

**INQUIRY INTO LEGISLATION ON ALTRUISTIC
SURROGACY IN NSW**

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Legislative Council of New South Wales Investigation into legislation on altruistic surrogacy in NSW

Background

I am a psychologist and family therapist and have worked in the areas of infertility and assisted reproduction for more than twenty five 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 40% of my work being related to infertility and assisted reproduction. This work includes the independent psychological assessment of altruistic surrogacy proposals which is required by a number of assisted reproduction clinics (in Sydney and Canberra) as part of the pre surrogacy treatment assessment process.

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
- Gestational Surrogates. ANZICA Workshop, Fertility Society of Australia Annual Conference, Brisbane 2008.

I made written submissions to the South Australia Legislative Council into Gestational Surrogacy in 2007; and to the Queensland Investigation into Altruistic Surrogacy Committee, as well as appearing before the recent Qld Committee hearings. These submissions were based on my early experience in supportive and assessment counselling of patients during surrogacy treatment at the then City West IVF, and my later extensive experience in independent psychological assessment of patients before clinic approval for altruistic surrogacy treatment.

Professional 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 then Medical Director to counsel the patients and write a pre treatment assessment report for consideration by the clinic 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 65 surrogacy cases, 11 of which have been this year. Two of the altruistic surrogacy proposals were insemination or traditional surrogacy (using the eggs of the surrogate) and the remainder used the eggs of the commissioning woman or an egg donor, and the sperm of the commissioning man. In more than 50 of these cases I have been requested to undertake an independent psychological assessment of those involved in a the surrogacy proposal with a report being submitted to the Assisted Reproductive Technology (ART) clinic, in Sydney or Canberra, for consideration, most often by an Ethics Committee or a Surrogacy Review Panel at the clinic.

The process which I currently use for pre surrogacy psychological assessment is outlined in my response to question b in 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 altruistic surrogacy treatment. In my opinion the pre-surrogacy independent psychological assessment is also an integral part of a fully informed consent process in altruistic surrogacy.

In the context of my professional qualifications as a psychologist, family therapist and infertility counsellor; and experience (30 years psychologist & relationship counsellor, 25 years infertility counsellor, 10 years surrogacy experience) I make my submission in response to the questions posed by the Terms of Reference of the Inquiry, as follows:

a. The role, if any, that the NSW Government should play in regulating altruistic surrogacy arrangements in NSW.

In Australia, until very recently, altruistic surrogacy has only been possible in NSW and the ACT. In my understanding, altruistic surrogacy has been able to occur in NSW because of the absence of legislation against surrogacy. With ACT legislation allowing altruistic surrogacy to commence in the late 1990s, ART clinics in NSW reviewed their approach to surrogacy treatment in the light of the ACT legislation, and developed protocols essentially along the lines of the ACT approach. In my view altruistic surrogacy has worked quite well in NSW even though there has been no legislation, because of the cautious, thorough, professional approach of the ART clinics. However I believe it is now an appropriate time for the NSW government to be involved in regulating altruistic surrogacy arrangements in NSW. There are parts of the surrogacy process which could be improved through legislation, mostly related to children born of surrogacy treatment and their parents, which would facilitate birth certificates (and Medicare cards, passports etc) and parenting arrangements, and which would validate the actions of all

involved in the surrogacy proposal: the commissioning or intended parents, and the surrogate and her partner, if she has one.

b. The criteria, if any, that the intended parent/s and/or birth parent/s should have to meet before entering an altruistic surrogacy arrangement.

Surrogacy is a big thing. It is a big thing for a woman to relinquish the baby that she has nurtured for 9 months, even if this relinquishment is planned. It is not just one incremental step on a spectrum of assisted reproductive treatment options, such that someone who has had a lack of success with other treatments can move on the same continuum to surrogacy treatment. For surrogacy treatment to be considered there has had to be a major impediment to a woman bearing a child herself, which has been usually related to congenital abnormalities (e.g. absence of uterus), or significant medical problems (e.g. hysterectomy following cancer, highly significant history of reproductive loss), or significant contra indications for the commissioning woman to undergo pregnancy. In my experience these criteria have related to heterosexual couples (married, de facto) which have been assessed by a range of medical practitioners, and which have also involved thorough medical assessment of the proposed surrogate woman/birth mother and her health risks in undergoing another pregnancy and delivery. I cannot give a submission on the medical criteria, though I can regarding the psychosocial/mental health assessment criteria.

