Submission Number 57

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Comments re Surrogacy

These brief notes are an inferior substitute for a face-to-face meeting and Q&A session and seem a most inadequate basis on which to consider/formulate important legislation.

I have many times, in the news media, advocated standardisation of legislation across the states; it is shameful that, in a tiny nation of 20 million people, patients have to commute from Perth to Canberra for basic treatment which any ART unit in WA could provide.

That said, I suggest you take the Substitute Parents' Act (ACT), the Parentage Act (ACT) and the Canberra Fertility Centre eligibility guidelines, counseling and legal requirements, together with our medical requirements, as your basis for legislation, and on which I can make comments, which in many respects are identical to those of the European Society for Human Reproduction and Embryology Taskforce on Surrogacy, as follows:

1. Legislation: The hand of enabling legislation should be as light as possible. Rigid eligibility criteria, for example, enshrined in law, mean that deserving cases falling just short of the criteria cannot be treated, while thoroughly undeserving or even potentially dangerous cases falling within the criteria, must be treated or the unit may face anti-discrimination legislation litigation. It should be for each unit to determine its own guidelines for eligibility (the ESHRE) guidelines are virtually identical to ours) and the final approval or rejection of each request left to the institution's ethics committee. The patients know that the composition of the committee is dictated by the NHMRC and its decisions are unlikely ever to be challenged at law.

   I do believe that regular counseling should be a legal and enforceable requirement, ideally initially as per our booklet, at 20 and 36 weeks of pregnancy, one month after delivery, after six months and one year.

   I do believe that advertising should be allowed but not through a brokering agency, since this raises the definite smell of commercialisation.

2. Traditional Surrogacy: In this situation, the woman who gestates the pregnancy also provides the egg and may become pregnant by a variety of ways out of the control of any legislation or responsible ART unit. Because she provides the egg, she is truly the child's mother (never mind the legal definition) and, my American colleagues tell me, is more likely to decide to keep the child after delivery. To avoid this and the embarrassing publicity that comes with it and to maintain some control over the

situation, I would recommend that all surrogacy should be of the gestational carrier pregnancy variety (where the surrogate does not provide the egg) carried out by IVF.

3. Donor Gametes: The proximity in time between the beginning of this push for uniform legislation and Senator Conroy's discovery that the surrogacy laws were inconvenient to him personally rather than to his constituents is inescapable. He required, as you know, a donor egg and you may find yourselves under pressure to include the use of donor gametes in surrogacy legislation. I have genuine concerns about this. Although the ACT legislation allows it, we and our ethics committee, took the decision not to do so for the following reasons:

   a) There is a good deal of public concern (and among some psychologists) regarding a child's (or adult's) ability to be comfortable with the fact that it has two other 'parents' in the case of simple use of sperm or egg donation. This concern extends to an individual's response to the knowledge that, although his/her parents provided the gametes, someone else carried the pregnancy and actually gave birth to him/her. There is a large body of counsellor/psychologist concern regarding the ability to deal with three sets of 'parents', as in commissioning parents, surrogate and partner and gamete donor and partner. You will be familiar with the term 'genetic bewilderment', often much overused but possibly applicable here. Much of this concern comes from American counsellors/psychologists who have great experience in surrogacy. I would strongly suggest you discuss this carefully with psychologists involved in surrogacy, obviously our own counsellor, Kim Riding, has the most experience in numbers, but an astute thinker on the subject (as well as having counselled many of our patients) is Roger Cook – email rcook@groupwise.swin.edu.au

   b) Single Women: The likelihood of a single woman of appropriate age requiring surrogacy is remote.

   c) Lesbian Couples: This is a more likely scenario and the surrogate would, in all possibility, be another lesbian.

   d) Homosexual Men: Allowing the use of donor gametes opens this particular Andora's box. We have rejected several requests of this nature. Again, because of social orientation, the surrogate is likely to be a lesbian.

   You may imagine how the news media would treat a surrogacy pregnancy under c) or d) above and how the general public (supportive of surrogacy for the guidelines we use) might react to you and your legislation. I must emphasise that there will be some who oppose surrogacy and some undecided. You need good happy news, not disastrous publicity, in the early years.

   The topic of disastrous publicity leads me to :

4. The Possibility of the Surrogate Wishing to Keep the Child:

This occurs virtually exclusively under two circumstances:

a) Traditional Surrogacy: as in baby Evelyn to whom you refer. See my comments.

b) When the Surrogate's expectations have not been met: Most surrogates want an ongoing relationship with the parents and the child. This is easy if it is a family friend or relation. However, if you allow advertising (which I support), this may become a problem if the couple treat the surrogate as an inanimate incubator. The ongoing relationship may need to be no more than a letter on the child's birthday, a Christmas card and perhaps an occasional visit, but the need is there for many surrogates and couples must understand this.

c) If the surrogate has not had children herself: Hence our guidelines. It also, at least partially, shows our surrogate is not herself infertile.

The above are the basics. I make the following comments from your issues paper which I have not yet addressed:

1) Guidelines: Our age limit for the commissioning mother is related to the plunging success rates after age 39. You need good publicity of good success rates to convince the sceptics. There is no proven place for surrogacy outside our guidelines.

2) Informed Consent and Mandatory Independent Counselling: Agreed entirely. See above comments, our clinic information, requirements and cooling-off period.

3) Age of Surrogate: You cannot legislate for different levels of maturity at the same age. That is up to the counsellors to determine. Previous parity is important (see above).

4) Pre-Conception Surrogacy Agreements: Very important, especially agreement on the number of embryos to be transferred, screening for foetal abnormality and what to do with an abnormal result.

5) Queensland Adoption Requirements: We got around the problem of single women, lesbians and homosexual men by linking our guidelines to ACT adoption requirements, i.e. heterosexual couples, married or in de facto relationships for at least three years. We also used the term "Australian residents" for all parties to prevent an Asian influx of patients.

6) Transfer of Legal Parentage: Please note that, rarely, partners may not be contactable to give approval. I like the idea of the long and short birth certificate. Release of information should be at the request of the child (aged >18 years) and with the agreement of all parties. Most of this information will already be given to the child under the disclosure plans of the agreement. Data regarding treatment should be held by the ART unit concerned, as required by NHMRC.

I would have preferred to go through your discussion paper line by line but clearly this is not possible.

For your information:

1. Queensland patients enquiring and meeting guidelines – 35
2. Queensland patients progressing to qualification – 8
3. Queensland patients dropped out because of difficulties accessing help/blood and ultrasound services in Queensland – 9
4. Queensland patients staying in ACT for the entire duration of treatment cycles – 5.

Yours sincerely

Signed

Martyn Stafford-Bell
10/6/08