the likely use was commercial
679 surrogacy).

680 *Regulation*

681 'Australians make a mistake often, we think that if there's an agency that has
682 something to do with health, fitness, it must have a licence from the government.
683 That's how we operate… But the reality of the surrogacy agencies in the US and
684 Canada is that they don't, they simply don't.' (Alec)

685 Very few of the participants supported any form of external regulation of their industry.
686 Within the facilitator group however, four suggested that peer regulation and industry norms
687 should be articulated to establish and promote accepted minimum standards of conduct
688 (reflecting the findings of Snyder et al's study of Canadian medical travel facilitators, some of
689 whom also expressed the desire for increased regulation).

690 Ruth, Lisa, Robyn and Paige all expressed the view that regulation should reflect existing best
691 practice standards; which they saw as very much their own model of practice based on many
692 years of experience. In Robyn's words, 'So if you did surrogacy correctly then the law would
693 not need to react to it, it would follow the rules which have been set [in the industry]'. One
694 facilitator had been involved in setting up a peer accreditation process for providers in her
695 field. In her view an overt commitment to minimum ethical standards meant a smoother
696 industry and less likelihood of regulation being externally imposed. Four facilitators had
697 already joined a voluntary US-based industry code for surrogacy and egg donation, although

698 two reported the view that it had been insufficiently adhered to by other members and one
699 reported that it 'lacked teeth' in terms of sanctions for non-compliance.

700 A number of professionals working within ostensibly altruistic systems (Australia, the UK and
701 Canada) such as Frank, David, Ruth and Justine, argued that removing legal restrictions on
702 commercial surrogacy would ultimately enable a more ethical and regulated field. Justine for
703 example repeatedly emphasised the extent of 'unhealthy' and 'underground' practice:

> 704 'Our frustration is that surrogates in [this jurisdiction] *are* compensated, and they're
> 705 not compensated much less than surrogates in the USA, so it is so unhealthy for people
> 706 because parents who are honest are anxious throughout the whole process.'

707 In addition, Justine was very concerned about the growth in people within her jurisdiction
708 matching in surrogacy arrangements unscreened through Facebook and other sites, 'People
709 are using these unregulated online ways of matching, the stuff we see is terrifying in terms of
710 the lack of information, and misinformation…'

711 Ruth expressed concern that agents and parents were routinely breaking the law on issues
712 such as expenses and that continued bans on commercial surrogacy impeded the opportunity
713 for overt and specialised regulation of professionals, whom she believed should be licensed
714 and subject to annual renewal of license. Frank argued that there should be specialist
715 accreditation in reproduction law, akin to family law accreditation, to prevent incompetence
716 and over-charging in the field.

717 **Conclusion**

718 This research sought to understand the role that facilitators and providers play in the travel
719 of Australians abroad for assisted reproductive treatment. The conduct of facilitators and
720 service providers was understood as a form of professional practice, based within a web of
721 tightly held relationships and enacted as a form of relational labour. A small number of closely
722 held and inter-linked entities in the largely unregulated CBRC field, with key personnel
723 occupying multiple roles in some cases, poses the prospect of commercial and professional
724 conflicts of interest, both real and perceived. We sought to examine how facilitators
725 understood ethical limits within their industry and their own conduct by probing how they
726 characterised the 'value add' of their role, what they understood to be conflicts of interest in

that role, their views on unethical or unscrupulous players and practices and their own standards on denial of service.

Inhorn and Gurtin note that,

> The specifics of CBRC organization, particularly as they pertain to 'hub' destinations and clinics, are essential in assessing the relevance of ethical and practical concerns raised by critical commentaries on CBRC, for developing adequate guidelines for professionals and patients and for directing policy strategies at the national and international level.
>
> … only by considering the mounting empirical evidence from a broad variety of global sites will professional organizations and regulatory bodies be able to set appropriate ethical guidelines and formulate effective policy. (2011, 668, 674).

This study found that informal practice-based norms dominate current understandings of ethical conduct in the facilitation and provision of cross border assisted reproductive services. When such norms were articulated, there was a degree of consensus among the participants, and particularly among the facilitator group, about minimum standards of practice within a broadly laissez faire context in which their role was to 'help people have children'. Broadly agreed standards included: minimalist eligibility standards for intended parents (indicated need for surrogacy, criminal record checks, relationship stability if in a relationship, but notably no other marital status requirement); rather more stringent eligibility standards for surrogates (including criminal record checks, relationship stability and support system, the birth of her own children and absence of financial need as a primary motivation); some form of separate representation of the parties in surrogacy and egg donation (both through independent lawyers and separate counsellors or support workers); ensuring that the clinical treatment of reproductive contributors and egg recipients was 'safe'; and matching protocols that aimed to fit the needs and expectations of contributors and recipients.

