1st Floor, Watkins Medical Centre
225 Wickham Terrace
Brisbane Qld 4000
Info@qfg.com.au
www.qfg.com.au

ACN 010 514 397
ABN 11 010 514 397

QUEENSLAND FERTILITY GROUP

QFG Office: 07 3833 1000
07 3833 1006
Fax: 07 3833 1014
Nurses: 07 3833 1001

91

16th June, 2008

Mrs Linda Lavarch MP,
Investigation into Altruistic Surrogacy Committee
Parliament House,
George Street,
BRISBANE QLD 4000

Dear Mrs Lavarch,

Thank you for accepting the Queensland Fertility Group submission into the investigation of altruistic surrogacy in Queensland. As the largest provider of fertility treatments in Queensland we have a special interest in surrogacy as an option for treatment for the limited number of clients who may otherwise remain childless.

The attached submission has been unanimously endorsed by the Directors, associates and the ethics committee of the Queensland Fertility Group. I trust this will aid the committee in their enquiry into surrogacy on behalf of the Queensland Parliament.

Regards

DR DAVID MOLLOY
Clinical Director

1st Floor, Watkins Medical Centre
225 Wickham Terrace
Brisbane Qld 4000
Info@qfg.com.au
www.qfg.com.au

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Queensland Fertility Group submission to the Parliamentary Enquiry into Altruistic Surrogacy

Should the legal restrictions and criminal penalties against altruistic surrogacy be removed from the Surrogate Parenthood Act 1988 *(Qld)?*

The legal restrictions and criminal penalties should be removed from the Surrogate Parenthood Act 1988(QLD). Scientific advances in reproductive technology have made surrogacy a real alternative for the many parents who otherwise would remain childless.

Should the Queensland Government play a role in regulating altruistic surrogacy arrangements in Queensland? If so, how can the Government regulate altruistic surrogacy arrangements in a way that:

- *ensures that the best interests of the child are protected;*
- *minimises intrusion into people's private lives;*
- *protects the health and wellbeing of all parties; and/or*
- *ensures that any conflict between the surrogate and the commissioning parents is prevented or minimised?*

Ideally altruistic surrogacy should only be permissible in limited and defined circumstances and performed only in a Reproductive Technology Accreditation Committee (RTAC) approved Assisted Reproductive Technology (ART) Units with a National Health and Medical Research Council (NHMRC) approved ethics committee.

ART units must comply with the RTAC code of practice and are nationally regulated with mandatory audits and inspections. In addition to this the National Perinatal Statistical Unit (NPSU) currently monitors statistics and clinical outcomes of surrogacy pregnancies. This provides the Queensland Government with an opportunity to utilize existing national frameworks through which altruistic surrogacy could be introduced, regulated and audited. This has many advantages and minimizes the regulatory role of government in individual surrogacy cases.

Surrogacy is not a simple alternative to having a child, the process itself is involved and the surrounding issues are complex. ART units have established multi-disciplinary teams with experience in providing the medical, counselling and support services necessary to maximize safety and preparation for all parties in a surrogacy arrangement.

The extensive preparation required for surrogacy is not unlike that required for successful facilitation of donor programs offered by many ART units. Inarguably the holistic approach to donor preparation helps to protect the health and wellbeing of all parties and is important in reducing the risk of conflict and problems throughout the donation process.
As with donation agreements all parties in surrogacy arrangements must have a clear understanding of the ethical and social implications of such an arrangement. Mandatory counselling must therefore be undertaken to consider the social and psychological significance for the persons born, the surrogate and the commissioning parents.

Preconception surrogacy agreements must be contractual and enforceable. This will best serve the child's interests, ensure the wellbeing of the surrogate and protect the rights of the commissioning parents.

What criteria, if any, should the commissioning parent/s and/or surrogate have to meet before entering into an altruistic surrogacy arrangement?
In responding to this question, please outline:

- *the reason for your choice;*
- *how you believe criteria could be monitored and enforced;*
- *any consequences or dilemmas you see in adopting the criteria; and*
- *any suggestions you may have to manage any of the issues identified.*

ART units with experienced NHMRC ethics committees can review and approve on a case by case basis the eligibility of commissioning couples and surrogates with reference to predetermined criteria and information provided by the clinic. The need to safeguard the welfare of any children born as a result of a surrogacy arrangement will be the guiding principle.

