

Who's the Mother? Midwifery Care in Adoption and 'Surrogacy'

Qui est la mère? Soins relevant de la pratique sage-femme dans les cas d'adoption et de « maternité de substitution »

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This article has been peer-reviewed.

THE ISSUE

The first time I ever heard about surrogacy was in 1986 during a phone call from a reporter about what came to be called the “Baby M” case, the first really publicized American surrogacy case and a story that dominated the airwaves and my life for months. I'd written a book about prenatal testing¹ and done the book tours one did in those days. When a new reproductive technology issue hit, (and we didn't even have that terminology yet) I was someone people in the media figured they could call for a quote. So the phone rang (in those days before e-mail), and a reporter started explaining to me that there was this woman who'd agreed to get pregnant by artificial insemination and turn the baby over to the guy and his wife. Now she'd apparently changed her mind and wanted to keep the baby. Did I have a comment?

I paused, I had to make sure I understood all of that, and began to think of something intelligent to say, when the reporter interrupted: “Oh, yeah, they haven't done the paternity testing, so actually they don't know for sure who the father is.” Then I had no need to think; I just blurted out, “I don't care who the father is; I know who the *mother* is!”

And thus was born the theme of my work for the next six months of media time and many more years of writing and thinking: every pregnant woman is the mother of the child in her belly, no matter what her plans are for the

rearing of the child, no matter the source of the sperm or the source of the egg. If she's pregnant, she's the mother of the baby in her belly.

You'd think that this isn't that complicated a thought. Just look at a pregnant woman. But I've been unpacking it ever since. And as the technologies have gotten more interesting and complicated and the marketing became more sophisticated and globalized, the ‘obviousness’ of who is the mother has gotten both less clear and more important. It's more important because, oddly, it's become less important; pregnancy is more and more reduced to housing, to a site. There's this fascinating circular thing that happens as a culture develops its technology and that technology then acts back to reinforce the culture. We conceptualized pregnancy as a condition of “carrying,” of “hosting,” of being inhabited by someone else's child, traditionally understood as the man's child in the body of the woman. And then we developed technologies that grew out of that idea—technologies that enabled us to see past the mother, to find the baby within, to wave at the little fetus, to send its photos around on Facebook, to track its growth, and to test its genes and development. In turn, those technologies act back on us, reinforcing the idea that the mother is just a place, a location, a bit of awkward geography separating the baby from the rest of us. Once that feels real to people—once that baby is named and its cute little clothes are waiting on the dresser in the baby's

room where the pink or blue curtains are hung—it seems almost irrelevant just where that pregnant belly is. Is it in the big bedroom down the hall? Or in an anonymous belly in India? The baby becomes the important thing, its medical records intact, its photos on the fridge and e-mailed to grandma.

WOMEN AS FATHERS

While I didn't think it mattered in the slightest who the father was in the Baby M case, mine is not the dominant American, European, or even worldwide view. In most of the world, fatherhood has been the defining relationship for the new baby, giving it its name and its identity, its place in the social world. But that is very much contested these days, and women, more and more, are seeking and gaining many of the rights and privileges of fatherhood. And what a fine thing that is! Women are now the legal parents of their own children, and the idea of an "illegitimate" child has become as arcane as it is absurd. That means that a woman can have all the legal and social status that used to reside in fatherhood and in motherhood, all for herself. But what happens when more than one woman is involved? When two women as partners, in a committed relationship are growing their family together, we are working toward developing laws that acknowledge both women as legal parents. This has had markedly greater success in some jurisdictions than in others.

A very different set of concerns arises when the two women are not partnered with each other, when one woman is using the "reproductive material" or "reproductive labour" of another woman to have a baby, as happens in adoption, egg donation, and surrogacy. In the world of adoption, we've learned to call these women the "birth mother" and the "adoptive mother," but—speaking as an adoptive mother—we also use much worse language here. The language problems of adoption would be funny if they weren't so sad (our adopted children are apparently made of plastic, because they are not "biological"). My motherhood of my child is dismissed as implicitly not real when someone asks me if I know the "real mother." The problem seems to lie with the very idea that there can be two mothers of a given child and that (inevitably) the motherhood of one invalidates the motherhood of the other.

