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Legislative Assembly of Queensland
Investigation into Altruistic Surrogacy Committee

Background

I am a psychologist and family therapist who has been involved in the areas of infertility and assisted reproduction for more than twenty years. For nine of those years (1992-2001) I worked as the clinic Infertility Counsellor at the then City West IVF (now IVF Australia, Western Sydney). I have also worked as a Couple Therapist at Relationships Australia, and also set up the CJD Counselling Service in NSW, which was funded to counsel people (and their families) who had been treated with human pituitary hormones and were at increased risk of iatrogenic CJD. Since 2001 I have worked exclusively in private practice in Glebe, Sydney, with about 50% of my work being related to infertility and assisted reproduction. This includes independent psychological assessment of gestational surrogacy cases which are required by a number of assisted reproduction clinics (in Sydney and Canberra) as part of the process before surrogacy treatment.

As an illustration of my professional background, I list here a small sample of the papers/presentations which I have given at professional conferences over the years:

- Ethical Considerations in ART – A baby at any price? – Psycho-Social Implications. (IFIPA) International Meeting of Consumers and Physicians, Sydney 1996
- Third Party Reproduction – Donor gametes, Surrogacy, Family Planning Association, Ashfield 1999
- Assisted Reproduction and possible long term family issues. Family Court Judges' Conference, Sydney 2001
- A Voluntary Contact Register: Stakeholders, Values, Processes, Dilemmas. Fertility Society of Australia Annual Conference, Perth 2003
- The Role of Assessment in Preparation for Surrogacy. ANZICA Workshop, Fertility Society of Australia Annual Conference, Sydney 2006

Experience with Surrogacy Treatment

My initial experience with surrogacy treatment was as clinic counsellor at City West IVF over 10 years ago. The climate of thinking had changed from a total prohibition against surrogacy treatment to the possibility of treatment for specific conditions. I was requested by the Medical Director to counsel the patients and write a report for consideration by the Ethics Committee. As this was in the early stages of treatment in Sydney and Canberra, there were no established processes, and I needed to develop my own processes, which were further informed as time and experience went by, and also informed by the processes developed initially at Canberra Fertility and later on at Sydney IVF. I have now been involved with more than 50 surrogacy cases, 2 of which were traditional insemination surrogacy (using the eggs of the surrogate) and the remainder using the eggs of the commissioning woman or a donor, and the sperm of the commissioning man. The process which I currently use for pre surrogacy psychological assessment is outlined in the Appendix to this submission. These independent psychological assessments are used as part of the information required by ART clinics for consideration as to whether or not to approve individual applications for surrogacy treatment. In my opinion the pre-surrogacy independent psychological assessment is also an integral part of the informed consent process.

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In the context of my professional qualifications and experience I offer my input to the questions posed in the May 2008 Issues Paper as follows:

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

I believe that the legal restrictions and criminal penalties against altruistic surrogacy should be removed from the Surrogate Parenthood Act 1988 (Qld). Nothing in my experience in undertaking pre-surrogacy psychological assessments in 50 cases in New South Wales would support the continuation of the current restrictions and penalties.

2. **Should the Queensland Government play a role in regulating altruistic surrogacy arrangements in Queensland?**

I would support the practice of assisted reproductive technology clinics industry standards being used for surrogacy treatment in Queensland. From my experience NSW and ACT fertility clinics follow NHMRC guidelines as well as the Reproductive Technology Accreditation Committee (RTAC) guidelines of the Fertility Society of Australia (FSA), and I would foresee Qld fertility clinics following the same practice as they currently do with the use of donor gametes and embryos.

If so, how can the Government regulate altruistic surrogacy arrangements in a way that:

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

The above issues need to be addressed both at the treatment stage before a surrogacy pregnancy and after the birth of a baby through surrogacy treatment. Before treatment there needs to be comprehensive medical and psychological assessment to protect the interests of the commissioning couple, the surrogate and her family and to consider the best interests of the hoped for offspring of surrogacy treatment. From my experience through a generous offer of help a party to a surrogacy proposal, such as the surrogate, can become emotionally trapped by an offer of help, without there having been full consideration of the above issues. A comprehensive pre-treatment assessment process allows space and time for the above issues to be fully explored as part of the informed consent process, which gives each party to the proposal a chance to consider the implications of their actions before committing to proceed with treatment.

After altruistic surrogacy treatment there are two different stages where I believe there can be interventions which address the above issues. The first is after confirmation of an ongoing surrogacy pregnancy. Canberra Fertility (but not clinics in New South Wales) currently has a requirement for counselling during the pregnancy by either the assessment counsellor or a counsellor nominated by the parties to the proposal. In my experience counselling sessions (once in each trimester, and once three months after delivery) allow for consideration of issues which have not arisen during the pre-treatment assessment stage, and for discussion of details around the birth and handover, as well as practical implications regarding existing children and families. Whilst it would be difficult to mandate post-pregnancy counselling in surrogacy treatment, there would be an incentive if it were then able to be used as the basis for a psycho-social report to the Family Court when a parenting order is requested by the commissioning couple and/or is required for transfer of legal parentage.

