

Chapter 17

Eligibility for Surrogacy



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Eligibility for Surrogacy

In Chapters 4 and 5, we discuss the eligibility criteria which apply to people seeking access to infertility treatment in Victoria. In this section, we consider how these criteria apply to surrogacy arrangements. We also make recommendations about eligibility for surrogacy.

CURRENT LAW

Altruistic surrogacy is legally permitted in Victoria, but the criteria which determine who is eligible for assisted reproductive technology (ART) services in a licensed clinic mean the circumstances in which a woman may act as a surrogate mother are extremely limited.

If an embryo formed with the commissioning mother's eggs and the commissioning father's sperm is to be used, or if the surrogate's own eggs need to be fertilised using ART, it will be necessary for the surrogate to undergo treatment in a clinic.

The *Infertility Treatment Act 1995* sets out the requirements that must be met before a woman may undergo artificial insemination or a fertilisation procedure at a licensed clinic. We examined these requirements in detail in Chapter 4. If a woman is married or is in a heterosexual de facto relationship,¹ she must be unlikely to become pregnant with her own egg, or with her partner's sperm, other than by a treatment procedure.² Alternatively, she must be at risk of having a child with a disease or genetic abnormality.³ Her partner must consent to her being treated.⁴

An embryo created with an egg and sperm produced by people other than the woman undergoing treatment and her partner can only be used in a treatment procedure if the woman undergoing treatment is unlikely to become pregnant from her own egg and her partner's sperm.⁵

If the woman does not have a male partner, she is only eligible for treatment if she has been assessed as clinically infertile⁶ or is likely to transmit a disease or genetic abnormality to a child.

These conditions apply to a potential surrogate

mother in the same way as they apply to a woman wanting to become pregnant with her own child. The fact that the commissioning person or couple may meet these conditions is of no relevance under the Act. The failure of the Act to distinguish between a woman who is seeking treatment to overcome her own inability to become pregnant and a woman who is seeking treatment for a surrogacy arrangement has the following possible consequences.

If a surrogate is to receive treatment in a clinic involving the use of her eggs (partial surrogacy) she must be:

- unlikely to become pregnant other than by a treatment procedure or likely to transmit a disease or genetic abnormality to a child (if married or in a de facto heterosexual relationship) or
- clinically infertile or likely to transmit a disease or genetic abnormality to a child born as a result of the pregnancy (if she does not have a male partner).

If a surrogate is to receive treatment in a clinic involving implantation of an embryo created using eggs from another woman (gestational surrogacy) she must be:

- unlikely to become pregnant other than by a treatment procedure or likely to transmit a disease or genetic abnormality to a child (if married or in a de facto heterosexual relationship) or
- clinically infertile or likely to transmit a disease or genetic abnormality to a child born as a result of the pregnancy (if she does not have a male partner).

In either of these situations, if the treatment also involves the commissioning father's sperm and the surrogate has a male partner, the partner must also be infertile.⁷

There are very few situations in which a woman who is willing and able to act as a surrogate mother will be able to meet these statutory criteria. The law therefore creates a significant barrier to altruistic surrogacy even though it is not actually prohibited under the Act.

RECOMMENDATIONS

99. If a person or couple wish to commission a woman to carry a child on their behalf, a doctor must be satisfied that:
 - they are in the circumstances in which they find themselves, unlikely to become pregnant, be able to carry a pregnancy or give birth; or
 - the commissioning woman is likely to place her life or health, or that of the baby, at risk if she becomes pregnant, carries a pregnancy or gives birth.
100. If, before a person or couple commission a woman to carry a child on their behalf, a doctor or counsellor believes that any child that might be born as a result of the arrangement may be at risk of abuse or neglect, he or she should seek advice about whether or not to proceed with treatment from the clinical ethics committee operating within the licensed clinic.
101. Where a clinical ethics committee decides that a person or couple should not be able to commission a surrogacy, or the surrogate mother and her partner (if any) should not be able to participate in a surrogacy arrangement:
 - (a) the person concerned may apply to the Infertility Treatment Authority review panel to have the decision reviewed;
 - (b) a clinic must not take any steps in relation to the surrogacy unless the committee's decision is reviewed by the Infertility Treatment Authority review panel, and the panel decides that there is no barrier to treatment or that, subject to compliance with certain conditions, there is no barrier to treatment.

PROBLEMS WITH THE LAW

We do not know how frequently surrogacy arrangements involving self-insemination occur in Victoria, if at all.⁸ However, we do know that no treatment procedures involving surrogates are being carried out in clinics in Victoria because of the eligibility requirements imposed by the present law.⁹ As a result of these restrictions, some people may decide not to continue their efforts to have a child, while others travel interstate and overseas to pursue surrogacy arrangements.