I would argue that there is no reason why there cannot be more than one mother, and there is certainly no problem

when those motherhoods are sequential. One woman mothers through the pregnancy and then cannot continue, turning the baby over to its next mother. Neither mother is anything less than "real." Adoption as it was usually practiced in North America posed no complications for the midwife. She dealt with the birth mother and worked with her through her pregnancy and birth and on to wherever the postpartum period took her (i.e., home with the baby, or separated). There might well have been issues of grief and loss, but those issues were also, sadly, within the purview of midwifery care.^{2,3} As adoptions have become more "open," the situation has grown more complicated. An adoptive mother might now be found standing in the birth room, and midwifery care for the birth mother might be torn in the immediate postpartum moments. As awkward as things may get however, power lies with the birth mother because she has and maintains legal rights over the child, and this power remains with her in the immediate postpartum weeks.

However, a more dramatic problem has occurred with the use of "new reproductive technologies" (including surrogacy) and the problems they pose for our definition of the mother. In this case, we are told, we have two mothers at the same time. I suggest that, no, we actually have one mother and one woman claiming the rights and privileges of fatherhood. If you're the midwife, your obligations are pretty clear: the woman you are with is the mother.

What does it mean to speak of women as fathers? It means you focus on the genetic connection, on the source of the "seed" that made the child, and not on the nurturer. But even more importantly, it means you focus on power. Fatherhood is also a legal relationship based on marriage: if a man is married to a woman, he is the father of her children. As children's books tell us, daddies plant seeds in mommies, and babies grow out of those seeds. The truth is that not all those daddies do plant those seeds in all those mommies, and about 10% of us are not actually genetically related to the men who claim to be our fathers.

Let's go back to the Baby M case and the paternity concerns expressed by that reporter. That situation and all of those earlier cases of surrogacy were not brought to us by any "new technologies." Surrogate motherhood was not brought to us by the march of scientific progress. It was brought to us by brokers, by people who saw a new market and went after it. The technology was artificial insemination, a technology used in human beings for well

over a hundred years and in animals for many hundreds of years before that. When artificial insemination was introduced for human use, it was to support the traditional family structure (husbands and wives having and raising babies). When a couple was infertile in earlier times, the infertility was assumed to be the fault of the wife, and men in many cultures had the recourse of divorce or the biblical practice of “surrogacy,” using another woman to bear the child (the necessary son, really). With the development of the microscope, male infertility could be diagnosed, and artificial insemination became a way to maintain the husband-wife unit. Wives were not encouraged to take a “surrogate,” substitute lover; rather, doctors used semen given anonymously (generally by doctors and medical students) to impregnate wives. The process was undertaken with the greatest of secrecy; no one (sometimes, not even the wife) was told what was being done.⁴ This enabled men to be the social fathers of the children their wives bore.

The use of donor or artificial insemination for female infertility was the new piece. By the 1980s, there was a recognized shortage of babies available for adoption. Everything that improves the lives of young women — contraception, abortion, education, financial support — seems to cut down the number of babies they bear that they cannot raise. If you make life good, adoption largely stops (see in-country adoption numbers for the Nordic countries). On the other hand, some of those same things may bring women to delayed childbearing and increased infertility. Infertility treatments grew, their press coverage far exceeding their success, and the “desperate infertile” became a media staple. People were seeking babies and no babies were to be had. And there you have it: a baby shortage and a new market. Enter the surrogacy brokers.

Mary Beth Whitehead, the birth mother in the Baby M case, eventually did win some legal rights over the child (visitation but not custody), because the courts recognized her as the legal birth mother. Surrogacy became unsafe and a risky business for purchasers. And so enters the “new” surrogacy. The “old” surrogacy, after less than a decade of use, was renamed “traditional surrogacy,” and the new was born as “gestational surrogacy.” In gestational surrogacy, the surrogate would not be the genetic mother of the child. Perhaps the adopting mother’s eggs would be used, but if not, then purchased eggs from a third woman could be substituted. Sperm would also be available on the open market, “banked,” as it were. Babies became available in

kit form: brokers put together the package and delivered the goods (the baby). Outsourcing became thinkable (go to where the labour is cheaper). India has become a major supplier of “gestational services”; poor women are removed from their own children and live in a “baby factory,” and births are induced (or sections performed) to meet the schedules of purchasers flying in to pick up the products.

But surrogacy also continues in Canada and the United States. If you search “surrogacy in Canada” or “surrogacy in the US” through a web browser, you will be led directly to brokers who will answer your questions and meet your needs for services. Traditional surrogacy, you will learn, is available only through informal relationships because it is “risky.” Gestational surrogacy is, in most states and provinces, available with varied and complicated payment issues. (Paying brokers appears to be just fine; paying surrogates, perhaps less so). Army wives—women in need of the money, removed from their home settings, perhaps in a culture of compliance—have become a major pool of candidates for surrogacy.