While participants were in general wary of external regulation, particularly in the form of legislation, not all were opposed to the prospect of some form of increased regulation, such as an increased role for peer regulation and guidance. Further engagement with facilitators and service providers of CBRC arguably presents a valuable source of expertise from which national and cross-border responsive regulatory frameworks could be informed in the future. Such hands-on experience could be well utilised if placed within a broader evidence-based framework, including the evolving social science research on outcomes for children in

759 surrogacy and donor conception (Blake et al., 2014; Jadva et al., 2012; Ilioi et al., 2015), egg
760 donor experiences (Almeling, 2011, 2014) and information needs and expectations of parties
761 in donor conception (Zadeh et al., 2018; Persaud et al., 2017).

762 While many forms of national regulation are arguably moot in the face of such dynamic
763 internationalised practices, I suggest that domestic regulators and agencies focused on
764 patient safety should consider first steps towards distilling and promulgating best practice,
765 such as accreditation of CBRC agencies or providers based on demonstrated minimum
766 standards, such that both patients and reproductive contributors can be better informed
767 about substandard operators and so that currently implicit industry norms and practices are
768 made explicit and transparent. Measures such as minimum standards would consolidate good
769 practice, allow the input of experienced professionals, and could be adapted and scaffolded
770 into later responsive regulatory measures, including through reforms to Australian surrogacy
771 and egg donation laws if the weight of evidence supported such changes.

772

773 **References**

774

775 Alleman, B.W., Luger, T., Reisinger, H.S., Martin, R., Horowitz, M.D., Cram, P., 2011. Medical
776 tourism services available to residents of the United States. J. Gen. Intern. Med. 26, 492–
777 497.

778 Almeling, R., 2011. Sex Cells: The Medical Market for Eggs and Sperm. University of
779 California Press, Berkeley, CA.

780 Almeling, R., 2014. Defining connections: gender and perceptions of relatedness in egg and
781 sperm donation, in: Freeman et al. (eds) Relatedness in Assisted Reproduction: Families,
782 Origins and Identities. Cambridge University Press, Cambridge, UK, pp. 147–161.

783 Blake L, Casey P, Jadva V, Golombok S., 2014. 'I was quite amazed': donor conception and
784 parent-child relationships from the child's perspective. Child Soc. 28, 425–437.

785 Chee, H.L., Whittaker, A., Por, H.H., 2017. Medical travel facilitators, private hospitals and
786 international medical travel in assemblage. Asia Pac. Viewp. 58, 242–254.

787 Cohen, L., 2005. Operability, bioavailability, and exception, in: Ong, A., Collier, J. (Eds.),
788 Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems. Blackwell
789 Publishing, Oxford, pp. 79–90.

790 Cormany, D., Baloglu, S., 2011. Medical travel facilitator websites: an exploratory study of
791 web page contents and services offered to the prospective medical tourist. Tour. Manag. 32,
792 709–716.

793 Crooks, V.A., Turner, L., Snyder, J., Johnston, R., Kingsbury, P., 2011. Promoting medical
794 tourism to India: messages, images, and the marketing of international patient travel. Soc.
795 Sci. Med. 72, 726–732.

796 Dalstrom, M., 2013. Medical travel facilitators: connecting patients and providers in a
797 globalized world. Anthropol. Med. 20, 24–35.

798 Everingham, S. G., Stafford-Bell, M.A., Hammarberg, K., 2014. Australians' use of surrogacy.
799 Med. J. Aust. 201 (5), 270–73.

800 Hanefeld, J., Lunt, N., Smith, R., Horsfall, D., 2015. Why do medical tourists travel to where
801 they do? The role of networks in determining medical travel. Soc. Sci. Med. 124, 356–363.

802 Holliday, R., Bell, D., 2015. Cosmetic surgery tourism, in: Lunt, N, Horsfall, D, Hanefeld, J
803 (Eds.), Handbook on Medical Tourism and Patient Mobility. Edward Elgar Publishing,
804 Cheltenham, pp. 421–430.

805 Inhorn, M., Birenbaum-Carmeli, D., 2008. Assisted reproductive technologies and culture
806 change. Annual Rev. Anthopolo. 37, 177–196.

807 Inhorn, M., Gurtin, Z., 2011. Cross Border Reproductive Care: A Future Research Agenda.
808 Reprod. Biomed. Online 23, 665–676.

809 Inhorn, M.C., Patrizio, P., 2012. The global landscape of cross-border reproductive care:
810 twenty key findings for the new millennium. Curr. Opin. Obstet. Gynecol. 24 (3), 158.
811 https://doi.org/10.1097/GCO.0b013e328352140a.

812 Ilioi, EC, Golombok, S., 2015. Psychological adjustment in adolescents conceived by assisted
813 reproduction techniques: a systematic review. Hum. Reprod. Update 21, 84–96.

814 Jackson, E., Millbank, J., Karpin, I., Stuhmcke, A., 2017. Learning from cross-border
815 reproduction. Med. Law Rev. 25, 23–46.

816 Johnston, R., Crooks, V.A., Adams, K., Snyder, J., Kingsbury, P., 2011. An industry perspective
817 on Canadian patients' involvement in Medical Tourism: implications for public health. BMC
818 Public Health 11, 416.

819 Karpin, I., Millbank, J., 2014. Assisted reproduction and surrogacy in Australia, in: Eekelaar, J.
820 (ed), Routledge Handbook of Family Law and Policy, Routledge, London, pp. 201–214.