Some people seek treatment in the ACT or NSW but receive counselling and other medical support in Victoria. In some cases, the surrogate gives birth to the child in Victoria.

The inability of people to seek treatment in their home state has serious implications. First, it puts the commissioning parent(s) and the surrogate to unnecessary inconvenience. Second, it means that the legal relationships between the parties involved are uncertain. In most cases, the surrogate mother will be presumed to be the legal parent of the child born, and the commissioning parents must seek a formal transfer of legal obligations. The laws regarding parentage in surrogacy arrangements are discussed more fully in Chapter 19.

The uncertainty surrounding the legal status of a child born of a surrogacy arrangement interstate may mean that parties do not disclose the nature of the conception upon their return to Victoria. During the pregnancy, it is possible that a surrogate mother may not disclose to medical staff that she is carrying the child on behalf of someone else. It is also possible that a surrogate may assume the identity of the commissioning mother while in hospital so that the child is recorded as having been born to the commissioning mother and not the surrogate.¹⁰ The true nature of the arrangement may not become apparent to medical staff unless the child needs medical treatment after birth. Without clarity as to who is the legal parent, there could be conflict between the commissioning parents and the surrogate mother at a time when critical medical decisions have to be made.

Excluding people from the Victorian clinic system means that the surrogate mother, commissioning parents and the child will not be protected by the safeguards offered by Victorian law. For example, if treatment was provided in a jurisdiction which does not require registration of such information, the child may not have the right to access information about his or her genetic origins where donated gametes have been used.

The commission also received submissions from people who have pursued, or are considering pursuing, surrogacy arrangements in the United States (US) because they are unable to access treatment in Victoria or other Australian jurisdictions. These arrangements involve substantial expense. One man wrote:

*Because my partner and I have been forced to go overseas in order to fulfil our dream of having children who are biologically related to us, we have been required to expend an enormous amount of money—several hundred thousand dollars—to do so. This was our choice, and with our children due in a few months, we certainly do not regret a cent.*¹¹

In some of these cases, as in the one above, the parties travel to jurisdictions where commercial surrogacy is permitted. Commercial surrogacy arrangements are clearly contrary to public policy in all Australian jurisdictions.¹²

If the government continues to permit altruistic surrogacy in Victoria, the commission believes the anomalies in the application of the Infertility Treatment Act eligibility criteria should be corrected to remove the barriers that currently exist for surrogacy arrangements. It makes no sense to prevent fertile women from acting as surrogates.

If the statutory barrier to treatment is removed, criteria to regulate access to surrogacy services should be implemented. The commission has considered the following questions in determining those criteria:

- Should people entering into surrogacy arrangements be subject to the same requirements as people seeking other forms of ART? Alternatively, should they have to meet other requirements?
- What criteria should apply to the commissioning person or couple?
- What criteria should apply to the surrogate mother?
- Should eligibility criteria be set out in legislation, or should they take the form of clinical guidelines?

- 1 *Infertility Treatment Act 1995* s 8(1).
- 2 *Infertility Treatment Act 1995* s 8(3)(a).
- 3 *Infertility Treatment Act 1995* s 8(3)(b).
- 4 *Infertility Treatment Act 1995* s 8(2).
- 5 *Infertility Treatment Act 1995* s 20(3)(a).
- 6 Interpretation of section 8 of the *Infertility Treatment Act 1995* according to opinion of Gavan Griffith QC, 4 August 2000. Copy provided to the commission by the Infertility Treatment Authority.
- 7 Interpretation of section 20 of the *Infertility Treatment Act 1995* according to opinion by Gavan Griffith QC, 16 May 2002. Copy provided to the commission by the Infertility Treatment Authority.
- 8 There are reports that surrogacy arrangements involving privately arranged self-insemination do occur: Clare Masters, 'Warning Over Home Insemination Baby Boom' *The Daily Telegraph* (Sydney) <www.news.com.au/dailytelegraph> 10 February 2007.
- 9 Information provided by Dr Gordon Baker, Melbourne IVF, 20 November 2006. In one of its submissions to the commission, the ITA reported that it was aware of a case where 'the husband of a woman who wished to act as an altruistic surrogate underwent a vasectomy ... it seems reasonable to believe that the man's decision to undergo a vasectomy was influenced by the requirements of section 20(3) of the *Infertility Treatment Act 1995*': Submission PP3 52 (Infertility Treatment Authority). The commission has no information about whether this surrogacy proceeded.
- 10 This practice was reported in the US case *Doe v Doe*, 710 A 2d 1297 (Conn 1998).
- 11 Submission PP3 45 (Anonymous).
- 12 The terms of reference for this inquiry required the commission to consider the legislation 'in relation to altruistic surrogacy' and not in relation to commercial surrogacy. However, some submissions argued that commercial surrogacy should be permitted in Victoria: submissions CP 247 (Adrian Tuazon), CP 245 (Jeremy Sayers), CP 244 (Tony Wood), CP 248 (Peter Usher and Dax Purvis), CP 246 (David Johnston-Bell), PP3 45 (Anonymous).