There have been a number of studies of surrogacy, particularly in regard to the relationship between the pregnant woman and the couple or individual she serves. There are studies set in North America and the United Kingdom and a growing body of work on surrogacy in India, where surrogacy has largely evolved as an export business. In some places, the situation of the surrogate is better; in some, it’s worse. In all, when the pregnant woman is defined as anything other than the mother of the baby in her belly, some of her essential rights are compromised. This sets a dangerous precedent. Allowing anyone to “claim” a child and thus claim rights over a pregnant woman’s body opens up a very dangerous path for all pregnant women.

This is true even in the most loving of situations. There are women helping sisters or much-loved friends to achieve their dream of having a baby. There are mothers who have acted as surrogates for their own daughters, bearing their soon-to-be grandbabies in their own bellies. These women, too, are—while pregnant and giving birth—the mothers of the babies that, once placed in other loving and welcoming arms, will become their grandchildren.

When I presented a paper on this subject at a meeting of the Canadian Association of Midwives, a number of midwives spoke or wrote to me afterwards about their experiences with surrogacy. One shared a thought that comes up all the time: people who want to have babies

and cannot (infertile women, say, or gay men) can be heartbreakingly sad, and we must not devalue their dream of a child. And I assure you, I do not; I hope to find ways to help them achieve the parenthood they so very much want. My concern is that we do so in a way that continues to respect and value the lived experience of pregnancy and the bodies, lives, and labours of the women who are, for the duration of the pregnancy, the mothers of the babies they carry. In our concern for the would-be parents and in our market-driven world, there is much pressure to focus only on the needs of the purchasers and the much-desired child.

SURROGACY IN ISRAEL

Let me take you now to the country with the most evolved surrogacy system, a system with complete state support, and ask you to see it as a warning. In Israel, the needs of infertile women are taken very seriously, indeed, as are the needs of the children produced. What is not taken as seriously are the bodily autonomy rights of the women who “host” these pregnancies.

The dystopia some of us feared when we first heard about surrogacy has arrived: bellies are medically maintained environments for the growth of tested, selected, and monitored fetal patients. Doctors put babies in and take them out. Babies are genes grown up. Elly Teman, in her book *Birthing a Mother: the Surrogate Body and the Pregnant Self*, tells us that this dystopia is Israeli, efficient, functioning well, and accepted and embraced by Israeli citizens.⁵ All's well. It totally works.

First, the facts. In Israel, surrogacy is recognized by the state. The state approves contracts, although purchasers can find birth mothers privately. The purchasers must be married to each other, and they must use the purchasing man's sperm. If he cannot produce sperm, no deal. The purchasing mother does not have to produce viable eggs; the couple can purchase those from another woman. Purchasers and birth mothers must be of the same religion. The birth mother cannot be legally married, but she can have a live-in male partner. He must have children of her own eggs to whom she has given birth. The birth mother is paid very little for the invasive treatments involved in artificial conception by invitro fertilization (IVF) and for pregnancies that are aborted (even late term) for fetal anomalies, as required by the purchasers. Full payment is made only upon the successful birth of a live baby. Purchasers and birth mothers must be Israeli citizens and

permanent residents. Purchasers make all decisions about which prenatal tests will be done. Purchasing mothers and birth mothers share a physician. Medical records for both are kept in one file under the name of the purchaser. (Yes, you read that right—the birth mother is a page in the purchaser's medical record. Teman speaks of her as a “conjoined patient.”) The purchasing mother routinely attends all medical appointments with the birth mother and is present at the birth. The baby is given directly to the purchaser, who chooses whether or not to let the birth mother see the newborn then or ever. While the birth mother is sent to the gynecology ward after giving birth, the purchasing mother is admitted to hospital and given a bed in the maternity ward.

Who Are the Purchasers?

