

Pregnant, Then Relationally Invisible? Family Formation, Legal-Cultural Figures and Post-Birth Care in Comparative Surrogacy

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Abstract

Surrogacy law makes the gestational surrogate legible through unstable cultural and legal figures: mother, patient, contractor, relative and stranger. Comparing England and Wales, California and Vietnam, this article identifies 'temporal truncation': protection is dense before conception and around parentage, then fragments after birth. It develops 'gestational-relational loss' to name contingent bodily, emotional and relational disruption without presuming motherhood or creating parental claims. Drawing on relational autonomy, reproductive justice, law and emotion, and embodied justice, the article separates parental status from care. A Surrogate-Centred Continuity of Care framework shows how secure parentage can coexist with bodily autonomy, support and effective remedy.

I. INTRODUCTION

Gestational surrogacy separates functions that law and culture have often compressed into a single figure of 'the mother': genetic contribution, gestation, birth, intention and post-birth parenting. In a gestational arrangement, a person carries an embryo to which they are ordinarily not genetically related for one or more intended parents. Professional guidance accordingly treats the gestational surrogate as a rights-bearing patient who must receive information about medical, legal and psychosocial risks and retain authority over medical care. Yet the dominant legal questions remain status questions: Who is the child's parent at birth? Is the agreement enforceable? Which payments are permissible? How will parentage be recognised across borders? (Ethics Committee of the American Society for Reproductive Medicine, 2023).

Those questions are indispensable, but they do not exhaust the legal significance of gestation. Law can stabilise intended parentage without concluding that a person who has undergone endometrial preparation, embryo transfer, pregnancy, labour and postpartum recovery has no continuing legal interests once the child is transferred. The familiar phrase 'pregnant but not a mother' captures a legal paradox, but it can also reproduce the equation that requires scrutiny. Gestation is not necessarily mothering, and a surrogate's experience should not become intelligible only by naming them as a mother (Mahmoud & Romanis, 2023).

This article addresses a narrower problem: the decline of surrogacy-specific legal protection after birth. The claim is not that the surrogate falls outside all law. Ordinary maternity, healthcare, employment and anti-discrimination rules may continue to apply. Rather, the legal architecture that carefully screens entry, formalises consent, regulates payment and allocates parentage rarely connects those stages to an integrated, enforceable continuity-of-care duty. Once the intended family is legally secured, postpartum recovery, emotional adjustment, altered relationships and possible mental-health needs are dispersed across professional discretion, general services and private goodwill. This is a problem of institutional design, not an assertion that surrogacy is inherently harmful (Horsey, 2016; Law Commission & Scottish Law Commission, 2023).

Across the three regimes, the surrogate is not merely assigned a legal status but narrated through unstable legal-cultural figures. England and Wales casts the gestating person as mother, California as contracting carrier, and Vietnam as altruistic relative. Each figure makes some interests intelligible while rendering others anomalous. Legal invisibility is therefore not only a gap in services. It is also a problem of legal imagination: once the figure that justified regulation has completed its assigned function, the person's embodied and relational aftermath becomes harder for law to recognise.

The empirical literature counsels against categorical claims. Systematic reviews generally report high satisfaction and frequently positive relationships between surrogates and intended parents, while also identifying heterogeneous experiences, changing contact, stigma and methodological limits. Longitudinal work reports many positive long-term outcomes; a population-based Ontario cohort nevertheless found a higher adjusted incidence of newly diagnosed mental illness among gestational carriers than comparison groups. Neither finding cancels the other. Together they require legal design for variation rather than an assumption of either trauma or effortless detachment (Jadva et al., 2026; Kneebone et al., 2022; Söderström-Anttila et al., 2016; Velez et al., 2025).

To identify the legally relevant but non-universal interest at issue, the article develops the concept of *gestational-relational loss*. The term denotes significant post-birth disruption associated with the ending of embodied pregnancy and/or a valued relationship created through the surrogacy arrangement. It does not presuppose maternal identity, prenatal bonding, a wish to parent or a claim to legal status. It is therefore both narrower than 'maternal loss' and more compatible with surrogates' diverse self-understandings.

The article makes three linked moves. First, it connects legal, psychosocial and professional literatures that usually proceed on parallel tracks. Secondly, it compares three functionally contrasting legal regimes: birth-based motherhood followed by a parental order in England and Wales; intention- and contract-centred pre-birth parentage in California; and an altruistic intrafamilial system in Vietnam that places intended parentage at birth while recognising maternity-related entitlements. Thirdly, it identifies *temporal truncation*, separates parental *status* from continuing *care*, and proposes a Surrogate-Centred Continuity of Care ('SCCC') framework. Stable intended parentage and enforceable duties of care are not opposites; they can operate on coordinated legal tracks.

Part II specifies the gap, questions and contribution. Part III explains the comparative design and evidence review. Part IV operationalises relational autonomy, reproductive justice and law-and-emotion. Part V develops gestational-relational loss. Part VI compares the three regimes. Parts VII and VIII derive the status-care distinction and SCCC framework. Part IX addresses objections and limitations before Part X concludes.

II. RESEARCH GAP, QUESTIONS AND CONTRIBUTION

A. The gap

The legal literature on surrogacy is substantial, but its centre of gravity remains parentage. It examines conflicts between gestation and intention, agreement validity, the welfare and identity rights of children, payment and commodification, and recognition of foreign parentage. These are foundational concerns, yet their institutional endpoint is commonly the same: a legally stable family in which intended parents hold status and the surrogate does not (McCandless, 2017; Zervogianni, 2019).