Depending on the specific ART clinic the non medical criteria for surrogacy treatment currently include independent psychosocial/mental health assessment (psychologist & sometimes psychiatrist) and legal advice regarding the current legal position. In my experience this psychosocial and legal pre treatment process works well, even though unfortunately there are financial costs involved for the commissioning couple. It could be argued that the psychosocial/mental health situation of those involved in a surrogacy proposal could be satisfied by in clinic implications counselling as is currently required for other third party reproductive treatment (donor gamete, donor embryo treatment). Having 25 years experience of this implications counselling, as well as 10 experience of independent psychological assessment as part of the pre surrogacy assessment I believe that there are significant differences in the treatments which requires formal psychological assessment as distinct from the implications and supportive counselling which is part of donor gamete or donor embryo treatment.

Pre Surrogacy Psychological Assessment: Issues for consideration as part of assessment:

Currently ART clinics require that the following issues be considered in the pre surrogacy psychological assessment. All parties receive written advice of these issues before commencing the psychological assessment and the issues are discussed with them during the assessment process, as well as being considered in the light of information obtained during the clinical interviews.

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.

These criteria are considered as part of the pre surrogacy psychological assessment which involves: clinical interviews (couple, individual and group) and an objective measure of psychopathology (Personality Assessment Interview – PAI). The assessment process involves the commissioning couple or intending parents and the surrogate and her partner to attend on two separate occasions for 3 to 4 hours on each occasion. In my experience this process is respectful of all involved, gives time, space and intensity for thorough consideration of the implications of the proposed treatment, and the space for a change of mind without rupture of relationships, before treatment. Whilst it is usual for all involved to state at the beginning of the assessment that they have considered all the issues, in my experience there is often an issue which has not been fully explored or there are issues (individual or relationship) which have not been given due consideration. In a few cases there have been psycho-social/mental health issues which have contraindicated surrogacy treatment; and on a few occasions there has been a change of mind by one of the parties even though the treatment may have been approved by the ART clinic. In my opinion this thorough pre-treatment independent psychological assessment is an integral step for full informed consent of all parties to surrogacy treatment. I have considered whether this belief is related to vested interest but am sure that this would be my professional opinion as an infertility counsellor even if I were not to be a psychologist doing independent assessments.

c. The legal rights and responsibilities that should be imposed upon the intended parent/s and/or birth parent/s.

I would not support any proposal for an enforceable surrogacy contract which could require that a surrogate would be forced to relinquish a child born of surrogacy. In my assessment counselling I believe that the right to change her mind acts paradoxically as well as legally. Thus it reduces any implicit pressure or coercion on the surrogate, underlines the gift of help to create life which the surrogate is making, and helps focus on the positive aspects such as the future child in the commissioning couple or intended parents' lives, rather than on the loss of a child the surrogate has carried. It also gives the surrogate implicit permission to have contact with the baby, initiated by her, particularly during the immediate post delivery period, when her body's sense of loss may be greatest. In this vein, regarding the transfer of legal parentage I support establishment of there being a short period of time after delivery of the baby, during which the surrogate could change her mind about relinquishment.

I believe that surrogacy should be altruistic, and that there should be payment to the surrogate of reasonable expenses only. Thus I would also not support a move to commercialisation of surrogacy (as occurs in the USA). This fits in with the situation in Australia where the donation of gametes and embryos is altruistic and not commercial which I believe is a very positive aspect of assisted reproduction in Australia.

d. The role that a genetic relationship between the child and the intended parent/s and/or birth parent/s should play in any altruistic surrogacy arrangements.

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 couple or intended parents, with a few situations using donated oocytes because of the medical history of the commissioning woman. In these gestational surrogacy arrangements the surrogate has been definite 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 detrimental difference in parent –child relationships where there has been the use of donor gametes or embryos to conceive a 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 or intending 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 same sex (lesbian) 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 same sex (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 may be an instinctive thought that there should be a genetic relationship, it is on the same continuum as the abovementioned treatments. Thus I do not believe it to be essential for there to be a genetic relationship to the commissioning parents.

e. The legislative amendments that should be made to clarify the legal status of any child born of such an arrangement.