RECOMMENDATIONS

102. A licensed clinic should not assist in a surrogacy arrangement without the approval of the Infertility Treatment Authority review panel where the person or couple commissioning the surrogacy, or the surrogate mother and/or her partner (if any):
- (a) has had charges proven against them for a sexual offence as defined in clause 1 of Schedule 2 to the *Sentencing Act 1991*; or
 - (b) has been convicted of a violent offence as defined in clause 2, Schedule 1 to the *Sentencing Act 1991*; or
 - (c) has had a child protection order (but not an interim order) made in respect of one or more children in their care under a child welfare law of Victoria, any equivalent law of the Commonwealth or any place outside Victoria (whether or not in Australia).
103. A person or couple should be able to commission a surrogacy arrangement regardless of relationship or marital status or sexual orientation.
104. Before entering into a surrogacy arrangement the person or couple commissioning the surrogacy and the woman intending to act as the surrogate and her partner (if any) should receive:
- counselling about the social and psychological implications of entering into the arrangement
 - advice and information about the legal consequences of entering into a surrogacy arrangement.

The commission's consideration of these questions has been assisted by submissions made by members of the public, our consultation with people who have experience in the practice of surrogacy and the legal frameworks governing it, and our research on approaches adopted in other jurisdictions. Further consultations were held in response to the commission's interim recommendations made in *Position Paper Three: Surrogacy*.

In this chapter, we will discuss the criteria which should apply to people entering into surrogacy arrangements. The commission's broad position is as follows:

- Any eligibility criteria based on fertility should apply to the commissioning couple or person and not to the surrogate mother.
- Women wishing to act as surrogate mothers should be required to undergo medical assessment and should (with their partners, if any) receive counselling to establish whether they are capable of being surrogates.
- There should be a legislative requirement that the commissioning couple or person receive counselling to establish whether they are capable of being able to deal with a surrogacy arrangement.
- If there is a concern that a child to be born could be at risk of harm from the surrogate and her partner (if any), or the commissioning person or couple, there should be a process for assessing that concern.

SURROGACY: A SPECIAL CASE

In Chapter 5 the commission made recommendations for eligibility criteria that should apply to people seeking ART. These criteria would supplement the existing requirements that people seeking treatment give informed consent and receive counselling and information about the implications of the treatment procedure. In summary, the commission's recommendations for additional eligibility criteria are:

- If a doctor or counsellor believes that any child who might be born as a result of a treatment procedure may be at risk of abuse or neglect, the doctor or counsellor must seek advice from a clinical ethics committee about whether to proceed with the treatment procedure. It should be possible that the decision of the ethics committee be reviewed by the ITA review panel.¹³
- A clinic should not be able to treat a person, without approval of the ITA review panel, where the woman seeking treatment and/or her partner has had charges proved against them for a serious sexual offence, been declared a serious violent offender under the *Crimes Act 1958*, or had a child protection order made for one or more children in their care under a child welfare law.¹⁴
- The requirement that a woman undergoing treatment be married or in a heterosexual de facto relationship should no longer apply, and, if a woman does not have a male partner, that should be sufficient to satisfy a doctor that she is unlikely to become pregnant.¹⁵

The commission has considered whether these criteria would be sufficient for surrogacy cases or whether additional criteria should apply.

The commission's assessment of surrogacy is that it is sufficiently different from other forms of ART to warrant a cautious regulatory approach, with an additional set of requirements for access to treatment services. Our view is that the eligibility criteria that apply to surrogacy should address the risks associated with surrogacy arrangements that do not arise in other forms of ART. In particular, surrogacy involves another party (the surrogate mother) who carries the child throughout pregnancy but will be asked to relinquish that child upon birth.

Because surrogacy involves the relinquishment of a baby by the woman who gives birth to it, the commission views it as having important similarities to adoption. As a community, we have learnt in the past that the adoption of children has caused significant grief and distress, both for the women who have relinquished their babies and for the children who have struggled with the emotional consequences of adoption.¹⁶

The commission recognises the differences between surrogacy and adoption, but does not want to ignore the lessons of the adoption experience in the context of surrogacy. The protection of children and surrogate mothers must be the primary concern of any law regulating surrogacy.

