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The Role of professional facilitators in cross-border assisted reproduction

Jenni Millbank

University of Technology Sydney, PO Box 123 Broadway, NSW 2007, Australia
E-mail address: Jenni.millbank@uts.edu.au.



Jenni Millbank is a Distinguished Professor of Law at the University of Technology Sydney and Director of the Law Health Justice Research Centre. Her work broadly concerns the regulation of family, relationships and reproduction, with a current empirical research project on Australian experiences of cross-border assisted reproduction.

Abstract The operations of those who facilitate travel across international borders for access to assisted reproduction are little understood. Within the broader field of research into medical travel facilitators, most empirical studies have addressed websites and promotional materials, with few qualitative investigations of individuals who are service providers. The research presented here centres on interviews with 23 professionals facilitating cross-border assisted reproduction. This study sought to understand how facilitators and service providers operate within a professional framework, examining their understanding of the ethical limits on their roles within a largely unregulated and rapidly evolving international 'marketplace'. Broadly, participants trusted in the market to 'find its own level', such that unscrupulous players would not succeed because others would not refer to, or work with, them. In instances where a clear risk to the health of reproductive contributors or to the well-being of future children was perceived, participants understood their own ethical duty to be limited to service denial or withdrawal of participation. Among the eight facilitators who were not legal or medical professionals, there was a striking commonality, in that all had personal experience of assisted reproduction, both as patients and as reproductive contributors. Within this group, and particularly among the six women who directly 'matchmade' arrangements between intended parents, egg donors and surrogates, was a strong sense of 'embodied' expertise and claims to ethical practice based upon that expertise. 

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Introduction

This research examined the roles of 23 professionals facilitating cross-border assisted reproduction, as part of a

broader socio-legal study of the Australian experience of this area. The aim was to understand how facilitators and service providers operate within a professional framework, examining their understandings of the ethical limits on their

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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; Inhorn and Patrizio, 2012). 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 have interviewed facilitators (Chee et al., 2017; Dalstrom, 2013; Holliday and Bell, 2015; Johnston et al., 2011; Lunt et al., 2014a, 2014b; Snyder et al., 2011; Speier, 2011, 2015). Perhaps unsurprisingly, researchers have found that facilitator companies emphasized 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 characterizing them as a sub-set of tourism or a mode of travel agency, or alternately analysing their operations as part of a system of information flow and, more recently with increasing complexity, as dynamic networks (Hanefeld et al., 2015; Lunt et al., 2014a, 2014b) and international 'assemblages' (Chee et al., 2017).

In the smaller field of empirical research on facilitators and providers of internationalized 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, Speier and Whittaker characterized the role of facilitators as one of 'intimate labour' (Speier, 2015; Whittaker and Speier, 2010), a characterization echoed in Holliday and Bell's more recent analysis of those facilitating cosmetic surgery travel (Holliday and Bell, 2015) in which small operations, run by those who are former patients themselves, provide both logistical and emotional support as explicit dimensions of their services. In the context of international surrogacy in India, Kotiswaran utilized the concept of 'relational work' drawn from economic sociology to characterize 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 (Kotiswaran, 2013: 134).

Speier stated 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 noted in their work that in-vitro fertilization (IVF) brokers 'assert the primacy of affective relationships in their trade' (Whittaker and Speier, 2010: 364). All of the professionals interviewed in the research presented here, to a greater or lesser degree, characterized 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, this study 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), and other professionals providing elements of the service 'assemblage' (Chee et al., 2017) – are in actual or potential conflict. Thus, this analysis sought 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. Informal practice-based norms were found to dominate current understandings of ethical conduct. These norms are largely implicit, and there appears to be little appetite to make them expressed, formal or binding, although 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 limit set on the number of cycles or upper 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 those in 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 for treatment via 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 (Millbank, 2015b; Rodino et al., 2014: 1425). 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); 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 around parentage and surrogacy obligations; and the belief that overseas providers are successful and accessible (Everingham et al., 2014; Jackson et al., 2017; Rodino et al., 2014: 1425, 1426). When gay men

undertake surrogacy, or when a female intended parent is unable to contribute her own eggs, overseas surrogacy arrangements also include the use of egg donation services. Common destinations for Australians seeking surrogacy in the 2000s were India and Thailand; following regulatory 'crack-downs', operators migrated across to Nepal and Cambodia, respectively, as well as Mexico, before these jurisdictions were also shut down (Everingham et al., 2014; Jackson et al., 2017: 24). Canada, the USA, Ukraine and Kenya remain common destinations at the time of writing.