Couples choose surrogacy in Israel for the same reasons couples do so in the rest of the world. One reason is female infertility, of course, but surrogacy is also often chosen because of a deeply eugenic kind of thinking—the larger eugenics of racism or the narrower eugenics of familial genetic determinism. While adoption is hard and expensive, so is surrogacy. International adoptions are at least as doable as are surrogacy arrangements, yet many people expressly prefer surrogacy for what can be overtly racist reasons. For example, a woman Teman interviewed told her the following:

*Adoption you go to Brazil, you go to places where you don't know the parents at all, you don't know anything about them, one day you will suddenly find out that it is an Arab, that you are raising an Arab. He has Arab blood. One day he will come and throw a stone at you and he won't know why at all. Because it's. . . it's in the blood, you can't do anything about it (in) the genes, and genes are very, very strong. So when you have surrogacy, with this law, you know that it is yours, the personality will be yours. The looks. He'll look like you. Do you understand?*⁵

Not all are that blatantly vile, of course. Some do not talk about race but draw on notions of “relatedness” and “naturalness.” I find it odd (truly bizarre, actually) that in the usual language of surrogacy, a woman involved in gestational surrogacy is not considered to be related to the fetus she carries. The “real” relationship is defined as that of the woman to her eggs, a “natural” thing, as one woman explained to Teman:

continued on page 26....

about

Jozi Grant was born and raised in a small town in northern B.C., and has been a portrait photographer for 14 years. Her photographic topics have varied over time, but she has a special affinity for portraiture; capturing the human spirit and documenting love. Her passion for birth photography began in 2005, and she has since also become a birth doula. She loves serving women and families as much as she loves photographing them.

Jozi has a background in marketing, communications and design, and spends her free time creating pretty things and honing her ukulele skills. She currently resides in Vancouver with two rambunctious young sons.



witness

My relationship to, and with, photography is deeply personal. I have an inexplicable fascination with the connection between people and the subtle emotional nuances that bubble at the surface in all of us. I am a communicator at heart and have a deep desire to capture and share those deep and precious moments between mother and midwife, mother and partner, mother and newborn.

My first experience inside a birth room was powerful and life changing; it ignited an interest in all things birth related and it touched my soul. There is something so sacred about being allowed to step into a woman's most vulnerable space and to take away evidence of the experience. I witness some incredibly raw, real and human moments inside those rooms. I witness the breaking of women, and the making of them. I witness labouring women gather courage from depths that they never knew existed and I witness the purest of joy on the other side of it. It is a world of contrasts. I am amazed by the power that comes through birth and the new life that it brings.

Birth photography is more than an art for me – it's a calling. **I document love.** In the case of birth photography, I document the very beginning of it and the magnitude of it. I come away from each one having learned something about nature, people and maybe even about life itself.



“I document love.”

It was very important to me that we have a biological child. That's why I went to surrogacy and not adoption . . . it just seems natural to you. First of all, a natural need. A natural need like any person has . . . If it is possible, there are eggs, there is sperm, (and) there are beautiful embryos. Technically I can't carry them, but my child is from my genes; it is just a need of the human race that it be yours.⁵

It is interesting to note that the discovery of human eggs (and the genes women contribute to babies) is relatively recent. One of the early uses of the microscope was to look at sperm and see the “homunculus” (what was thought to be the complete little baby) curled up inside the head of the sperm. Thus, the presumed “natural human need” to have children from one's own eggs came rather late in evolutionary history.

Also worth noting is that gestational surrogacy in Israel, as in the rest of the world, purchased eggs are readily available and are often used. Women who are infertile often have at least as much trouble with egg production as with gestation. So sometimes the “naturalness” is not about the purchaser's relationship with her own eggs but rather about her relationship with her husband's sperm; the child is “naturally” his and thus hers to raise. The Israeli system, within a culture with a strong patriarchal tradition but also a long history of experienced racism and associated rape, requires that the gestational surrogate be of the same religion as the purchasers (because religion is traced in a matrilineal line) but does not permit the use of purchased sperm, only purchased eggs (maintaining the patrilineal line). Thus, the purchasing mothers—the “intended” mothers, as the industry calls them—find a “natural” basis for claiming their own children out of the bodies of other women, just as men traditionally have found a “natural” basis for claiming their own children out of the bodies of women. The purchasing mothers function as fathers.

As with fathers, ultrasound imaging is enormously appealing and useful for adoptive mothers. The transparency of the woman's body and its erasure in ultrasound imaging of the fetus “enables the intended mother to conceptualize the fetus apart from the surrogate and to access the role she covets.”⁵ Some women feel that with surrogacy, the intended mother is even more “attached” to the baby than a pregnant woman is. Speaking like a true patriarch, one woman interviewed by Teman offered the following:

I think I felt more than a regular woman because . . .

for me the pregnancy was very sterile, and there was just them (the twins), and I see them on the ultrasound and I know that “this is mine.” The pregnancy isn't mine, but what is inside is mine. I mean the womb and the belly aren't (mine) but this (the twins) is.
Spoken like a true patriarch.