A second literature examines the surrogate as a worker, patient or potentially exploited actor. Feminist, sociological and anthropological scholarship shows how reproductive labour is organised through clinics, markets, kinship expectations and narratives of altruism. It also shows that agency can be exercised within unequal structures, making the exploitation/choice binary inadequate. This scholarship renders the surrogate visible during the arrangement, but it less often translates post-birth bodily, relational or emotional interests into specifically allocated public-law, health-law or contractual duties (Cammu, 2024; Pande, 2014; Teman, 2010).

A third body of work—psychological research and professional guidance—addresses screening, counselling, boundaries, relationships, mental health and post-birth adjustment. ASRM and ESHRE guidance recognises the need for independent information, medical autonomy and psychological support before, during and after participation. Professional standards, however, do not automatically create enforceable rights. They may even mask the regulatory gap if formal law assumes that clinics or counsellors will supply support without specifying independence, duration, funding, accountability or remedies (ASRM & SART Practice Committees, 2022; ESHRE Ethics Committee, 2025).

The gap is therefore both temporal and translational. It is temporal because surrogacy law is most detailed before embryo transfer and at parentage allocation. It is translational because knowledge about embodied and relational experience remains framed as counselling expertise rather than a basis for legal obligation. The unresolved question is not whether a surrogate is 'really' a mother. It is whether a legal system can deny parental status while recognising that gestation and relationship may generate foreseeable interests that survive birth.

B. Research questions

RQ1. How do England and Wales, California and Vietnam construct the gestational surrogate's legal position before treatment, during pregnancy and after birth while allocating parentage?

RQ2. Which bodily, emotional, relational and mental-health interests documented in empirical and professional literature remain weakly protected when consent is treated primarily as ex ante and birth as the regulatory endpoint?

RQ3. Which legal duties can recognise and mitigate those interests without re-maternalising the surrogate, duplicating or displacing ordinary postpartum rights, or destabilising intended parentage?

C. Contributions and bounded claims

The article makes four specific contributions. Conceptually, *gestational-relational loss* names a contingent post-birth interest without equating pregnancy with motherhood. Analytically, *temporal truncation* identifies a cross-regime mechanism: legal density falls when parentage is secured, even though pregnancy-related consequences continue. Doctrinally, the *status-care distinction* demonstrates that stable intended parentage does not exhaust legal responsibility to the person who gestated. Normatively, SCCC translates those insights into actor-specific, non-waivable duties for states, clinics, intermediaries, insurers or fund-holders, intended parents and independent advisers.

These claims are deliberately bounded. The article does not argue that every surrogate experiences loss, that attachment is inevitable, that emotional difficulty retrospectively invalidates consent, or that all general maternity and health protections are absent. Nor does it propose a post-birth veto over parentage. Its narrower claim is that foreseeable heterogeneity, combined with law's role in authorising and structuring the arrangement, justifies a minimum surrogate-specific infrastructure of information, supported transition, care, complaint and monitoring.

III. RESEARCH DESIGN AND METHOD

A. Comparative design and case selection

The study is a comparative socio-legal doctrinal inquiry informed by a critical interpretive review of published empirical and professional evidence. Doctrinal analysis identifies the legal categories, rights, duties and institutional actors structuring surrogacy. The socio-legal dimension asks how those categories interact with embodied experience, relationships and professional practice. The article is neither a conventional black-letter survey nor an original empirical study (Banakar & Travers, 2005; Van Hoecke, 2011).

Case selection is purposive and follows a most-different-systems logic. England and Wales represents a birth-based model in which the gestating person is the legal mother and intended parents ordinarily obtain a post-birth parental order. California represents an intention- and contract-centred model permitting pre-birth parentage orders after a formally compliant gestational-carrier agreement. Vietnam represents a non-commercial intrafamilial model in which intended spouses are parents from birth and the surrogate receives specified maternity-related entitlements. These are compared as *legal regimes*, not equivalent sovereign states: US surrogacy law is substantially state-based, which makes California the relevant regulatory unit. The cases maximise variation in parentage architecture, market orientation and kinship design while governing the same functional sequence—matching, treatment, pregnancy, birth, transfer and postpartum recovery (Siems, 2022; Zweigert & Kötz, 1998).

The unit of comparison is the surrogate's legal position over time. The analysis proceeds in three stages. First, each regime is reconstructed on its own terms. Secondly, rules are mapped across common functions rather than compared solely by doctrinal labels. Thirdly, cross-case explanation asks whether different parentage architectures produce common gaps in continuity and accountability.

B. Legal corpus and interpretive evidence review

The source corpus combines legislation, reported decisions, official law-reform materials and current professional guidance, stated as at 19 July 2026. For England and Wales, it includes the Human Fertilisation and Embryology Act 2008, the Surrogacy Arrangements Act 1985, official guidance and the 2023 Law Commissions' report together with the Government's subsequent position. For California, it includes the Family Code, leading cases and official pregnancy-disability guidance. For Vietnam, it includes the 2014 Law on Marriage and Family, Decree No 207/2025/NĐ-CP and Circular No 38/2025/TT-BYT. Vietnamese instruments were read in Vietnamese; English descriptions are functional translations supplied for this article.

The evidence review began with systematic reviews, longitudinal studies, population-level health research and current professional guidance. Backward and forward citation-chaining and targeted searches were then used to locate legal, medical, psychological and socio-legal studies addressing surrogate experience, autonomy, relationships, counselling, post-birth adjustment or reproductive labour. Core journal literature was drawn principally from established peer-reviewed outlets, many indexed in Scopus and/or the Web of Science Core Collection; database status was used as a discovery and verification aid rather than as a substantive quality gate or inclusion rule. Foundational monographs and official reports were retained where they supplied concepts or primary institutional context.