Materials and methods

The broader study examined the experiences of Australians who travel, both internationally and within Australia, to undertake assisted reproduction. Semi-structured interviews took place between June 2015 and June 2018, with a total of 93 interviews conducted (66 with patients¹ and 27 with professionals). Interviews were transcribed, anonymized and entered into NVivo software to enable thematic coding and analysis.

Among the patients, 37 interviews were with people who had travelled overseas. Countries travelled to were: India, Thailand, Nepal, Mexico, Spain, South Africa, Greece, Canada and the USA. Ten participants travelled to more than one country in different attempts. Several participants also undertook treatment with more than one provider in a given country in subsequent pregnancy attempts. Twenty patient interviews involved participants who had entered into one or more surrogacy arrangements overseas (seven gay men, 12 women, and one man and woman interviewed as a couple). Seventeen interviews involved patients who travelled to receive egg or embryo donation in order to try to achieve a pregnancy themselves (16 women, and one man and woman interviewed as a couple). Among the interviewees, 30 had children born as a result of cross-border reproductive care (CBRC)² and a further four participants were pregnant at the time of interview.

Among the cohort of 27 professionals, four only worked to facilitate treatment within Australia. Thus, 23 interviews were conducted with professionals involved in CBRC; 12 by telephone and 11 in person. Interviews were semi-structured and took between 40 and 90 min. Recruitment was targeted at services named by patient interviewees in the study, as well as by members of online message boards examined in the study, as those which they or others known to them had utilized. A number of other providers were identified through their placement of advertising or sponsorship, or personal appearance, at fertility 'roadshows' (Jackson et al., 2017) held within Australia and directed primarily at Australian clients. Those services were also approached via email and, in a small number of cases, in person at the relevant events. No provider declined to participate, but

four providers did not respond to requests. This targeted recruitment process reflected the aim of the study, which was to identify services utilized by Australians, and, indeed, most services reported a substantial proportion of Australian clientele.

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

The major limitation of the research methodology lies in the self-selecting nature of those who participated, in that they typically saw themselves as 'good' market players, and they had a strong interest in showing a positive face of their operation to Australian researchers. In addition, the dynamic and fast-changing marketplace in 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, so purportedly distinct or arms-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. The next section outlines the main characteristics of, and divisions between, the professional groups. The major focus of this article is 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 practice.

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 assisted reproduction was largely through marketing their expertise in egg donation and/or surrogacy to Australian clients (often directly, for example through participating in webinars or travelling fertility 'roadshows'), drawing on their experience, success rates, professional standing, personal charisma and access to a ready supply of reproductive contributors as 'pull' factors. The medical

¹ 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.

² Three other interviewees who had undertaken CBRC subsequently had children through other means: one through domestic surrogacy and two through domestic adoption/permanent placement.

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 recruited egg donors directly, and one recruited surrogates directly; 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 view 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 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. Due to 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 characterized 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 organizing 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 12 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 upon another agency or agencies to provide donor eggs. Even among surrogacy agents, there were very different levels of service provided, reflecting both commercial scale and jurisdictional legal restraints. For example, Robyn ran a large US-based surrogacy agency which provided very extensive screening and direct matching services; this is in contrast to Ruth's small home-based surrogacy agency in Canada, where it is unlawful to be paid a fee to directly match parents and surrogates, and she instead ran a closed website where previously screened parties self-matched and were provided with support services. Both large and small agencies offered a variety of other practical support to patients beyond the reproductive arrangement, often providing a range of 'concierge' services such as arranging travel and accommodation, and referring or linking clients with local IVF providers and lawyers in order to facilitate treatment, legal parentage and travel documentation. Significantly, a range of such services was also provided to reproductive contributors, including assistance in travelling to medical appointments, taking injections, peer support groups and counselling.

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

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

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

What is the role of the facilitator, and what value do they provide?