What of the Birth Mothers, or “Surrogates”?

I have repeatedly rejected the language of surrogacy, or “substitution,” as it is translated into French and some other languages. No woman is a substitute or surrogate for the fetus in her belly. Her substitution is as wife, not as mother. Pregnancy is itself a relationship, a relationship between the woman and the baby she is growing, as intimate a physical relationship as there can be. I have often written about this—women are not pregnant with just their uteri but with their whole bodies, from their swollen ankles to the images of the baby they hold in their minds. In direct response to that, Teman says that no, these women are not pregnant with their whole beings but in fact create “body maps,” not touching their pregnant bellies, separating out the parts that are not theirs. Teman points out that these women are exercising autonomy and control, and she is completely right of course – the women who come to be the surrogates are not literally enslaved but do it by their own choice; they exercise enormous agency in making surrogacy work, are not remotely interested in keeping these babies for themselves, and find highly effective ways of distancing themselves from the fetuses while pregnant. Most of the surrogates Teman interviewed told her that they actually did touch their bellies during pregnancy, but only for “practical” reasons, such as making sure the fetus was alive.⁵ They constructed “red lines,” boundaries to limit bodily and social intrusion by the purchasers. In this they functioned much like prostitutes, who distance themselves from certain body parts and acts and hold other acts (like kissing) to be too intimate and personal to share with clients. It works. People are amazing in the ways that they can make things work.

I found it particularly noteworthy that the surrogates were able to use their milk coming in as part and parcel of this separating of the hired pregnancy from the true self. They interpreted those first few days without milk as a sign of total separation. In their earlier pregnancies, with babies by their sides, milk came in earlier, whereas it was delayed in these pregnancies—proof that the babies were not their

babies, not really part of them. But when the milk came in on day three, the surrogates saw it as a return to their own bodies, their own hormones.

Birth itself, of course, is a dramatic turning point. Some of the surrogates, having given birth before, feared birth for its threatening emotional possibilities in the blurring that happens. "One popular strategy was to harness technology to take personal control of the event. This strategy involved requesting an elective cesarean section during the thirty-eighth week of pregnancy... Elective cesareans were requested by more than half."⁵

Although this is an interesting (if strange) way of thinking about taking control of birth, it makes sense; these women were taking control over parts of their lives by giving away control over their bodies. Not everyone can do this, and the ability to do so deserves to be recognized as an accomplishment. In the early days of surrogacy, back in the time of Mary Beth Whitehead, women were chosen on the basis of their physical health and their willingness to participate. Brokers have become much more sophisticated: the women in Israel, as in North America, are carefully tested (Teman reports six hours of psychological testing) for "mission focus" and "docility." Passing the tests makes them feel like "superwomen" and "heroes" and, yes (in Israel), even soldiers. But like women in the traditional role of wife, they are chosen and groomed first and foremost for obedience.

And What of the Midwives?

In the Israeli setting, physicians held most of the control during the prenatal period, but midwives were participants in the births. As mentioned earlier, medical records were kept in the name of the purchasing, "intended" mother. One woman Teman interviewed, somewhat of an outlier, who had a lot of trouble with the surrogacy system, herself had earned a PhD and was a childbirth educator. She interpreted the hospital protocol as denying her respect. She felt sidelined by the doctor's treatment of the intended mother as his primary patient: "*From the moment of the embryo transfer. . . I became as if invisible.*"⁵ This surrogate was astounded that she wasn't the one informed she was pregnant, that her name wasn't recorded, and that she did not exist in the patient log. "Her reaction to the discovery that her intended mother was being treated by the medical system as the primary pregnant patient brings the agency of surrogates who DO comply with this categorization into sharp relief."⁵

The Israeli system privileges the purchaser and expects the providers to do so as well.

As half of the conjoined patient, intended mothers often became mediators between physicians and surrogates; they would sometimes even visit the doctor alone at certain stages of the pregnancy to obtain prescriptions for the surrogate's treatment and to obtain referrals for prenatal diagnostic tests to be performed on the surrogate's body.