Evidence was included when it concerned the bodily, psychological or relational experience of gestational surrogacy, or professional duties owed to surrogates. Studies focused exclusively on intended parents or children were used only where directly relevant to transition or relationship design. Systematic reviews and longitudinal or population-level studies were used to test breadth and durability; qualitative studies were used to identify mechanisms and meanings. The review is informed by critical interpretive synthesis, but does not claim the completeness or reproducibility of a new systematic review. Its purpose is to construct and discipline a legal argument from heterogeneous evidence, not to pool effects or estimate prevalence (Dixon-Woods et al., 2006).

C. Analytical procedure

Materials were coded across eight dimensions: parentage allocation; enforceability and private ordering; bodily and medical autonomy; consent over time; relational, family or market pressure; independent counselling and advice; postpartum physical and mental-health protection; and remedies, data and oversight. RQ1 is answered by the jurisdictional reconstructions in Part VI. RQ2 is answered by combining the evidence review in Part V with the cross-case comparison. RQ3 is answered by the status-care distinction and SCCC framework in Parts VII and VIII. Table 1 summarises the comparative questions and operational indicators used across these eight dimensions.

[Insert Table 1 here]

Table 1

Comparative research design: analytical dimensions, comparative questions and operational indicators

Dimension	Comparative question	Operational indicators
Parentage allocation	When and through which rule are intended parents and the surrogate assigned or denied parental status?	Status at birth; post-birth or pre-birth orders; consent to transfer; legal consequences for the surrogate.
Enforceability and private ordering	How far may agreements organise conduct, payment, risk and parentage?	Agreement validity; prohibited terms; independent representation; fund management; judicial oversight.
Bodily and medical autonomy	Who controls treatment and pregnancy-related medical decisions?	Authority over procedures, abortion, fetal reduction, delivery and access to healthcare.
Consent over time	Is consent treated as a single ex ante act or a continuing process?	Timing of consent; confidential review; opportunities to revise care preferences; safeguards against pressure.
Relational, family or market pressure	Which structural relationships may enable or constrain choice?	Financial dependence; agency incentives; kinship obligation; spousal permission; family hierarchy.
Independent counselling and advice	Are legal and psychosocial advisers independent, accessible and confidential?	Who selects and funds advisers; conflicts of interest; timing; confidentiality; referral pathways.
Postpartum protection	What pregnancy-related care continues after birth?	Maternity rights; physical follow-up; mental-health screening; counselling; duration and funding.
Remedies, data and oversight	How are failures identified, challenged and monitored?	Complaint routes; regulator authority; expense enforcement; de-identified outcomes; audit and accountability.

D. Safeguards, scope and limitations

Four safeguards reduce overclaiming. First, legal rules are distinguished from professional recommendations, general social rights and common practice. Secondly, positive, neutral and adverse psychosocial findings are reported together. Thirdly, attachment, loss and grief are not treated as diagnoses. Fourthly, normative duties are justified by foreseeability, institutional connection and capacity to mitigate harm, not by an assertion that harm is typical.

The design has corresponding limits. It cannot establish prevalence or causal pathways because it contains no original interviews or survey data. The evidence base relies heavily on English-language research, often uses self-selected or clinic-specific samples, and sometimes combines traditional and gestational surrogacy. The legal comparison is selective rather than globally representative and compares regimes at different constitutional levels. Those limitations restrict generalisation; they do not

erase the cross-case design problem identified below. Because the study uses public legal materials and published research only, it involves no human participants and did not require research-ethics approval.

Generative AI disclosure: A generative-AI tool was used only for language editing, structural review and citation-format checking. It was not used to generate legal authorities, empirical findings, analysis or conclusions. All sources and propositions were independently verified by the author or authors, who accept full responsibility for the manuscript.

IV. ANALYTICAL FRAMEWORK

The article treats surrogacy law as a practice of legal and cultural representation, not only rule allocation. Its categories narrate the gestating person through figures—mother, patient, contractor, relative and stranger—that distribute visibility, credibility and institutional concern. Relational autonomy supplies the primary account of agency across time; reproductive justice provides the distributive test; law-and-emotion explains which experiences doctrine recognises; and embodied justice states the normative implication that status rules must not erase lived pregnancy. The theories therefore converge on a shared question: how does law organise recognition before, during and after the reproductive project?

A. Relational autonomy

Relational autonomy rejects the image of autonomy as a momentary choice made by an isolated individual. Agency is formed and exercised through relationships, material conditions, social norms and institutional power. In surrogacy, consent may be shaped by financial dependence, gratitude, kinship obligation, clinic routines, intended parents' expectations or a desire to help. None of these influences automatically negates agency. They do make a signed agreement an incomplete measure of voluntariness (Mackenzie & Stoljar, 2000; Nedelsky, 2011).

Relational autonomy also introduces time. A person may autonomously consent to treatment and later confront an unforeseen medical choice, a changed relationship, family pressure or emotional difficulty. 'Continuing consent' in this article does not mean that every change of feeling reopens parentage. It means that bodily and medical decisions remain the surrogate's, and that the institutional pathway must create recurring confidential opportunities to disclose pressure, revise care preferences or seek support. Work on altruistic surrogacy likewise shows that kinship can enable generosity while generating expectations that are difficult to refuse (Gunnarsson Payne, 2018).

B. Reproductive justice

Reproductive justice broadens the inquiry beyond a negative right against state interference. It asks whether people have meaningful capacity to have children, not have children and parent children in safe and sustainable communities. Applied to surrogacy, it recognises intended parents' interest in family formation while asking who undergoes treatment and pregnancy, who bears medical and social risk,

whose reproductive labour is valued and whose needs attract continuing resources (Ross & Solinger, 2017).