Mandatory counselling and a compulsory three month cooling off period must apply to allow either party to withdraw from the arrangement. The aim is to adequately prepare both couples, allowing sufficient time to consider this treatment and to look specifically at the short term and long term implications of a surrogacy arrangement.

Criteria for commissioning parents:

Maternal Age 25 – 50 years

Inability of the commissioning mother to safely carry an intrauterine pregnancy to viability

A pregnancy presents a significant physical health risk to commissioning mother which may result in long term physical complications, death or significant long term disability

Psychological wellness as defined by no ongoing significant history of mental illness, psychiatric conditions, significant personality disorders or intellectual disability.

The commissioning parents demonstrate the informed consent process through specialist medical, counselling and independent legal advice.

Exclusion Criteria:

If there is a current significant medical condition which may significantly decrease the person's life expectancy or parenting ability

Surrogacy for social or personal reasons

Concern for passing on an inherited genetic condition is not relevant as donor gametes/embryos can be utilized to prevent this from occurring.

Criteria for surrogate:

The age of the surrogate be between 25 and 40 years

The Surrogate must be deemed medically able to carry a pregnancy based on an appropriate risk assessment of potential complications.

The surrogate and her partner have psychological wellness as defined by no ongoing significant history of mental illness, psychiatric conditions, significant personality disorders or intellectual disability.

Partial surrogacy should be limited to the surrogate having a direct genetic relationship with one of the commissioning parents.

Exclusion of both surrogate and partner in the event either are convicted of sexual or violent offences in any jurisdiction.

The surrogate demonstrates the process of informed consent through specialist medical, counselling and independent legal advice.

The prospective surrogate should have had at least one child before becoming a surrogate.

Should criteria for commissioning parents be similar to that for adoptive parents?

The criteria should not be similar to that of adoption as it is not relevant in surrogacy arrangements. The strict criteria adopted by the Department of Child Safety preclude a number of people from adoption.
The aforementioned age restrictions of 25-50 are more lenient than that prescribed by authorities for prospective adoptive parents but are indicative of the age of people seeking reproductive treatment.

Certainly establishing the physical and psychological health of commissioning parents is of paramount importance in determining their ongoing ability to provide stable long term care for any resultant children. However under current adoption criteria if either parent requires wheelchair or other locomotion assistance then the couple are excluded, even though there is no evidence to suggest these people make less able parents.

What role should a genetic relationship between the child and the commissioning parent/s and/or surrogate play in an altruistic surrogacy arrangement?
In responding to this issue, you might wish to consider any evidence or experience relevant to:

- *the role genetic relationships may play in the outcomes for the surrogate, commissioning parents and child;*
- *the impact of genetic relationships on the legal parentage of the child; and*
- *any other relevant matters*

As previously stated partial surrogacy should be limited to the surrogate having a first degree genetic relationship with one of the commissioning parents. This situation maintains a genetic link and may decrease the likelihood of conflict. In partial surrogacy where there is no genetic relationship between commissioning parents and gestational parent, the gestational carrier has a legitimate and complicating genetic claim on the child after delivery. This type of surrogacy agreement is less likely to be in the best interests of any resultant children particularly if the agreement is contested.

IVF procedures must be used to collect eggs in any of the above, rather than utilization of artificial insemination procedures. This will then clearly define family related surrogacy as **two separate acts**, one being **oocyte donation** and the other being **gestational carrier**.

Donor oocytes may be utilized if necessary in altruistic surrogacy arrangements but ideally these should be sourced from a third party not the gestational carrier.

Should at least one of the commissioning parents have a genetic relationship with the child?

No it is not necessary for one of the genetic parents to have a genetic relationship with the child. Genetic conditions or loss of fertility due to oocyte or sperm difficulties are treated by the use of donated gametes or embryos.

The NHMRC ethical guidelines on the use of ART in clinical practice endorse embryo donation as an ethical option in the treatment of infertility. In this instance neither the birth mother nor the social father of the person born is the genetic parent.

What legal rights and responsibilities should be imposed upon the commissioning parent/s and/or surrogate?

- *If relevant, it would be helpful to detail your comments in relation to the following:*
    - *conditions for access to assisted reproductive technology;*
    - *conditions for transfer of legal parentage;*
    - *reasonable expenses for surrogates;*
    - *monitoring and enforceability of surrogacy agreements; and*
    - *access to advertising and brokerage services.*

Brokerage of a non-commercial nature should be permissible. It is reasonable to allow ART clinics to facilitate the introduction of potential surrogates to commissioning parents. ART clinics are currently the intermediary between unknown donors and recipient couples. The potential surrogate can be counselled as to the process of surrogacy prior to meeting any commissioning parents thus reducing the likelihood of exploitation and coercion.