3. What other issues should be addressed by the Government?

In my opinion there are less risks regarding the above issues when altruistic surrogacy is gestational (not using the eggs of the surrogate) and carried out as part of IVF treatment at a fertility clinic because the clinics follow industry guidelines. There are more risks potentially in traditional or insemination surrogacy (which does not require IVF treatment) because it can be done without the assistance of fertility clinics. I believe that there should be encouragement of insemination surrogacy to occur at fertility clinics, to minimise the physical and psycho-social risks to all involved in the altruistic surrogacy. If however people make a decision to act on their own behalf and do a home insemination outside a clinic then I do not believe there should be penalties for their actions. If unwanted outcomes occur then they would need to be addressed through processes such as those of the Family Court.

4. 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:

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

I believe that there should be significant medical and/or health risks which mean that the commissioning woman is unable to carry a baby. This would need to be decided by medical professionals at a fertility clinic, but could include: congenital absence of the uterus, removal of a uterus after cancer, significant other health problems of the commissioning woman which preclude her carrying a baby, or significant reproductive loss. I do not believe that a short term lack of success in IVF treatment is an indicator for surrogacy treatment, though it is a belief which I have encountered in general infertility counselling, and at the preliminary stages of consideration of surrogacy, rather than the pre-treatment assessment stage. I do not believe that this would need monitoring by the State but that it can be well managed by fertility clinics under industry standard guidelines. Whilst there may be members of the community who could see this as an impediment to treatment, and may decide to undertake their own home insemination, I do not believe that this is sufficient reason for relaxing the current strict medical requirements for surrogacy treatment.

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

My understanding of criteria for adoptive parents is that they are more stringent (e.g. duration of assessment period, number and type of assessment contacts and requiring home assessment) than those required for commissioning parents in surrogacy. The exceptions include the medical requirements regarding uterus problems, and I do not believe that requirements for adoptive parents involve the use of an objective measure of psychopathology as is required in pre surrogacy assessment. This is a tool which I find particularly helpful as part of the pre-surrogacy psychological assessment process as it highlights personality profiles of each party to the surrogacy proposal and the relationship implications can be considered by using the interpersonal styles dimension of the psychopathology measure.

There is one further important difference between adoption and surrogacy. In the former a baby is conceived without any planning or consideration on the part of the proposed relinquishing or adoptive parents, and a future consideration for the adopted child is the meaning of having been given up for adoption. In the latter, the assessment process occurs before a child is conceived,

and the parties to the surrogacy proposal make an informed decision to act with the prior intention of a child being born of the surrogacy being raised in a situation other than the birth situation.

6. **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:
   a. **the role genetic relationships may play in the outcomes for the surrogate, commissioning parents and child;**
   b. **the impact of genetic relationships on the legal parentage of the child; and**
   c. **any other relevant matters.**

My experience of psychological assessment has related mostly to gestational surrogacy where the surrogate is not related genetically to the child. In most of these situations the genetic material is that of the commissioning parents, with a few situations using donated oocytes because of the medical history of the commissioning mother. In these gestational surrogacy arrangements the surrogate is clear that the situation would be different for her if the surrogacy were to require her to use her own oocytes. From a general family functioning aspect, if there were to be any question regarding quality of relationship between parents and children with genetic heritage other than their own, then a range of research such as that by Golombok et al (e.g. The European Study of Assisted Reproduction, Human Reproduction, Vol 17, No 3, 830840, March 2002) indicates no significant difference in parent –child relationships.

7. **Should at least one of the genetic parents have a genetic relationship with the child?**

I have not encountered a situation where there has not been a genetic relationship with the child by at least one of the proposed commissioning parents. However given that embryo donation is available in Australia, then it is foreseeable that in the future there could be such a surrogacy proposal. It could be argued that this process is not so different from the use of donated oocytes or sperm to create a embryo for use in surrogacy, or the use of donated embryos by a couple for their own use. The treatment of gay (female) couples with known or anonymous donor sperm is routine, as is the treatment of single women with donor sperm. I am also aware that there have been gay (male) couples who have travelled to the USA to undergo surrogacy treatment, though I am not aware of any single men or women having done so, but presumably it could be argued that this treatment could be done also. In adoption there is no genetic relationship with the child and thus it could be argued that surrogacy treatment be undertaken where there is no genetic relationship with the child. Whilst there is an instinctive thought that there should be a genetic relationship, it is on the same continuum as the abovementioned treatments.

8. **Should the surrogate be able to use her gametes or should she have no genetic relationship to the child?**

It is not usual for IVF clinics to undertake traditional or insemination surrogacy, but this process also does not require the use of IVF treatment. There is however anecdotal evidence that traditional insemination surrogacy is being performed outside of ART clinics, with commissioning parents and surrogates undertaking home monitoring and inseminations. This is, I believe, a concern because of the lack of health and safety precautions (e.g. no universal precautions) and the lack of medical and psychological assessment. Whilst individuals may believe that they are caring for their own safety and the safety of others, and that they have carefully considered the implications, I believe that it is a minefield. Thus I believe it would be preferable if ART clinics and the law could be more open to insemination surrogacy.