This distributive lens exposes the limits of treating formal agreement as the whole justice inquiry. A system may enlarge reproductive opportunity for intended parents while externalising predictable health, income or emotional costs to the person who gestates. Mohapatra's analysis of international surrogacy illustrates why choice must be assessed alongside structural inequality and institutional allocation (Mohapatra, 2012).

C. Law, emotion and embodied recognition

Law-and-emotion asks how doctrine classifies and legitimates experience. Categories such as parent, patient, contractor, relative and stranger shape which emotions appear legally intelligible. If the surrogate is defined only as a non-parent who completed an agreement, post-birth sadness or disruption may appear inconsistent with the chosen role and lack an institutional audience (Bandes & Blumenthal, 2012).

The literature on disenfranchised grief helps explain loss that is not socially acknowledged or supported, but it must be bounded. It cannot prove that grief is inherent in surrogacy and should not relabel the surrogate as a bereaved mother. Its relevance lies in showing how a voluntary transfer can coexist with distress that is difficult to disclose (Attig, 2004; Doka, 1989).

Embodied justice supplies the normative bridge: law should attend to the lived body rather than treat it as a neutral vessel for abstract choice. It is not a separate predictive theory here. It directs the analysis back to bodily integrity, postpartum recovery and the distribution of care once status is resolved (Karpin & Mykitiuk, 2011).

D. Integrated propositions

The framework yields three propositions used in the comparison. P1: ex ante agreement cannot exhaust autonomy over later bodily and medical decisions or the need for support. P2: a lawful surrogacy regime should internalise foreseeable pregnancy-related care costs and guard against both market and relational pressure. P3: a non-parental emotional or relational interest can be legally cognisable without creating parental status. Together, the propositions connect the empirical evidence to legal indicators rather than using theory as a descriptive label.

V. GESTATIONAL-RELATIONAL LOSS AS A LEGAL CONCEPT

The first conceptual task is to reject the proposition that gestation establishes motherhood in a comprehensive social or moral sense. Assisted reproduction makes visible what ordinary language often conceals: genetics, gestation, intention, care and law are distinct bases of relatedness. Reproductive technologies coordinate bodies, expertise, documents and relationships to produce recognised parents. Surrogates themselves commonly distinguish carrying from parenting and may locate parenthood in

intention, genetics or the intended parents' continuing project (Franklin, 2013; Ragoné, 1994; Thompson, 2005).

Mahmoud and Romanis show that law and medicine frequently treat gestation as mothering before birth, assigning maternal expectations to a pregnant person whether or not they identify as a mother. That critique matters because 'maternal loss' can reproduce the same assumption. It implies that emotional significance must be maternal and can marginalise surrogates who understand their role through friendship, care, work, kinship or custodianship (Mahmoud & Romanis, 2023).

The opposite proposition—that rejecting maternal identity removes all possibility of loss—is equally unsound. The empirical literature does not present a binary between maternal attachment and emotional detachment. In an early UK study, most participants reported positive experiences and no major difficulty relinquishing the child, while a minority described short-term difficulty (Jadva et al., 2003). Longitudinal studies found continuing positive evaluations and psychological well-being for many participants ten and twenty years later, albeit in selected and relatively small samples (Jadva et al., 2015, 2026).

Qualitative work also illustrates deliberate boundary-making: referring to the fetus as the intended parents' baby, differentiating pregnancy from motherhood and directing emotional investment toward the intended family. Such practices may be affirming rather than defensive. 'Detachment' should not be pathologised; it can be an intentional relational accomplishment. Yet a successful strategy does not establish that support is unnecessary when birth, contact or the relationship develops differently from expectation (Baslington, 2002; Shaw et al., 2024).

Evidence of risk requires equal calibration. Lamba and colleagues reported lower prenatal bonding and higher depression among gestational surrogates in an Indian sample, with social support and secrecy among relevant factors (Lamba et al., 2018). Velez and colleagues' population-based Ontario cohort found a higher adjusted incidence of new-onset mental illness among gestational carriers than two comparison groups. That finding supports enhanced screening and support; it does not establish that relinquishment, attachment or grief caused the diagnoses (Velez et al., 2025). The reported outcome was a diagnosis of new-onset mental illness; the study did not directly measure grief, attachment, or the causal mechanism producing the diagnosis. Critical reviews likewise emphasise variation by jurisdiction, commercial context, family ties, communication and organisation of care (Gunnarsson Payne et al., 2020; van den Akker, 2007).

Against this evidence, gestational-relational loss has four elements. First, it follows the ending of gestation and/or a valued relationship formed through the arrangement. Secondly, it is experienced as significant disruption, distress or loss of meaning rather than ordinary transient emotion alone. Thirdly, it does not depend on maternal identity, genetic connection, a wish to parent or a challenge to intended parentage. Fourthly, its legal relevance arises where the arrangement's institutional design contributed to the risk and reasonable information, transition planning, healthcare or support could prevent or mitigate harm.

The concept is not a clinical diagnosis, a presumption of prenatal attachment or a synonym for disenfranchised grief. A surrogate may experience no loss, physical recovery alone, relational disappointment without attachment to the child, distress linked to the end of pregnancy, conflict after expected contact changes, or clinically significant anxiety or depression with multiple causes. The concept marks a family of contingent interests, not a single pathology.