In cases of altruistic surrogacy, reimbursement of expenses is ethically justifiable, provided it is based on a direct expenses model. This would ensure the surrogate neither gained nor suffered financially from entering into an agreement. The incurred medical fees, travelling expenses, additional nutritional costs, incidentals as well as insurance to cover the surrogate need to be taken into consideration when compensating reasonable expenses.

The legal rights and responsibilities of both the commissioning parents and the surrogate need to be well defined in an agreement prior to impregnation.

The surrogacy process should be closely monitored, during the pregnancy and post transfer of parentage by the counsellor. Follow up will ensure continued psychological health and wellbeing of all parties involved.

Should the definition of altruistic surrogacy only include pre-conception agreements in Queensland?

Altruistic surrogacy arrangements must have enforceable preconception agreements, allowing for adequate preparation including medical, psychological and legal counselling and advice. Agreements must be contractual and enforceable allowing for the greatest moral and legal certainty for all parties.

An enforceable agreement would clearly define parentage and the provision of long term care of any child born through surrogacy agreements, particularly in the situation of abnormality or illness or separation of the parents prior to transfer of parentage.

The safety and wellbeing of the surrogate is also assured especially in the provision of ongoing medical care and expense re-imbursement. Disability and life insurance should be arranged for the surrogate to protect the surrogate and her family in the event of an adverse outcome.

In preconception agreements the commissioning parents who in most cases provide the genetic material are also provided with protection to ensure that transfer of parentage eventuates. It is unreasonable that a surrogate should enter a well defined prospective agreement to carry a child to whom she has no genetic relationship and then elect to keep the baby. This amounts effectively to theft of a couple's genetic material. Unless enforceable preconception contracts exist, infertility as a pre existing condition is justification to reject that female as a potential gestational surrogate.

If infertility and/or health risk to the mother or child is a criterion for surrogacy, how should these criteria be defined?

The rights of a child born through altruistic surrogacy must take precedence over all matters. As stated previously it is important to clearly define the criterion for surrogacy as the inability of the commissioning mother to safely carry an intrauterine pregnancy to viability.

The formation of stable families is socially desirable and necessary. Based on this premise surrogacy would certainly be warranted in circumstances where a pregnancy presents a significant physical health risk to a mother which will result in long term complications, death or significant long term disability.

How important is it for there to be a mechanism for the transfer of legal parentage that is specific to surrogacy arrangements? What would this be?

Legal transfer of parentage guarantees the parentage of the commissioning parents and protects the status of the child as a child of the commissioning parents. The Status of Children Act 1978 will require amendment.

The adoption process as the means for transfer of parentage is inappropriate and leads to the greatest degree of uncertainty for any child born through surrogacy arrangements.

In instances where infants are born with abnormalities, adoption as the means of transfer of parentage poses a significant risk, should the prospective parents choose not to proceed with the adoption. This potentially leaves the child and the surrogate in a difficult situation, resulting in the child being the legal responsibility of the surrogate.

In reality, utilizing an adoption framework challenges the rights of the commissioning parents as it fully implies both legally and morally that the child is/was a child of the gestational carrier.

What are the consequences for children born of a surrogacy arrangement in Queensland of maintaining the status quo?

The current situation encourages commissioning parents to engage in "reproductive tourism" by having to seek treatment and give birth in jurisdictions which permit surrogacy. Decriminalizing surrogacy in Queensland would bring us into line with other states and territories and remove the need to "shop" for surrogacy laws which fitted their individual needs.

Should the surrogate's rights to be automatically recorded as the child's parent on the birth certificate and to approve legal transfer after birth remain if she has no genetic connection to the child?

Yes this ensures an accurate record of the child's birth circumstances is held with the existing Births, Deaths and Marriages Register. An amendment to this record must following the transfer of parentage permitting the commissioning parents to obtain a birth certificate with their details on it. This protects the privacy of the child as a birth certificate is offered as formal identification for everything from applying for a passport to playing sport.

What rights should a child born through an altruistic surrogacy arrangement have to access information relating his or her genetic parentage? Who should hold this information?