Our cautious approach is also informed by the lack of detailed and longitudinal research into the potential impact of surrogacy on children and surrogate mothers. Although recent research conducted in Australia and the United Kingdom (UK) suggests the outcomes are generally positive, we do not yet have any data on the long-term consequences for children.

In addition, the commission has been reminded that surrogacy arrangements can and do go wrong, and that this can be painful and damaging for all involved.¹⁷ The commission recognises this and notes that although only 4–5% of surrogates refuse to relinquish the child in countries where altruistic surrogacy is permitted, the pain caused in these cases could be profound.¹⁸ Any conflict over child custody has the potential to be very damaging for all parties involved. Women who act as surrogates may experience distress during pregnancy or after birth at the prospect of relinquishing the baby. The commissioning person or couple may feel deprived of ‘their’ child, the surrogate and her family (if any) may find themselves responsible for a child not originally intended to be theirs, and the child, whose infancy may be the subject of protracted legal proceedings and conflict, may suffer as a result.¹⁹ These possibilities cannot be ignored.

RECOMMENDATIONS

ELIGIBILITY

Earlier in this chapter we described the eligibility requirements that currently apply to surrogacy arrangements in Victoria. In order to meet these requirements, the surrogate (and her partner) must be unlikely to become pregnant, be clinically infertile or likely to transmit a disease or genetic abnormality to a child born.²⁰

The commission received submissions that highlighted the illogical and ‘absurd’ nature of current eligibility requirements.²¹ The Fertility Society of Australia said:

It makes little sense to require the surrogate to be infertile when she is attempting to relieve the infertility of the commissioning person/couple.²²

One submission posed the question:

Why would an infertile woman be a surrogate for someone else when she by the term ‘infertile’ has had her own difficulties starting a family?²³

The commission also heard from people who had considered surrogacy, but were prevented from accessing treatment in Victoria because of the current eligibility criteria. These people pointed out that while altruistic surrogacy is not illegal in Victoria, the law makes it virtually impossible to pursue.²⁴

One couple investigated surrogacy after nine years of unsuccessful IVF treatment. In Victoria, the surrogate, not the commissioning couple themselves, had to meet eligibility criteria. As a result of these restrictions, the couple eventually sought treatment in NSW. The commissioning father wrote of his experience:

The Victorian legislation was explained to us by our IVF physician ... It seemed incredulous that treatment was not available to us in Victoria but we could achieve our objective via the Canberra Fertility Clinic or Sydney IVF.²⁵

The commission agrees that any eligibility criteria based on fertility should apply to the commissioning couple, not the surrogate (or her partner). Further, the fertility of the surrogate’s partner should have no bearing on a clinic’s decision to provide ART to the surrogate.

- 13 Recommendations 3 and 10.
- 14 Recommendation 12.
- 15 Recommendations 26 and 28.
- 16 See Chapter 2 for discussion of this point.
- 17 Surrogacy roundtable, 20 October 2004.
- 18 Department of Health [UK], *Surrogacy: Review for Health Ministers of Current Arrangements for Payments and Regulation* Cm 4068 (1998) 26.
- 19 Ibid.
- 20 See page 170.
- 21 Submissions PP3 35 (Dr Maggie Kirkman), PP3 42 (Anonymous).
- 22 Submission PP3 18 (Fertility Society of Australia).
- 23 Submission PP3 24 (Katrina Harrison).
- 24 Submissions CP 236 (Anonymous), PP3 24 (Katrina Harrison).
- 25 Submission PP3 31 (Robert Rushford).

Chapter 17

Eligibility for Surrogacy

RECOMMENDATIONS

105. The regulations should specify the following matters to be addressed during counselling:
- the implications of surrogacy for relationships between members of a commissioning couple and between the surrogate mother and any partner
 - the implications of surrogacy for the relationship between commissioning parent(s) and the surrogate mother
 - the implications of surrogacy for any existing children of the surrogate mother and/or commissioning parent(s)
 - the possibility of medical complications
 - the possibility that any of the parties may change their mind
 - refusal of the surrogate mother to relinquish the child
 - refusal of the commissioning parent(s) to accept the child
 - the motivation and attitudes of the surrogate mother
 - attitudes of all parties towards the conduct of the pregnancy
 - attitudes of the commissioning parents to the possibility that the child may have a disability
 - attitudes of all parties to investigation of a genetic abnormality, the possibility of termination of pregnancy or other complications
 - a process for the resolution of disputes
 - the commissioning parent(s)' intentions for custody of the child, if one of them should die
 - possible grief reactions on the part of the surrogate mother and/or her partner
 - ways of telling the child about the surrogacy
 - attitudes to an ongoing relationship between the surrogate mother and the child
 - access to support networks.