9. **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:
   a. **conditions for access to assisted reproductive technology;**
   b. **conditions for transfer of legal parentage;**
   c. **reasonable expenses for surrogates;**
   d. **monitoring and enforceability of surrogacy arrangements; and**
   e. **access to advertising and brokerage services.**

I would not support any proposal for an enforceable contract which could require that a surrogate would be forced to relinquish a child born of surrogacy. I would also not support a move to commercialisation of surrogacy and thus do not support the payment of other than reasonable expenses for surrogates. With regard to advertising and brokerage services my understanding is that there are no brokerage services in Australia, and that advertising occurs through websites, which I believe are non-commercial. This fits in with the situations for the donation of gametes and embryos in Australia, and is in the spirit of altruism which I believe is a very positive aspect of assisted reproduction in Australia. Regarding the transfer of legal parentage I support the continuation of approval being required by the surrogate, though following on from my answers to questions 7 and 8, I do not believe it to be essential for there to be a genetic relationship to the commissioning parents.

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

I would support the requirement of pre-conception agreements for transfer of legal parentage in surrogacy to encourage the use of ART clinics and a formal pre surrogacy assessment process. If traditional insemination surrogacy is undertaken through a home insemination outside of an ART clinic, then I believe it should be considered as private adoption.

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

Refer my response to Question 4, which I believe answers this.

12. **How well does the transfer of legal parentage in a surrogacy arrangement fit with contemporary approaches in family law and adoption?**

I am unable to comment on this question.

13. **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?**

I am unable to comment on this question, other than to say that I believe there should be a transparent mechanism of the transfer of legal parentage from the surrogate to the commissioning parents. This would be appreciated by the commissioning parents and the surrogates and their partners whom I have seen over the years.

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

I am unable to comment on this as I do not have experience of the current situation in Queensland.

15. 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?

I believe that the surrogate's name should appear on the child's birth certificate even if she has no genetic connection to the child, because she gives birth to the child. I believe that there should be transparency of process which respects the rights of all parties and gives a child full knowledge of all that was involved in his or birth, be it genetic heritage or birth details.

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

I believe that a child born through altruistic surrogacy should have access to information relating to his or her genetic parentage. The fact that this information is currently held in ART clinics in the use of gamete or embryo donation treatment is satisfactory, but I believe that it would be preferable long term for this information to be held in a government agency. The information regarding genetic heritage and birth history is of a similar quality to that currently held by a government department of births, deaths and marriages, and thus I believe should be retained and made available according to the same standards.

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

In my opinion the Issues Paper and related questions for consideration have covered surrogacy and there are no other matters which I believe should be considered in the regulation of this issue.

Miranda Montrone
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June 18, 2008

Appendix: Pre-Surrogacy Treatment Psychological Assessment Process

Assessment CounsellingProcess:

1. Appointment 1: Clinical Interviews with the adults involved: separate sessions with the commissioning couple and the surrogate and partner, and a short joint session with all four people. As well each person is required to complete the Personality Assessment Inventory, which is an objective measure of psychopathology. The total time required for this appointment is usually 3 to 4 hours.
2. Appointment 2: Individual counselling sessions with each adult individually to report on the Personality Assessment Inventory results and discuss individual issues. A joint counselling session with all adults to consider the issues listed below. If the surrogate or commissioning couple have children between the ages of 4 and 14 years, Canberra Fertility requires that they also be seen as part of the psychological assessment process, though other clinics (e.g. Sydney IVF, Fertility First) do not require this. The time required for this appointment is usually 3 to 4 hours.
3. A report is sent to the referring clinic within two weeks after the second appointment. A copy of the report is also sent to the commissioning couple and to the surrogate and her partner.
4. The current cost for the independent psychological assessment is $1600, which is discounted from the rates recommended by the Australian Psychological Society, which is currently a total of $2490.

Issues considered in assessment counselling for surrogacy:

The issues which are required for consideration in the psychological assessment are listed below. All parties receive written advice of these issues before commencing the psychological assessment and the issues are discussed with them during the assessment process.

1. Relationships between the couples and implications of surrogacy (capacity to make independent decisions – financial or emotional dependence issues).
2. Commitment to and motivation for surrogacy and its unique demands, potential benefits and costs to surrogate.
3. Reproductive and infertility history, how these have been coped with.
4. Informed consent and what it means for all parties.
5. Change of mind for a party before or during the process.
6. Other stress factors – any major upheavals or transitions.
7. Mental health history and current state.
8. Psychological and marital stability of both couples.
9. Implications for any existing children and risk factors (any loss issues and how parents intend to deal with them).
10. Possibilities of complications that may affect couples or individuals: e.g. relationship breakdowns, medical problems, even death.
11. Attitude to prenatal screening and termination.
12. Issue of relinquishment or refusal to do so.
13. Dealing with a disabled child, refusal by a commissioning couple to take on such a child.
14. Ideas re future relationships.
15. Intentions re disclosure and explanation to others.
16. Differences in parenting styles.
17. Awareness and acceptance of legal ramifications.