Its distinct legal contribution is the three-part relevance test embedded in the definition: foreseeability, institutional nexus and mitigability. That test avoids converting every difficult feeling into a legal wrong, while preventing parentage doctrine from treating all post-birth effects as private misfortune. Where law authorises and structures a medically assisted reproductive project, it can allocate duties of information, independent support, continuity of healthcare, cost coverage and remedy without conferring parentage (Cammu, 2024; Mahmoud & Romanis, 2023).

VI. COMPARATIVE LEGAL ANALYSIS

A. England and Wales: gestation as status, fragmented continuity as care

English law begins with gestation. Section 33(1) of the Human Fertilisation and Embryology Act 2008 provides that the person who carries or has carried a child following placement of an embryo, sperm and eggs is to be treated as the mother. The rule applies irrespective of genetics and cannot be displaced by a pre-conception agreement (Human Fertilisation and Embryology Act 2008, s. 33(1)).

Intended parents ordinarily obtain legal status through a parental order after birth. Statutory criteria include the consent of the surrogate and any other legal parent; the surrogate's consent is ineffective until six weeks after birth. Surrogacy agreements remain unenforceable. This design protects a post-birth space for consent and prevents specific performance of a promise to transfer a child, but it also creates a period in which legal status may diverge from day-to-day care (Human Fertilisation and Embryology Act 2008, ss. 54-54A, especially s. 54(7); Surrogacy Arrangements Act 1985, s. 1A).

The model appears to recognise gestation strongly because it confers motherhood. Yet that recognition is status-heavy and its care consequences are fragmented. The six-week rule protects the authenticity of status transfer; it is not itself a right to independent counselling or a surrogacy-specific recovery pathway. At the same time, it would be inaccurate to say that the surrogate loses all protection after birth. Official guidance confirms continuing access to ordinary maternity leave and qualifying pay or allowance, and recommends planning for post-birth contact (Department of Health and Social Care, 2018, sections 6–7). The narrower deficiency is the absence of an integrated, enforceable and independently accountable continuity floor tied to the surrogacy pathway.

Empirical work with UK surrogates complicates the premise of birth-based legal motherhood. Many respondents did not regard themselves as the child's mother and supported intended parenthood from birth under a safeguarded pathway. That evidence supports reform of status allocation; it should not be

read as evidence that gestation has no continuing bodily or relational significance (Horsey, 2016; Horsey et al., 2022).

The Law Commissions' 2023 report proposed a regulated pathway under which intended parents would be parents from birth, subject to the surrogate's right to withdraw, with pre-conception screening, independent legal advice, counselling and oversight by regulated non-profit organisations. It substantially improved ex ante safeguards and status alignment. The current political position is less favourable: in April 2025 the Government stated that it did not intend to take the recommendations forward at that time (Department of Health and Social Care, 2025; Law Commission & Scottish Law Commission, 2023). Even if implemented later, the pathway would still require a clearer minimum for post-birth care, complaint and outcome monitoring.

England and Wales therefore reveal a double mismatch. Gestation is over-recognised as parental status where that identity may be unwanted, while surrogacy-specific continuity is under-developed even though ordinary maternity rights remain. Reform should remove unwanted legal motherhood without substituting legal disappearance after birth.

B. California: intention, private ordering and pre-birth certainty

California adopts a different architecture. The Family Code defines an intended parent as a person who manifests an intention to be legally bound as the parent of a child resulting from assisted reproduction. A gestational carrier is a person who is not an intended parent and agrees to gestate a genetically unrelated embryo under an assisted-reproduction agreement (California Family Code § 7960(c), (f)).

The intention principle has deep judicial roots. In *Johnson v Calvert*, the California Supreme Court relied on procreative intent to resolve competing claims by a genetic intended mother and the gestating woman; *Buzzanca* later extended intentional parenthood where neither intended parent had a genetic connection (*Buzzanca v. Buzzanca*, 1998; *Johnson v. Calvert*, 1993).

The statutory regime formalises private ordering. Sections 7961–7962 require protected fund management in relevant facilitated arrangements; a written agreement disclosing gamete origin, intended parents and medical-expense or insurance arrangements; separate independent attorneys chosen by the parties; notarised or equivalent affirmation; and full execution before injectable medication or embryo transfer. A parentage action may be filed before birth, and a compliant agreement supports an order establishing intended parentage and the carrier's absence of parental rights or duties (California Family Code §§ 7961–7962).

This model performs the status function efficiently. It reduces legal mismatch, supports medical and administrative planning, and treats independent representation and financial disclosure as conditions of valid ordering. California's extensive case law and statutory formalisation make it a leading intention-based regime.

California also supplies general protections outside the surrogacy statute. Eligible employees disabled by pregnancy, childbirth or a related medical condition may obtain pregnancy disability leave, including for postnatal care and recovery (California Civil Rights Department, 2022, pp. 1–2). Medical malpractice, insurance and ordinary mental-health rules may also apply. Those protections matter, but they do not amount to a surrogate-specific continuity system: eligibility varies, care is not coordinated across the reproductive arrangement, and section 7962 does not itself guarantee independent post-birth counselling, transition support, a neutral complaint route or longitudinal monitoring.

California is therefore not simply the mirror image of England and Wales. It solves status earlier and imposes sophisticated ex ante formality, but continuing care remains principally dispersed among contract terms, agencies, clinics, insurance and general law. Separate counsel reduces informational asymmetry at formation; it cannot by itself ensure confidential support when circumstances change months later. A public floor could preserve pre-birth parentage while reducing dependence on bargaining power and intermediary quality (Crocker et al., 2020).