The commission believes it is important for people pursuing surrogacy arrangements to have a serious and genuine reason for wishing to do so. Those reasons should relate broadly to an inability to become pregnant, carry a pregnancy to term or avoid any risk to their life or health, or that of the child.

The commission believes that it is appropriate to require the person or couple seeking to commission a surrogacy arrangement to meet the eligibility criteria that apply to all people seeking ART. In Chapter 5 the commission recommended that if there is a concern that a prospective child will be at risk of harm from one or both of his or her parents, treatment should be refused (with a right of review). We recommend that the commissioning person or couple be subject to those criteria, as well as all counselling, consent and information provisions contained in the Infertility Treatment Act. The relevant provisions would need to be modified to apply to the circumstances of surrogacy arrangements.

We believe it is appropriate that the criteria relating to notification of a child's potential risk of abuse or neglect also apply to the surrogate and her partner because it is possible they may remain the primary carers of the child. We discuss and make recommendations in relation to parentage in surrogacy arrangements in Chapter 19.

The commission also received submissions from gay men who wished to commission surrogacy arrangements but who were unable to have access in Victoria. The commission does not believe it is justified to require people who are commissioning a surrogacy arrangement to be married or in a heterosexual de facto relationship. This reflects the commission's conclusion that a person's marital status or sexuality are not factors that are considered by child welfare authorities or experts to be predictors of harm to children.²⁶ As discussed earlier, excluding people from access to ART services may result in their seeking arrangements elsewhere in Australia or overseas. This may increase the potential for negative outcomes for children, for example, by depriving them of the capacity to obtain information about their genetic origins or the circumstances of their birth.

COUNSELLING

The commission believes that some criteria additional to those which apply to surrogates should apply to the commissioning person or couple because of the complexity of surrogacy arrangements.

In Position Paper Three, the commission recommended that the commissioning person or couple undergo psychological assessment, including a home study, to determine whether they are able to cope with all stages of the surrogacy. We also suggested that the commissioning person or couple receive counselling on specific matters regarding surrogacy.

Among the responses to the Position Paper, the commission heard from people who had participated in or are intending to participate in surrogacy arrangements. People involved in surrogacy arrangements were generally supportive of the counselling process.²⁷ Some people who had accessed treatment in other Australian states because of restrictions in Victoria commented on the process they underwent, which included medical and psychological assessment, counselling and legal advice:

We were grateful for the insights gained by following the above protocol and agreed after its completion all parties were capable of undertaking the surrogacy arrangement ... The process followed by us prior to commencing medical treatment was thorough and of high standard. It allowed us to fully understand the surrogacy process and beyond.²⁸

A woman considering commissioning a surrogacy told the commission:

Counselling prior to a surrogacy arrangement does seem important, both to make sure all parties make the right choices, and to prevent surrogates being pressured into surrogacy. Many infertility clinics already have excellent, well qualified counselling staff who might be able to fill this role.²⁹

Professionals involved in ART also supported counselling for the parties. Counselling is already a standard requirement of participation in ART programs.³⁰ Dr Ruth McNair observed that more than one counselling session would be required, and that information and support would be necessary at all stages of the process.³¹

However, some people expressed concern about a potential requirement that a person or couple must be assessed as 'fit and proper people to enter into a surrogacy arrangement', on the grounds that a person who has no other option than to have a child through surrogacy should not have to have their fitness to parent assessed. One woman considering acting as a surrogate commented:

Couples are already subject to scrutiny by a doctor and counsellor, and need to convince their surrogate that they are worthy parents before an arrangement can go ahead. Furthermore, they are likely to have already explored multiple other avenues to have a child.³²

In a roundtable discussion on surrogacy convened by the commission, participants agreed that people who undertake surrogacy are generally well-informed about the medical process, the legal implications and the potential conflicts involved in surrogacy before they make the decision to seek professional assistance.³³

There was also confusion about the distinction between psychological assessment and counselling, and about the purposes of each process. In surrogacy arrangements conducted interstate, counselling is sometimes provided by the same psychologist who assesses the parties' capacity to participate in a surrogacy arrangement.³⁴

In response to these concerns, the commission has reviewed its interim recommendations. We have decided that assessment of the commissioning parents should not be conducted as a separate process, but should instead form part of the counselling process. The clinical ethics committee of the clinic where treatment is sought should review all applications for surrogacy.