I believe that legislative amendments should be made such that a child born of surrogacy treatment should have his or her commissioning or intended parents' names on their birth certificate. This birth certificate should be made available after a short period of time during which the surrogate could change her mind regarding relinquishment. Currently there are difficulties for the intended parents of a baby born through surrogacy in not being able to put the baby's name on their Medicare card (hence there are difficulties with medical treatment such as immunisation) or obtain a passport, or sign documents as the child's parents such as those

required by child care centres, or schools. I cannot comment on the legislative amendments which would be required to remedy problems such as these. I do not believe that any significant parenting/psychosocial assessment of the intended parents should occur at this stage, after the birth of the baby, as they will have undergone psycho-social assessment before surrogacy treatment.

f. The rights that a child born through an altruistic surrogacy arrangement should have to access information relating to his or her genetic parentage, and who should hold this information.

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, whether it be genetic heritage or birth details. A child born through altruistic surrogacy should have access to information relating to his or her birth and genetic parentage. This means that there should be implemented a system which includes information as to all stages of the birth and genetic heritage, even if though birth certificate shows the commissioning or intended parents. Thus I believe that the birth certificate for a child born of surrogacy treatment should indicate the commissioning couple or intended parents as the parents, but that there should be an indication on this birth certificate that there is additional information available, information which is accessible on a similar basis to the recent NSW legislation regarding donor gamete or embryo information. In my opinion this information regarding genetic heritage and birth history is of a similar quality to that currently held by the NSW Registry of Births, Deaths and Marriages, and thus I believe should be retained and made available according to the same standards. Thus genetic information and birth history of offspring of altruistic surrogacy treatment could be held in the same Register which is being established for offspring of gamete and embryo donation in NSW.

g. The efficacy of surrogacy legislation in other jurisdictions and the possibility and desirability of working towards national consistency in legislation dealing with surrogacy.

In my non legal opinion the ACT legislation appears to function well, and a similar approach would be a good starting point. There has also been a recent extensive and thorough investigation into altruistic surrogacy in Queensland which I believe to have resulted in recommendations which respect the rights of all involved in surrogacy, including the offspring of treatment. The current situation of differing legislation in differing states and territories is not a desirable situation. It has meant that residents of some states have been unable to access treatment in their own state, and have travelled to NSW or the ACT to undergo pre treatment assessment and surrogacy treatment. This means that there are significantly increased financial costs and inconvenience for those in states where surrogacy treatment is not permitted. Thus I believe it is very important to work towards national consistency in legislation dealing with surrogacy.

h. The interplay between existing State and Federal legislation as it affects all individuals involved in, and affected by, surrogacy.

From my non legal understanding I do not believe that there is currently Federal legislation related directly to surrogacy, only different state and territory legislation. Issues such as Medicare cards, and immigration and passport issues would obviously be covered by Federal legislation, but I am unable to comment any further.

i. Any other relevant matter.

Currently it is not usual for ART clinics to undertake traditional or insemination surrogacy, but this process also does not require the use of IVF treatment. In this type of surrogacy the surrogate uses her own eggs and the sperm of the commissioning or intended father. Whilst this type of surrogacy is rarely offered through ART clinics, there is anecdotal evidence that traditional insemination surrogacy is being performed outside of ART clinics, with commissioning or intended parents and surrogates undertaking home monitoring and inseminations. These surrogacy situations may involve parties with no previous relationship who may have found each other through advertising or via the internet, and there may be an exchange of money. This is, I believe, a significant concern because of the lack of health and safety precautions (e.g. no universal precautions) and the lack of medical and psychological assessment and support. 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 for themselves and others involved in surrogacy, in my experience this is not always so. I believe the current situation is a medical and psycho-social minefield. Thus I believe it would be preferable if ART clinics and the law could be more open to insemination surrogacy being conducted in the increased professionalism and safety (physical, mental and relationship) of an ART clinic.

I apologise for the lateness of this submission though I understand that submissions are still being accepted. However given my experience I believe it is important for the Committee to have some understanding of what I have learnt over the years. If the Committee wishes me to appear before them to provide more information, or answer questions, I am available to do so.

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Sent by email, October 28, 2008 to Rachel Callinan