C. Vietnam: intended parentage, altruistic kinship and partial social protection

Vietnam's 2014 Law on Marriage and Family permits only altruistic gestational surrogacy under strict conditions. The embryo must be created from the requesting wife's ovum and the husband's sperm; commercial surrogacy is prohibited. A child born through a lawful arrangement is treated as the common child of the requesting spouses from birth. Vietnam therefore secures intended parentage immediately without first making the surrogate the legal mother. The implementing framework was renewed by Decree No 207/2025 and Circular No 38/2025, both in force from 1 October 2025 (Government of Vietnam, 2025; Law on Marriage and Family No. 52/2014/QH13, 2014, arts. 3(22)-(23), 94–98; Ministry of Health of Vietnam, 2025).

Eligibility is narrow. The requesting parties must be a married different-sex couple, be medically certified that the wife cannot carry and give birth even with assisted reproductive technology, have no common child and receive medical, legal and psychological counselling. The surrogate must be a relative of the same line of either spouse, have previously given birth, be medically eligible, undertake surrogacy only once and, if married, obtain the husband's written consent (Law on Marriage and Family No. 52/2014/QH13, 2014, art. 95).

Decree No 207/2025 requires authorised hospitals to have qualified medical, psychological and legal counsellors and to provide and certify counselling after medical eligibility is established. It also protects private and family information and provides for shared assisted-reproduction data. These are significant institutional safeguards, but counselling remains organised through the treating facility and is concentrated before treatment. The framework does not clearly establish an independently chosen counsellor, recurrent confidential post-birth assessments or a funded long-term support pathway (Government of Vietnam, 2025, arts. 3(5), 12(2), 14(2)-(3), 15, 17(1)(b)-(c); Ministry of Health of Vietnam, 2025).

Vietnamese law also contains post-birth protections often omitted from surrogacy-specific statutes. The written agreement must address obstetric incidents, reproductive-health support and the parties' rights and duties. The surrogate receives reproductive-health support and a maternity-leave entitlement of at least 60 days after birth, irrespective of transfer timing (Law on Marriage and Family No. 52/2014/QH13, 2014, arts. 96–97). These provisions demonstrate that intended parentage and continuing recognition of gestational consequences are legally compatible.

The model nonetheless creates relational risk. Restricting surrogacy to close relatives is intended to preserve altruism and prevent market exploitation, but kinship may generate less visible pressure: obligation to an infertile sibling, deference to elders, dependence within a marital family or difficulty withdrawing after a collective family decision. Requiring a married surrogate's husband to consent further complicates an individual assessment of voluntariness (Hibino, 2019; T. H. L. Nguyen & T. H. Nguyen, 2022).

Vietnam is consequently more explicit than the other two regimes about maternity-related recovery, yet less developed on independence and relational coercion. Its 60-day entitlement should not be understated; neither should it be mistaken for a complete psychosocial continuity system. The duration, independence, complaint architecture and outcome monitoring remain under-specified.

D. Cross-case comparison

The regimes are best compared across four layers: parentage status; entry safeguards; ordinary health, employment or social rights; and surrogacy-specific continuity after birth. This symmetrical structure avoids treating Vietnam's maternity entitlement as part of surrogacy law while ignoring general maternity protections in England and Wales or California. Table 2 summarises the resulting comparison across these four layers.

[Insert Table 2 here]

Table 2

Comparative legal treatment of parentage status, entry safeguards, ordinary post-birth rights, surrogacy-specific continuity and principal visibility gaps

Legal dimension	England and Wales	California	Vietnam
Parentage status	Gestating person is the legal mother at birth; intended parents ordinarily obtain a post-birth parental order.	Intended parentage may be established through a compliant agreement and pre-birth order; carrier has no parental rights or duties.	Requesting spouses are parents from birth in a lawful altruistic arrangement; surrogate is not assigned parental status.
Entry safeguards	Post-birth consent to parental order; agreements unenforceable; guidance and proposed regulated-pathway safeguards.	Written agreement, independent attorneys, financial and insurance disclosure, formal execution before treatment.	Medical eligibility, intrafamilial relationship, prior birth, counselling, written agreement and, where married, husband's consent.
Ordinary post-birth rights	Maternity leave and qualifying pay or allowance may continue; ordinary healthcare remains available.	Pregnancy disability leave and general medical, insurance and malpractice protections may apply.	Reproductive-health support and at least 60 days of maternity leave after birth.
Surrogacy-specific continuity	No integrated minimum for independent postpartum counselling, funded care, complaint and monitoring.	Continuity depends largely on contracts, agencies, clinics, insurance and general law.	Some explicit recovery protection, but independence, longer-term support, complaint and outcome monitoring remain limited.
Principal visibility gap	The surrogate is over-recognised as mother for status but under-recognised as a former reproductive patient.	The carrier is visible as a contracting party before performance and may disappear after performance.	The surrogate remains visible as an altruistic relative, but kinship may conceal pressure and inhibit complaint.

The comparison identifies convergence without erasing difference. England and Wales over-allocates gestation to status, California relies heavily on formal private ordering, and Vietnam embeds altruism in kinship. All three provide some protection after birth, but none links the surrogacy pathway to a comprehensive floor of independently accessible postpartum care, transition support, complaint and outcome accountability.

Temporal truncation therefore does not mean a total legal vacuum. It describes a decline in legal density and integration: entry and parentage are organised as one coherent project, whereas post-birth interests are scattered across general law, professional guidance and private arrangements. That mechanism answers RQ1 and frames the legal invisibility identified by RQ2.

VII. TEMPORAL TRUNCATION AND THE STATUS-CARE DISTINCTION

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Temporal truncation is a regulatory pattern in which the most specific protections cluster before conception and around parentage, then contract or fragment once the child's status is secure. Screening, counselling, agreements and court orders are treated as inputs into a successful reproductive project. Post-birth support appears as an ancillary service rather than a legal consequence of a medically and relationally intensive process.