821 Kotiswaran, P., 2013. Do feminists need an economic sociology of law? J. Law Soc. 40, 115–
822 136.

823 Krawiec, K., 2009. Altruism and intermediation in the market for babies. Wash. & Lee Law
824 Rev. 66, 203.

825 Lee, H., Wright, K.B., O'Connor, M., Wombacher, K., 2014. Framing medical tourism: an
826 analysis of persuasive appeals, risks and benefits, and new media features of medical
827 tourism broker websites. Health Commun. 29, 637–645.

828 Lunt, N, 2015. Networks and supply chains: the nature of medical tourism markets, in: Lunt,
829 N, Horsfall, D, Hanefeld, J (Eds.), Handbook on Medical Tourism and Patient Mobility.
830 Edward Elgar Publishing, Cheltenham, pp. 184–192.

831 Lunt, N., Carrera, P., 2011. Systematic review of web sites for prospective medical tourists.
832 Tour. Rev. 66, 57–67.

833 Lunt, N., Horsfall, D., Smith, R., Exworthy, M., Hanefeld, J., Mannion, R., 2014a. Market size,
834 market share and market strategy: three myths of medical tourism. Policy Polit. 42, 597–
835 614.

836 Lunt, N., Jin, K.N., Horsfall, D., Hanefeld, J., 2014b. Insights on medical tourism: markets as
837 networks and the role of strong ties. Korean Soc. Sci. J. 41, 19–37.

838 Maguire, Á., Bussmann, S., Köcker, C.M. zu, Verra, S.E., Giurgi, L.A., Ruggeri, K., 2016. Raising
839 concern about the information provided on medical travel agency websites: a place for
840 policy. Health Policy Technol. 5, 414–422.

841 Mason, A., Wright, K.B., 2011. Framing medical tourism: an examination of appeal, risk,
842 convalescence, accreditation, and interactivity in medical tourism web sites. J. Health
843 Commun. 16, 163–177.

844 Millbank, J., 2015a. Rethinking "commercial" surrogacy. Journal of Bioethical Inquiry 12, 477–
845 490.

846 Millbank, J., 2015b. Responsive regulation of cross border assisted reproduction. *Journal of*
847 *Law and Medicine* 22, 346–364

848 Penney, K., Snyder, J., Crooks, V.A., Johnston, R., 2011. Risk communication and informed
849 consent in the medical tourism industry: a thematic content analysis of canadian broker
850 websites. BMC Med. Ethics 12, 17.

851 Persaud S, Freeman T, Jadva V, Slutsky J, Kramer W, Steele M, Golombok S., 2017.
852 Adolescents conceived through donor insemination in mother-headed families: a qualitative
853 study of motivations and experiences of contacting and meeting same-donor offspring.
854 Child Soc. 31, 13–22

855 Peters, C.R., Sauer, K.M., 2011. A survey of medical tourism service providers. J. Mark. Dev.
856 Compet. 5, 117.

857 Rodino, I.S., Goedeke, S., Nowoweiski., S., 2014. Motivations and experiences of patients
858 seeking cross-border reproductive care: the Australian and New Zealand context. Fertility
859 and Sterility 102 (5), 1422–31. https://doi.org/10.1016/j.fertnstert.2014.07.1252.

860 Snyder, J., Crooks, V.A., Adams, K., Kingsbury, P., Johnston, R., 2011. The 'patient's physician
861 one-step removed': the evolving roles of medical tourism facilitators. J. Med. Ethics 37, 530–
862 534.

863 Sobo, E.J., Herlihy, E., Bicker, M., 2011. Selling medical travel to US patient-consumers: the
864 cultural appeal of website marketing messages. Anthropol. Med. 18, 119–136.

865 Speier, A., 2015. Czech Hosts creating 'a real home away from home' for North American
866 fertility travellers. Anthropologica 57, 27–39.

867 Speier, A.R., 2011. Brokers, consumers and the internet: how North American consumers
868 navigate their infertility journeys. Reprod. Biomed. Online, Symposium: Cross-Border
869 Reproductive Care – Ethical, Legal, and Socio-Cultural Perspectives 23, 592–599.

870 Turner, L., 2012. Beyond 'medical tourism': Canadian companies marketing medical travel.
871 Glob. Health 8, 16.

872 Whittaker, A., Speier, A, 2010. 'Cycling overseas': care, commodification, and stratification
873 in cross-border reproductive travel. *Medical anthropology*, *29*(4), 363–383.

874 Zadeh, S., Ilioi, E.C., Jadva, V., S Golombok, S. The perspectives of adolescents conceived
875 using surrogacy, egg or sperm donation. Human Reproduction, advance access
876 https://doi.org/10.1093/humrep/dey088

877

[i] This number does not include five additional follow-up interviews with patients who had been at the beginning of their process at the time of the original interview; these were counted as a single interview for each participant.
[ii] Three other interviewees who had undertaken CBRC later had children through other means: one through domestic surrogacy and two through domestic adoption/permanent placement.
[iii] Society for Ethics in Egg Donation and Surrogacy (SEED): see http://www.seedsethics.org