As for adopted persons and persons born as a result of reproductive treatment using donated gametes or embryos, children born through surrogacy arrangements are entitled to know their genetic origin and the existence of any genetically related siblings.

ART units have an existing obligatory requirement to maintain all donor records indefinitely, any use of donor gametes in surrogacy would be covered by these existing arrangements. As with preparation of recipients of donated material, counselling must encourage the commissioning parents to inform any resultant children of the circumstances of birth and their genetic origins if applicable.

What, if any, other matters should be considered in the regulation of this issue?

Attachment 1

Paper prepared by Dr Molloy for presentation to Members of the Parliamentary Select Committee.

Attachment 1:

SHORT BRIEFING PAPER RE SURROGACY PREPARED AS AN AID TO THE QLD PARLIAMENTARY SELECT COMMITTEE

Dr David Molloy
Clinical Director Queensland Fertility Group

This short brief has been prepared as an aid for the committee. It is not an exhaustive discussion of the issues and is meant to complement the high quality issues paper which has been distributed.

1. Surrogacy should be decriminalized in Queensland.

2. The Queensland Government should introduce arrangements which facilitate altruistic surrogacy in limited and defined circumstances. Such arrangements should include laws to allow transfer of parentage to the commissioning parents and contractually enforceable surrogacy agreements.

3. Surrogacy should be performed only in RTAC registered ART units with an NHMRC approved ethics committee. The arguments in favour of this include:
    - Most or all surrogacy should involve medical ART or IVF.
    - ART units have expertise in facilitating reproductive options for patients including extensive experience with donor programmes.
    - ART units have in-house multidisciplinary teams to provide all medical, counseling, and support services to maximize safety and preparation for all parties in a surrogacy arrangement.
    - ART units are nationally regulated.
    - All pregnancy outcomes of ART units are nationally reported and audited by the AIHW and the NPSU.
    - The regulatory model of ART units means that State governments have an existing regulatory framework through which surrogacy arrangements could be introduced, structured and audited. This has many advantages and minimizes the regulatory role of government in individual surrogacy arrangements.
    - ART units have the regulatory obligation of long term record keeping therefore protecting the interests of the child for access to birth records and genetic parentage.
    - Experienced ethics committees can review individual cases.

4. The concept of partial surrogacy (gestational carrier is also the provider of the oocyte) should be limited (perhaps to within families) or banned.
    - This is not surrogacy, it is 2 separate acts i.e. oocyte donation + becoming a gestational carrier. It should therefore be so defined.
    - IVF/ART units have well defined protocols to counsel and prepare patients for oocyte donation. The act of oocyte donation should be definitively separated from surrogacy.
    - In this circumstance the gestational carrier has a legitimate and complicating genetic claim on the child after delivery.
    - It is less likely to be in the child's interests to be the result of a surrogacy arrangement which may be contested or where the birth mother is also the genetic mother.
    - This form of surrogacy has the highest potential for difficulty and conflict.
    - Although donor oocytes may be used they should ideally be from a 3rd party, not the surrogate.

5. Surrogacy arrangements require extensive counseling, preparation and agreement prior to impregnation. The interests of the child are paramount but safety of the surrogate is also vital. The rights of the commissioning parents need protection. Such agreements should therefore be contractual and enforceable in the situation of complete surrogacy.
    - The greatest moral and legal certainty is created.
    - This creates maximal certainty for the child in terms of defined parentage and long term care, especially in the situation of abnormality or illness i.e. the child has a defined home.
    - The surrogate is protected, especially in such areas as medical care, expense reimbursement and she is maximally protected in the event of untoward events such as pregnancy complications, and death or separation of the commissioning parents. Disability and life insurance should be arranged for the surrogate.
    - The commissioning parents who have provided the genetic material are protected and have the best chance of transfer of parentage. It is unreasonable that a surrogate could enter a well defined prospective agreement to carry a child to whom she has no genetic relationship and then elect to keep the baby. This amounts effectively to theft of a couple's genetic material. Infertility as a pre existing condition in the surrogate is a reason to disqualify that female as a potential gestational carrier unless enforceable preconception contracts exist.

6.

Brokerage of a non commercial nature should be permissible.

- ART/ IVF units may be contacted by a female offering to be a surrogate. They should be allowed to introduce them to potential commissioning parents.
- Unless the legal definition of brokerage is very broad it may be difficult to outlaw it.