The pattern is produced by categories, not only omissions. In England and Wales, the surrogate is highly visible as 'mother' for status transfer but less visible as a former reproductive patient requiring coordinated continuity. In California, the surrogate is visible as an independently represented contracting party but may disappear after performance. In Vietnam, the surrogate remains visible as an altruistic relative with maternity-related rights, while family membership may conceal pressure and inhibit complaint. Each category captures one dimension and suppresses another.

Temporal truncation is also a narrative operation. Each regime gives the surrogate a recognisable role at the moment law needs consent, gestation or status transfer, then narrows that role when the reproductive project is completed. The shift from mother, contractor or relative to legal outsider is not a neutral description of time. It helps determine which post-birth claims sound coherent, which emotions appear legitimate and which institutions are expected to respond. The status-care distinction interrupts that narrative without extending parental status.

The status-care distinction resolves the conceptual impasse. Status asks who has parental rights and duties toward the child. Care asks what continuing obligations are owed to the person who gestated because they underwent treatment, pregnancy and birth in a legally authorised arrangement. The questions are analytically separate. A legal system can conclusively allocate parentage to intended parents while imposing non-parental duties protecting bodily integrity, mental health, privacy, dignity and a fair transition.

The distinction also bounds continuing consent. Consent to the intended-parentage project is not a blanket transfer of control over the surrogate's body. Medical decisions during pregnancy remain theirs under ordinary law. Recurring confidential check-ins should assess safety, pressure and support; they should not create a rolling referendum on parentage. Professional guidance already recognises medical autonomy and access to counselling before, during and after participation (Ethics Committee of the American Society for Reproductive Medicine, 2023; ESHRE Ethics Committee, 2025).

Care responsibility is plural. The state sets mandatory standards and remedies. Clinics owe treatment-related duties and ensure referral. Intermediaries coordinate without conflicts of interest. Insurers or pre-funded accounts secure continuity if relationships deteriorate. Intended parents bear transparently defined pregnancy-related and postpartum costs but must not control clinical access. Independent lawyers and counsellors protect voice and confidentiality. Stable parentage and supported transition also advance child welfare by reducing conflict and making expectations around birth and contact more predictable.

VIII. A SURROGATE-CENTRED CONTINUITY OF CARE FRAMEWORK

SCCC is a dual-track legal model. Track A secures intended parentage under the governing regime. Track B creates non-derogable rights and institutional duties for the surrogate before treatment, throughout pregnancy and after birth. The tracks communicate but do not collapse into one another.

A. Minimum duties

First, legal and psychosocial advice must be substantively independent. Separate lawyers are necessary but insufficient where counsellors, agencies and clinics share incentives to complete treatment. The surrogate should be able to select an accredited adviser from an independent pool. Intended parents may fund the service without selecting or directing the professional. Confidentiality, conflicts and limited safety-related disclosure must be explained. Screening should identify support needs, not search for an unrealistically 'emotionless' candidate (ASRM & SART Practice Committees, 2022).

Secondly, consent must continue for bodily and medical decisions. Confidential check-ins should occur before medication and embryo transfer, at meaningful stages of pregnancy, when material medical choices arise, before birth and after birth. Their purpose is to assess understanding, voluntariness, relational pressure, safety and emerging health needs. They are not repeated contractual assent to parentage and must not become surveillance by intended parents or intermediaries.

Thirdly, the parties should co-produce a birth, transition and contact plan with a neutral facilitator. The plan should address attendance at birth, immediate contact, feeding or expression of milk, communication with the surrogate's family, transfer timing, photographs, updates, privacy and possible future contact. It must remain revisable and distinguish enforceable logistical or financial terms from non-coercive relational aspirations. Law need not compel affection; it can require informed discussion and a fair process for change.

Fourthly, funded postpartum care should be guaranteed rather than merely recommended. The minimum package should include obstetric follow-up, pain and wound care, lactation-related care where relevant, mental-health screening, and confidential access to an independent clinician or counsellor. Statute or regulation should require at least an early and a later follow-up and a low-threshold route back into care while pregnancy-related need remains clinically indicated. The exact timetable should be set with perinatal expertise rather than fixed by contract. A person who declines routine counselling must retain the ability to re-enter care without intended-parent permission (Velez et al., 2025).

Fifthly, core protections must be non-waivable. An agreement should not penalise a surrogate for seeking healthcare, reporting pressure, refusing a non-essential intervention or revising a contact preference. Clauses purporting to transfer final authority over abortion, fetal reduction, mode of delivery or other bodily decisions should be void. Stable parentage must not depend on silence or medical obedience.

Sixthly, oversight must continue after birth. Each regime should provide a confidential complaint route outside the clinic or agency, require de-identified outcome reporting and audit whether services were offered and accessed. Relevant data include obstetric outcomes, mental-health referrals, unmet expenses, disputes, relationship breakdown and satisfaction over time. Monitoring must protect privacy and avoid constructing surrogates as presumptively unwell.

B. Funding and allocation of responsibility

Continuity cannot depend on the solvency or goodwill of a relationship after birth. Before treatment, the legally required agreement should identify the payer and secure essential funds through insurance, a regulated escrow or an equivalent guarantee. The clinic remains responsible for treatment-related follow-up and referral; the fund-holder or insurer pays covered services; the regulator supervises minimum standards and complaints; and intended parents cannot terminate access by disputing a relationship term. Public funding may supplement this floor where surrogacy is integrated into public healthcare.