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

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

Specialist knowledge and 'navigation'

Specialist knowledge and 'navigation' were stressed by arms-length facilitators such as Alec and Travis, as well as by lawyer/facilitators Mark and Justine, and lawyer/agency owner Talia. Alec was at pains to characterize his role as neither an advisor nor a facilitator in potentially unlawful commercial surrogacy arrangements: 'really it's not a legal service, it's really one parent giving advice to another parent' (Alec, information facilitator). Likewise, Travis described himself as a 'local communication piece' or 'client manager' for a large multi-national surrogacy provider. Travis explained that he is not facilitating commercial surrogacy because he 'doesn't sign the contracts', adding, 'I'm just the person that is a channel of information back and forth'. Travis said that the value he provides is that when engaging in surrogacy abroad, 'you're jumping in with no parachute':

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

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

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

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

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

Quality control

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

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

In Robyn's words:

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

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

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

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

Support services and relational labour

Many facilitators characterized their role as 'helping' infertile people or as a form of helping profession; indeed, more than one described themselves as a 'kind of counsellor':

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

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

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

Within these statements was a consistent claim to emotional investment, personal presence and care. Saffy explained her role in shorthand as 'handholding', stressing this emotional link as a vital part of the chain between patient and clinician:

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

The relational nature of the labour of facilitators was particularly inflected with the idioms of intimacy for the six

women who directly brokered 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 for whom she, and her team, were responsible.

Among the six female facilitators who arranged reproductive relationships, all characterized 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:

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

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

The marketplace in which facilitators are operating is one in which there are few, if any, formal professional or ethical codes of practice in operation [recollecting that three stated that they abided by local peer regulation in the form of assisted reproductive technology (ART) guidance, and noting that four facilitators had signed onto a USA-based voluntary code of practice for egg donation and surrogacy services].³ Yet in international treatment, even more than in domestic third-party reproduction, there is the potential for serious power disparities between intended parents and reproductive contributors, as well as informational disparities between intended parents and 'repeat players' in service provision. Particularly given that facilitators saw themselves as 'taking care' of their reproductive contributors and their patients at the same time as the patients were the paying clients, this study sought to elucidate the professionals' sense of ethical codes by examining their views on conflicts of interest and client refusal.

Ethical duties and limits

In order to explore participants' views about the role of regulation in a concrete way, they were asked: 'Do you see any conflict of interest in your role? Are there any clients you have turned away, and if so, why? Are there any other providers you have concerns about?' This allowed the exploration of specific examples before turning to the more abstract question of: 'Do you think that there should be some regulation of your industry?' Interviewees were markedly reluctant 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

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

Facilitators Robyn, Paige and 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 programme 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.

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 4 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 utilized 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 emphasized 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,

³ Society for Ethics in Egg Donation and Surrogacy (SEED): see <http://www.seedethics.org>

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 characterized 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 to provide 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': [Snyder et al., 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 said, 'it's 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 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, facilitator).

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 the 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 jeopardize the health or safety or well-being 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 specialized 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 or egg donation, utilized a word-of-mouth chain recruitment system in which former egg donors or surrogates sent them new contributors. As Robyn put it, the parents are her clients, 'but without surrogate mums I don't exist in this world'. The value of the 'reputational capital' ([Krawiec, 2009: 236](#)) that brokers amassed not just among clientele but throughout their network of reproductive contributors should not be underestimated. I suggest that this capital was

jealously guarded by those who held it, and that a number of interviewees saw it as acting as an important form of quality control in the market.

Client refusal

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

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

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

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

A few doctors and facilitators said that they were not 'comfortable with' or refused to act for 'older' clients, even if there was no age limit in the relevant jurisdiction relating to the provision of IVF. For Alec, this meant those over 50 years of age; for Talia, it was over 60 years of age. Alec was also not 'comfortable' with surrogacy for those who already had children but were seeking more, giving the example of those with age-related infertility in second marriages seeking more children:

Well look, so there's a sense among many of us that you should prioritize surrogacy for people who are childless.

Conversely, Paige reported 'ignoring' requests from a gay male couple seeking surrogacy whom she regarded as too young (under 25 years of age).

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

Several interviewees stressed that it was not for them to 'make value judgments' (Alec, facilitator), 'impart my

personal belief system upon the clients' (Nigel, lawyer), or 'to decide who can have a child and who cannot have a child' (Lucas, doctor). This prevailing view was that it was for clients themselves to judge their own suitability to parent, and that professionals were neither equipped nor inclined to do so.

However, there was a minority who saw themselves as 'gate-keepers'. Paige acknowledged that:

I am the one that judges if they are going to be good parents or not, because that is what I am looking for.

Four interviewees stressed that they would only accept clients who agreed with what they regard as an ethical or workable model for surrogacy or egg donation. For those facilitators, their commitment to their model of 'successful' or 'good' practice required a commitment to relationality in the process; that is, for intended parents to be willing to form a relationship with the surrogate before and during the pregnancy, and/or for egg donors to be identifiable at a later point to donor-conceived children. This was not so much a judgement on parental suitability as it was a commitment to what they believed was a successful model of practice in their field.