*Although some may be quick to point out the potential for conflict of interest when a doctor treats both surrogate and intended mother, a doctor's knowledge of both sides of the surrogacy relationship can also help the women advance their common goals; to deflect responsibility for the medical aspects of the pregnancy from the surrogate onto the intended mother and to cultivate the intended mother's claiming practices.*⁵

Teman says the physician, the midwife, and (most profoundly) the surrogate are mothering the purchasing mother, "birthing" a mother. More than simply caring for the child, the surrogate is caring for the mother. Teman distinguishes this from child care, but it seems to me that nannies and child care providers actually do a lot of "mothering the mother," teaching and caring and supporting the woman in her new motherhood. But at the time of the birth, the midwife's role is clear: she is there to serve the purchaser. "In the surrogacy guidelines of one major Israeli hospital, the midwives are instructed not to show the surrogate the baby but to ask the intended mother for permission to do so."⁵

Does this not violate midwife ethics? Can this possibly be acceptable behaviour?

The surrogate is hospitalized in the gynecology ward, while the intended mother is usually hospitalized in the maternity ward. She is admitted and expected to change into a hospital gown and lie in her hospital bed to hold her baby and greet her visitors. (Note that mothers of sick babies do not have to wear hospital gowns when they stay with their hospitalized infants.) Nearly all the intended mothers Teman interviewed chose to stay at the hospital. One woman had a theatre company prepare a pregnancy costume for her to wear in the preceding months. People came and saw all of these intended mothers with their babies in the maternity ward, and some visitors didn't know that these mothers hadn't given birth. Through a glass wall, the birth mothers

could see the adoptive parents with the baby.

*The glass wall symbolically replaces the transparent medium that was present throughout the pregnancy—the ultrasound screen. Whereas only ten hours earlier, it was Sarit who peered through Rinat's skin with the aid of the ultrasound mechanism, now Rinat peers through the clear glass at Sarit with the newborn child. . . . In this role, the medical professionals ensure the final shifting of the mother/child boundary and seal off the intended mother's body with the child attached.*⁵

At that point, the intended mother ceases to be the father and takes on the rights and privileges of motherhood, albeit a most traditional kind of motherhood. The midwife, the surrogate, the nurses, and the doctors all work to ensure that one woman, and only one woman, is the “real” mother.

SO WHO IS THE MOTHER?

Some of us believe that relationships make people who they are, that loving and caring attention calls forth the person. And some of us are more focused on genetic material as the essence of the being. But even if you truly believe that absolutely everything that really matters in a person—grace, agility, intelligence, ability, talent, energy, beauty, empathy—is right there in the fertilized egg and that everything that could ever develop is all there at the moment of fertilization, you still have to grow the thing somewhere. Even if it is just a matter of maturing the egg and safely nurturing the egg while it blossoms into its true self, there is still the problem of placement. If you think that nurturing matters, then you think of the pregnancy, the birth, and the early months as part of a relationship, a familial connection.

Much is made of intention in these cases. The purchasers (the would-be adopters) are called the “intended parents,” while the woman who might be standing there—heavily pregnant, her ankles swollen, her belly extended, the movement of the baby within observable through her clothing—is called a “gestational carrier” and is talked about as a babysitter just taking care of someone else's baby. These contracts put enormous weight on intentionality in parenthood. No society has ever offered such a definition of parenthood. If intentionality made parents, a huge segment of the population would be orphans. Parenting is a relationship and not an intention.

Pregnancy – I don't have to tell midwives, but I do

seem to need to keep reminding other people – exists as an intimate, physical, psychological, and social relationship. At birth, babies recognize the sound of their mothers' voices; a bond has been formed. Mothers feel their babies' movements, but the relationship is yet more intimate: fetal cells are in maternal circulation; maternal muscle and blood hold and nurture the forthcoming child.

Our laws have recognized that intention and desire do not determine parenthood. In cases of adoption, no matter what the agreements decided upon before the birth of the child, the mother is the parent of the child she gives birth to. Nothing in that relationship is changed by changing the source of the egg or the sperm. Surrogacy is a form of adoption, and the rights of birth mothers must continue to apply: a woman who gives birth to a child is the birth mother of that child. Some children would not exist but for rapists, and women who have been raped enter pregnancy without the desire or intention to have a child. Yet we would hardly claim that such children can be removed from the mother against her will because she did not “intend” her motherhood. At the time of birth, motherhood is a fact determined by lived physical experience and not by the intentions of the parties who began the pregnancy.

And so who is the mother? I urge you, as midwives, to acknowledge, recognize, and insist that every pregnant woman is the mother of the baby she bears. She may keep that baby and raise it, she may give that baby into her own daughter's loving arms, or she may place that baby for adoption, but she is the mother, and you are her midwife.

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