C. Implementation across the three regimes

In England and Wales, SCCC could be attached to parental-order practice now and to any future regulated pathway. Existing maternity rights would remain, while an HFEA-designated or equivalent regulator would set a surrogacy-specific continuity standard, require pre-funded support and receive de-identified outcomes. This would ensure that any future move to intended parentage from birth does not make the surrogate less visible.

In California, the legislature could amend section 7962 to require non-waivable bodily-autonomy clauses, pre-funded postpartum care and independent complaint information. Licensed facilitators could be required to report whether minimum services were secured and offered. Pre-birth orders would remain intact; the reform would place a public floor beneath sophisticated private ordering rather than displace it.

In Vietnam, reform could build on Decree No 207/2025's counselling, privacy and data infrastructure and on the statutory 60-day entitlement. It should guarantee independent counsellor selection, replace spousal permission with direct assessment of the surrogate's own voluntary consent, create recurring confidential check-ins and extend referral beyond the formal maternity period where clinically indicated. Because relational pressure may be the central risk, complaints should be institutionally separate from both families and the treating hospital.

Across the three regimes, gestational-relational loss would remain a preventive and remedial concept, not a status-creating one. SCCC governs bodily decision-making, service provision, cost allocation, transition and remedies. It does not create a continuing power to revoke intended parentage after birth.

IX. OBJECTIONS AND LIMITATIONS

The first objection is over-pathologisation. Most surrogates in several studies report positive experiences and long-term adjustment; a framework organised around loss could depict them as fragile or irrational. SCCC responds by making access, not compulsory therapy, the baseline. It respects refusal, rejects emotional detachment as a screening ideal and treats positive relationships as compatible with legal protection (Jadva et al., 2026; Shaw et al., 2024; Söderström-Anttila et al., 2016).

The second objection is paternalism. Repeated assessments may appear to question an original decision. Relational autonomy does not authorise professional vetoes over competent choices. Its implication is procedural: supply independent information, create safe opportunities to revise care preferences and protect bodily authority. The check-in is a route to voice and care, not a licence to invalidate participation.

The third objection concerns cost and access. Mandatory postpartum services may increase the price of surrogacy and constrain intended parents' reproductive opportunities. Reproductive justice requires that effect to be acknowledged. It also rejects making access affordable by externalising foreseeable costs to the person who gestates. A proportionate care floor is a legitimate cost of a safe arrangement; transparent insurance, escrow and public support can distribute that cost without turning care into compensation for parentage (Cammu, 2024; Ross & Solinger, 2017).

A fourth objection is that transition and contact plans are unenforceable or intrusive. The answer is to separate process duties from compelled intimacy. Law need not force affection, photographs or continuing contact. It can require facilitated discussion, documentation of preferences, allocation of expenses and privacy, and a method for renegotiation. The objective is to reduce avoidable rupture, not judicially supervise relationships.

A fifth objection is that recognising post-birth interests may destabilise the child's family. The status-care distinction is designed to prevent that result. Parentage and care are placed on separate tracks; the surrogate's access to healthcare or complaint does not become a claim to custody. Predictable transition, reduced conflict and clear responsibility can strengthen rather than weaken the child's legal and relational security.

Finally, the article's limitations define a future research agenda. Gestational-relational loss requires testing through ethically approved qualitative and longitudinal research across compensated, non-commercial, intrafamilial and cross-border arrangements. Research should include surrogates who experienced no distress, ended relationships, regretted participation or declined contact, as well as intended parents, clinicians, intermediaries and existing children. SCCC should be evaluated for unintended coercion, unequal access, administrative burden and cultural fit.

X. CONCLUSION

Surrogacy law has long been organised around a contest between gestation and intention. That contest asks an essential but incomplete question: who is the parent? Once parentage is resolved, the person

who underwent pregnancy can become legally peripheral even though bodily recovery, relationship change and mental-health needs continue.

Neither maternalisation nor emotional erasure is satisfactory. Gestation does not necessarily make a person a mother, and many surrogates reject that identity. Non-motherhood does not make pregnancy bodily, emotional or relationally neutral. Gestational-relational loss identifies a contingent form of post-birth disruption without turning it into a claim to the child.

The comparison of England and Wales, California and Vietnam shows that divergent status rules converge in temporal truncation. Each regime supplies some ordinary or specific post-birth protection, but none integrates entry, pregnancy, transition and postpartum care into an accountable whole. The status-care distinction explains how intended parents can receive secure legal status while the surrogate retains non-parental rights to independent support, bodily autonomy, funded care and remedy.

The humanities significance of this comparison lies in the relationship between legal categories and legal visibility. Mother, carrier, patient, contractor, relative and stranger are not descriptive labels alone; they are cultural scripts that determine when embodied experience counts as a legal concern. Temporal truncation occurs when law closes the reproductive story at the moment of parentage, even though the gestating person's bodily and relational story continues. SCCC reopens that institutional narrative without reopening parentage.

Surrogacy law should not require a person to be a legal mother before it can recognise the consequences of pregnancy. Nor should parentage certainty be purchased through institutional disappearance. A complete surrogacy regime governs not only entry into pregnancy and transfer of status, but also a supported, dignified and accountable exit from the reproductive project.

Declarations

Ethics: This article reports no original research involving human participants. Ethical approval was therefore not required.

Data availability: No new dataset was generated. The analysis is based on legislation, cases, official reports, professional guidance and published scholarship cited in the reference list.

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Author Contribution

Pham Ngoc Minh Tu wrote the main content of the manuscript. Le Minh Hoang prepared the tables and contributed to the analysis of foreign laws. All authors reviewed and approved the final manuscript.

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