Taken together, it appeared that the interviewees largely saw their mission as assisting the alleviation of infertility (defined as both medical and social infertility, inclusive of gay men), working from a presumption of fitness of intended parents that could be rebutted by clear evidence of past harm to children or by strong indications of current relationship, or emotional, instability. Within that frame, eligibility requirements or background checks for intended parents were limited, and client refusal was uncommon. As will be seen below, interviewees were generally more concerned about the unethical practice of other market players than they were about the suitability of their clients.

Unethical providers

All of the facilitators, and many of the lawyers, acknowledged that the unregulated nature of cross-border reproduction meant that unqualified and unethical players were rife. Alec noted:

It is the Wild West in surrogacy still ... Any Joe Blow can open up a surrogacy agency...

Several interviewees reported that their clients had paid thousands of dollars to other agencies or facilitators who had then 'shut up shop' and disappeared. As lawyer David put it, there are 'plenty of sharks in the water'. Lawyer/facilitator Mark said:

If you're looking for crooks, this is the industry to find them in. There are so many people out there who are out to make a quick buck.

Alec, Mark, Talia and Bob were all strongly critical of agencies which 'sold' clients into countries where they did not actually have staff on the ground. Alec characterized these agencies as 'outsourcing' the crucial elements of

recruitment, and 'just taking a cut at the start'. Mark volunteered as one 'shocker' a person:

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

When serious problems arose, such as regulatory shut-downs in India or Thailand, or natural disasters such as in Nepal, remote agencies who were not located within the relevant country were seen as more likely to cut and run: for example, Alec named one agency who:

... once Thailand closed down, they said 'oh well you're on your own now everybody, you can 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 lacked a legal background or social work skills, do not understand the law and do not 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: utilizing 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; utilizing 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 from (or indeed, in the case of one medical professional, referred to each other when he did not wish to engage with them) but not confronted; the market was trusted to 'find its own level'. Saffy noted that, in her view, agencies 'who don't run ethically don't last long, because the clinics won't refer people to them'.

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

Regulation

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

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

Ruth, Lisa, Robyn and Paige all expressed the view that regulation should reflect existing best practice standards, which they saw as very much their own model of practice based on many years of experience. In Robyn's words:

So if you did surrogacy correctly then the law would not need to react to it, it would follow the rules which have been set [in the industry].

One facilitator had been involved in setting up a peer accreditation process for providers in her field. In her view, an overt commitment to minimum ethical standards meant a smoother industry and less likelihood of regulation being externally imposed. Four facilitators had already joined a voluntary US-based industry code for surrogacy and egg donation, although two reported the view that it had been insufficiently adhered to by other members, and one reported that it 'lacked teeth' in terms of sanctions for non-compliance.

A number of professionals working within ostensibly altruistic systems (Australia, the UK and Canada), such as Frank, David, Ruth and Justine, argued that removing legal restrictions on commercial surrogacy would ultimately

enable a more ethical and regulated field. Justine, for example, repeatedly emphasized the extent of 'unhealthy' and 'underground' practice:

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

In addition, Justine was very concerned about the growth in people within her jurisdiction matching in surrogacy arrangements unscreened through Facebook and other sites saying:

People are using these unregulated online ways of matching, the stuff we see is terrifying in terms of the lack of information, and misinformation...

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

Conclusion

This research sought to understand the role that facilitators and providers play in the travel of Australians abroad for treatment with ART. The conduct of facilitators and service providers was understood as a form of professional practice, based within a web of tightly held relationships and enacted as a form of relational labour. A small number of closely held and interlinked entities in the largely unregulated CBRC field, with key personnel occupying multiple roles in some cases, poses the prospect of commercial and professional conflicts of interest, both real and perceived. This study sought to examine how facilitators understood ethical limits within their industry and their own conduct by probing how they characterized 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 (Inhorn and Gurtin, 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 utilized if placed within a broader evidence-based framework, including the evolving social science research on outcomes for children in surrogacy and donor conception (Blake et al., 2014; Jadva et al., 2012; Ilioi and Golombok, 2015), egg donor experiences (Almeling, 2011, 2014), and information needs and expectations of parties in donor conception (Persaud et al., 2017; Zadeh et al., 2018).

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

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