The purpose of counselling is to ensure that the parties to a surrogacy arrangement are aware of and have considered the issues which arise in surrogacy arrangements. The matters to be addressed in counselling should be listed in regulations (in the same way as the matters to be addressed in counselling for ART are set out in the regulations).³⁵ Counselling should address three broad themes including the parties' attitudes towards pregnancy, birth and relinquishment of a child born, the implications of surrogacy for relationships between the parties and the possibility that the arrangement does not proceed as intended by the parties.³⁶

26 See the discussion in Chapter 5.

27 Surrogacy roundtable, 21 February 2006.

28 Submission PP3 31 (Robert Rushford).

29 Submission CP 236 (Anonymous).

30 Submission PP3 39 (Rhonda Brown).

31 Submission PP3 28 (Dr Ruth McNair).

32 Submission PP3 27 (Katherine Harding).

33 Surrogacy roundtable, 21 February 2006.

34 Surrogacy roundtable, 21 February 2006.

35 Infertility Treatment Regulations 1997 rr 6 and 7.

36 The matters to be addressed in counselling have been adapted from the specific issues addressed in counselling for people undergoing surrogacy in the ACT: John James Memorial Hospital Ethics Committee, 'Guidelines for Independent Clinical Psychologist Initial Assessment', *Guidelines for Surrogacy* (January 2003). The Reproductive Technology Accreditation Committee also provides guidelines for issues to be addressed in counselling: Reproductive Technology Accreditation Committee, *Code of Practice for Assisted Reproductive Technology Units* (rev ed, 2005) [1.3], 80.

37 See Chapter 11.

38 See Chapter 11.

39 Surrogacy roundtable, 21 February 2006.

40 Surrogacy roundtable, 21 February 2006.

RECOMMENDATIONS

106. The Infertility Treatment Authority should develop guidelines about the application of these regulations, in consultation with clinics, and should evaluate and monitor their effectiveness over time.
107. If the counsellor considers it appropriate, independent psychological testing (in accordance with accepted professional standards) or a home study should be permitted.
108. In each surrogacy arrangement, the clinical ethics committee at the licensed clinic where treatment is proposed to be carried out must decide whether treatment can proceed.
109. In making a decision about whether the surrogacy can proceed, the clinical ethics committee must be satisfied that the parties:
 - are aware of and understand the personal and legal consequences of the surrogacy arrangement
 - are prepared for the consequences of the arrangement if it does not proceed in accordance with the parties' original intentions
 - are able to make informed decisions about proceeding with the arrangement.
110. The clinical ethics committee's decision should be based on a report from a counsellor and an acknowledgement from the parties that they have received all the required and relevant information and advice.
111. A decision made by the clinical ethics committee about whether the surrogacy can proceed should be reviewable by a review panel.
112. A woman intending to act as a surrogate should not be subject to the requirement that she is unlikely to become pregnant other than by a treatment procedure.

LEGAL ADVICE

It is also important that all parties to a surrogacy arrangement are aware of the legal consequences that may arise. The laws surrounding surrogacy are especially complex because of the inconsistencies and conflicts between federal and state laws regarding parentage of the child.³⁷ There are a number of areas of unsettled law which create additional uncertainty.³⁸

People who have participated in surrogacy arrangements and those intending to commission a surrogacy told the commission that they support a requirement to obtain independent legal advice.³⁹ They cited numerous areas of legal uncertainty which affect their families, including acquiring passports, accessing medical treatment, determining estate entitlements, and child support obligations.⁴⁰ The commission is aware that obtaining legal advice will not necessarily solve or avoid the legal complications that might arise, but it should help clarify existing rights and obligations. We also note that it will be important to ensure that independent legal advice be affordable, particularly for the surrogate mother.

The ITA should develop guidelines about the application of the regulations about counselling and legal advice, in consultation with clinics, and should evaluate and monitor their effectiveness over time.

The commission is aware that in Australia parties to surrogacy arrangements are counselled by a clinic's senior counsellor. We support this practice. If the counsellor considers it prudent, independent psychological testing (in accordance with accepted professional standards) or a home study should be permitted; however, these steps should not be mandatory.

APPROVAL

In Chapter 5 we recommended that all licensed clinics establish a clinical ethics committee to consider particular cases where there are concerns about the welfare of children to be born. The commission believes that the clinical ethics committee should also oversee all surrogacy arrangements. Before a surrogacy can proceed, a clinical ethics committee should decide whether treatment can proceed, based on an assessment that the parties:

- are aware of and understand the personal and legal consequences of the surrogacy arrangement

- are prepared for the consequences of the arrangement if it does not proceed in accordance with the parties' original intentions
- are able to make informed decisions about proceeding with the arrangement.

The approval should be based on a report from a counsellor that the parties have been supplied with all relevant required information, and have sought and obtained legal advice. The parties should also be required to acknowledge they have received the relevant information and advice.

