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Made in India: A Film About Surrogacy

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DVD

By Rebecca Haimowitz and Vaishali Sinha

97 min, color, Hindi/English (subtitled), pricing available from the distributor

New York, NY, Women Make Movies, 2010

Available for purchase at <http://www.wmm.com/filmcatalog/pages/c805.shtml>

What is now called “medical tourism” was once largely a privilege of the elite. England's Bath, Germany's Baden Baden, and Belgium's Spa all achieved fame as places for Europe's wealthy to “take the waters” as cures for various health ailments.

Modern medical tourism is a much more diverse phenomenon and has a different clientele. Many of today's medical tourists are patients of modest means who travel to less developed nations for treatment that is unaffordable at home and much cheaper abroad. Their trips may include sightseeing but are motivated primarily by financial considerations.

This new category of medical tourism is the subject of *Made in India: A Film About Surrogacy*. The film illustrates numerous clinical, legal, and ethical issues raised by medical tourism, both in general and in the context of surrogacy.

In the film, a childless couple from San Antonio, Texas, risks their savings to use a California-based medical tourism company to arrange for a surrogate pregnancy with an Indian surrogate mother. The couple lives in what appears to be, by US standards, a middle-income neighborhood. The surrogate mother, who has 3 children of her own, is illiterate and lives in Mumbai, where the clinic responsible for the assisted reproductive services is located. The couple flies to Mumbai, and after additional fertility treatment there, the genetic mother conceives. Several of her embryos are implanted in the surrogate.

In month 7 of a mostly uneventful pregnancy, the surrogate moves from her family's apartment to a surrogacy home. Shortly thereafter she experiences prepartum hemorrhage, at which point she is transferred to a large Mumbai hospital, where she gives birth to healthy twins by cesarean delivery. The twins are monitored in neonatal intensive care.

The surrogate mother remains in the hospital at least another 11 days, during which time the genetic mother (joined later by the father) has again arrived from the United States. In the interval, a dispute concerning the legal status of the twins has arisen among the genetic parents, the surrogate, and the hospital and clinic, requiring intervention by the US consulate. After a near stalemate, it is resolved in favor of having the birth certificate issued in the name of the genetic mother. The twins are granted US citizenship, and the couple returns to the United States.

At the end of the film, one of the twins is reported to have died from sudden infant death syndrome. The other remains healthy and is reported to be normal. Although the surrogate was paid much less than she was promised, and far less than the Texas couple was initially told she would be, she says that she plans to undertake another surrogacy in the future.

Made in India refrains from making explicit judgments about the issues it raises, but it highlights these issues in a way that constitutes a message. Both the genetic parents and the surrogate appear satisfied with their choices. Things might have been different, however, if the outcomes had been less favorable, and it is evident from the film that this could have occurred at any point in the process. Conception or implantation might not have succeeded. The surrogate mother could have died as a result of hemorrhage or surgery. The legal status of the twins might have been resolved in favor of the surrogate mother.

The film also suggests that the lines of responsibility among the medical tourism company in California and the clinicians in India were poorly drawn. This, combined with the distance involved and the disparate cultural and legal settings, appears to have impaired their ability to address unexpected problems as they arose. For example, the stalemate about the children's legal status could easily have remained a stalemate.

Similar difficulties would have confronted any effort to obtain recourse for adverse outcomes through litigation after the fact. Malpractice litigation is cumbersome enough in the United States. A lawsuit involving parties halfway around the world, in very different cultures, is orders of magnitude more challenging. Aside from specifically legal questions such as where a suit arising from these circumstances would be heard (Texas, India, or both) and which jurisdiction would provide the relevant legal standards, the practical costs of obtaining evidence and securing witnesses at such a distance would almost surely be prohibitive.

The ethics of surrogate motherhood have been extensively debated, but medical tourism casts a different light on these issues. For example, the surrogate mother received a little

more than \$100 per month for running the risks and bearing the burdens of pregnancy, raising questions of exploitation that have not been fully examined in this context. The extent to which the surrogate was able to provide informed consent to the procedure is also questionable, especially given her level of education. The film does not indicate, for example, whether she was advised of the possibilities of multiparity, hemorrhage, or surgery.

The medical tourism industry is expanding. As health care costs increase in developed countries it will almost surely continue to do so. *Made in India* tells the story of only a single case, and there is no reason to believe that it is representative. Other arrangements for medical tourism may be, and likely are, more reassuring than those depicted in this film.

Still, even a single case such as this points out the need for a far more coherent and serviceable international regulatory effort to govern this area of health care. It is unlikely that such an effort will soon be forthcoming. In the meantime, *Made in India* delivers an important cautionary message to patients considering medical tourism for themselves and to professionals advising them about this option.

AUTHOR INFORMATION

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