Although these requirements will add additional steps to the process usually required for ART, the commission considers this to be justified because of the unknown and potentially significant ramifications of surrogacy arrangements. The process is consistent with the commission's recommendations in Chapter 5 which require that decisions about complex cases are referred to specialist bodies such as ethics committees.

The decision of the ethics committee should be reviewable in the same way as decisions about access to other forms of ART (as described in Chapter 5). The review panel should be able to review the committee's decision; further judicial review should be available by the Supreme Court.

SURROGATE MOTHERS

A woman intending to act as a surrogate mother should also have to meet some additional criteria before the surrogacy can proceed. Leaving aside the criterion 'unlikely to become pregnant', a woman intending to act as a surrogate should be assessed for eligibility in the same way that applies to other woman undergoing ART, as recommended above.

During the consultation process, the commission explored whether a woman should have reached a particular age before being able to act as a surrogate. It was suggested to us that an age requirement might assist in establishing that a surrogate has reached a level of maturity to understand the implications of the arrangement.⁴¹ Others said that age was only one factor in assessing maturity and that the purpose of the age requirement could be addressed in counselling.⁴²

The commission's view is that a woman intending to act as a surrogate should be at least 25 years old. A woman acting as a surrogate requires a sufficient level of maturity to be able to understand the implications of entering into the arrangement. Becoming a surrogate should not be seen as the mere exercise of a legal right attained on turning 18, but rather a decision

that requires a level of maturity that most people have not developed at that age. It is worth noting in this context that although people become legal adults at 18, the United Nations' definition of youth extends to anyone under 25.⁴³ Requiring the surrogate to be at least 25 years old may also act as an additional protection against any unequal bargaining power between her and the commissioning parents.

The commission has also considered whether it should be a requirement that the surrogate have already experienced pregnancy and childbirth. The Fertility Society of Australia said that a potential surrogate should have experienced pregnancy and childbirth so that she is 'able to give informed consent as to the task she proposes to undertake'.⁴⁴ Others argued that a prior pregnancy could be a factor in assessing maturity and capacity to be a surrogate, but that it should not be a requirement.⁴⁵ It was also suggested that some women who have not had children may wish to become surrogates and may be quite capable of doing so.⁴⁶

The commission has concluded that although it is desirable that the intending surrogate has experienced pregnancy and childbirth, this should not be a steadfast requirement. Exceptions should be allowed where it is apparent that the surrogate understands the implications of the arrangement, and is able to make an informed decision.

GENETIC CONNECTION

The commission has considered whether the gametes of at least one of the people commissioning the surrogacy should be used to conceive the child and whether the surrogate should be prevented from using her own eggs in the conception of the child. Imposing either of these conditions would limit the forms of altruistic surrogacy permitted in Victoria.

- 41 Submissions PP3 18 (Fertility Society of Australia), PP3 8 (VANISH), PP3 45 (Anonymous), PP3 54 (AIS Forum), PP3 56 (Melbourne IVF Counselling Service).
- 42 Submission PP3 28 (Dr Ruth McNair), PP3 32 (Anonymous), PP3 55 (Fertility Access Rights).
- 43 United Nations Educational, Scientific and Cultural Organization, *Resolution on the Role of UNESCO in Improving the Situation of Young People and the Contribution of UNESCO to International Youth Year*, General Conference, 22nd sess., Paris, 1983.
- 44 Submissions PP3 18 (Fertility Society of Australia), see also PP3 45 (Anonymous), PP3 56 (Melbourne IVF Counselling Service).
- 45 Submission PP3 48 (Women's Health West).
- 46 Submission PP3 55 (Fertility Access Rights).
- 47 ABC Radio National, Paul Barclay interview with Dr Martyn Stafford-Bell, 'Surrogacy', Australia Talks Back, 9 November 2006; Sydney IVF, *Surrogacy at Sydney IVF* (September 2005), Surrogacy roundtables, 20 October 2004 and 21 February 2006.
- 48 Gina Goble, *Carrying Someone Else's Baby: A Qualitative Study of the Psychological and Social Experiences of Women who Undertake Gestational Surrogacy* (Unpublished Master in Psychology (Counselling Psychology) Thesis, Swinburne University of Technology, 2005), 70–72.
- 49 'Kay', quoted in *ibid* 71.
- 50 *Ibid* 68.
- 51 Canberra Fertility Centre, *Surrogacy Information Pack* (September 2004); Sydney IVF, *Surrogacy at Sydney IVF* (September 2005).
- 52 *Parentage Act 2004* (ACT) s 24.
- 53 'Carla', quoted in Goble (2005), above n 48, 72.
- 54 Some submissions said that adoption is sometimes suggested as an alternative to surrogacy without consideration of the eligibility requirements or availability of adoption: submissions PP3 52 (Infertility Treatment Authority), PP3 24 (Katrina Harrison).

RECOMMENDATIONS

113. Apart from the above recommendation, a woman intending to act as a surrogate mother should be subject to the same criteria that apply to all women undergoing ART services.
114. A woman intending to act as a surrogate mother should be at least 25 years old.
115. In assessing whether a woman is able to give informed consent to act as a surrogate mother, consideration should be given to whether she has already experienced pregnancy and childbirth, however, this should not be a prerequisite.
116. Partial surrogacy should be permitted. That is, it should be possible for the surrogate mother's egg to be used in the conception of the child.
117. If the surrogate mother's egg is used in the conception of the child, counselling must address the implications of this for:
- the relinquishment of the child
 - the relationship between the surrogate and the child once it is born.
- The clinical ethics committee should confirm these matters have been the subject of counselling.
118. A genetic connection between the child and the commissioning parents is to be preferred, but people should not be excluded from commissioning a surrogacy arrangement if they are unable to contribute their own gametes.

Surrogate Mothers

Some commentators argue that only gestational surrogacy should be permitted because a surrogate mother is less likely to experience difficulty in giving up a child who is not genetically related to her.⁴⁷ The surrogate may find it easier to regard the commissioning couple as the child's parents if their gametes have been used in the conception of the child. This would also mean that a child born as a result of a gestational surrogacy arrangement will not be the genetic sibling of any other children of the surrogate mother.

In an Australian study of women who acted as gestational surrogates, not being a genetic parent of the child was found to be an important factor.⁴⁸ The participants in this study indicated that using the commissioning couple's gametes helped them to treat the pregnancy differently to their previous pregnancies with their own children. One woman said:

[The baby is] not part of me ... It's their egg, their sperm ... Basically I am just growing it, so it's no part of me. I am just helping it grow. I couldn't do it if it wasn't my sister and it was any part of [my partner] and myself.⁴⁹

The study revealed a common attitude among the surrogate mothers who felt that after birth, they were not required to 'relinquish' the child. Goble reported that the women did not see themselves as 'the true mothers of the babies' but that the children 'rightfully belonged to the commissioning couple who were the true parents'.⁵⁰ Some women also used specific language such as 'babysitter' or 'doing a job' to emphasise their roles as surrogates. Women who used their own eggs were not part of this study. In the ACT, surrogacy is only permitted when genetic parentage and gestation are separated.⁵¹ Under the *Parentage Act 2004* (ACT), the commissioning couple can only be recognised as the parents of the child if the surrogate and partner are not the genetic parents of the child, and at least one of the commissioning couple is a genetic parent of the child.⁵²

On the other hand, some people argue there are many circumstances in which a surrogate should be able to use her own eggs in conception. This is known as partial surrogacy.

If a commissioning parent does not have any eggs to contribute, it may be difficult to find both an egg donor and a surrogate. A surrogate may be quite willing to use her own eggs to

conceive a child. This was the case for one woman who participated in Goble's study. After agreeing to act as a gestational surrogate, the woman considered partial surrogacy:

She (commissioning mother) was a bit worried about her age, so I said if her eggs were not very good, she could have a couple of mine.⁵³

Partial surrogacy is less likely to expose the surrogate to medical hazards because conception can normally be achieved by assisted insemination. If using assisted insemination, a woman may not need to take medication to induce ovulation. Sometimes, the medications used to induce ovulation cause serious side effects. Assisted insemination is also significantly less expensive than other more invasive forms of ART.

Often the surrogate is related to the commissioning parents, for example, she may be a sister of one of them. In such cases the child will have some genetic links with the surrogate, whether or not the surrogate's eggs were used to conceive the child. If the commissioning mother is unable to provide eggs and her sister is acting as the surrogate (which is quite common), she may wish her sister's eggs to be used to preserve a genetic connection with the child.

Commissioning Parents

Some submissions argued that the gametes of at least one of the commissioning couple should be

55 Different academic and personal viewpoints were submitted to the commission, eg, submissions PP3 35 (Dr Maggie Kirkman), PP3 15 (Gina Goble), PP3 51 (Laura Clark and Dominic Dillon), CP 243 (Nicole Poustie).

56 The study by Vasanti Jadva et al, 'Surrogacy: The Experiences of Surrogate Mothers' (2003) 18(10) *Human Reproduction* 2196, concluded that '[a]lthough it may be assumed that genetic surrogate mothers would be more likely to feel a special bond towards the child, this was not found to be the case. Genetically related surrogate mothers were, however, more likely than genetically unrelated surrogate mothers to wish the child to be told about the surrogacy arrangement': 2203.

57 Surrogacy roundtable, 21 February 2006 (Dr Maggie Kirkman).