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REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON LAW AND JUSTICE

INQUIRY INTO LEGISLATION ON ALTRUISTIC SURROGACY IN NEW SOUTH WALES

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At Sydney on Wednesday 18 March 2009

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The Committee met at 9.00 a.m.

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PRESENT

The Hon. C. M. Robertson (Chair)
The Hon. J. G. Ajaka
The Hon. D. J. Clarke
The Hon. G. J. Donnelly
The Hon. A. R. Fazio
Ms S. P. Hale

CHAIR: I welcome everyone to the third public hearing of the Standing Committee on Law and Justice's inquiry into legislation on altruistic surrogacy in New South Wales. Today we will hear evidence from a number of individuals and organisations, including New South Wales Health, Sydney IVF, and Access—Australia's national infertility network. Before commencing I will make some comments about certain aspects of the hearing. We will have teleconference evidence later in the day, and I will not deal with that now. We have broadcasting guidelines, in which the media are well versed, and there are instructions on the table at the back of the room. If the witnesses wish to deliver any messages or documents to the Committee, the secretariat persons will assist with that.

Committee hearings are not intended to provide a forum in which people may make adverse reflection about others. The protection afforded to Committee witnesses under parliamentary privilege should not be abused during these hearings. I therefore request that witnesses avoid the mention of other individuals unless it is absolutely essential to address the terms of reference. Some mobile phones interfere with the reporting of proceedings by Hansard, and it is preferable for them to be turned off rather than switched to silent mode. I welcome our witnesses and thank them for coming in this morning.

LEANNE O'SHANNESSY, Director—Legal and Legislation, and General Counsel, New South Wales Health, and

IAIN WILLIAM ENOS MARTIN, Manager—Legislation, New South Wales Department of Health, affirmed and examined:

CHAIR: Are you conversant with the terms of reference for this inquiry?

Ms O'SHANNESSY: Yes.

Mr MARTIN: Yes.

CHAIR: If you should consider at any stage that certain evidence you wish to give or documents you may wish to tender should be heard and seen only by the Committee, please indicate that fact and the Committee will consider your request. If you take any questions on notice, the Committee would appreciate your forwarding the responses to those questions to the secretariat by Friday 3 April. Would you like to commence with a short statement?

Ms O'SHANNESSY: I would like to make just a very short statement, mainly to establish the framework of our approach to this issue from the New South Wales Health perspective. Our approach to date has primarily been to focus on the health aspects of the medical procedure, which is assisted reproductive technology [ART]. We are looking at those procedures and related health-type issues, such as access to information of donor offspring. The assisted reproductive technology [ART] legislation had its genesis in a very lengthy review of the Human Tissue Act, which looked at a whole range of issues. It was just one offshoot of that review.

Ultimately it touches briefly on surrogacy, as you no doubt would be aware from looking at the legislation. It touches on the issue in two areas: its prohibition on commercial surrogacy arrangements, and its statement that altruistic surrogacy arrangements will be unenforceable. The first was a broad reflection of the views expressed at the time in legislation that was being developed and a review was being conducted. The second is more a statement of what we considered to be probably the Commonwealth position on these matters. The legislation does not, nor is it intended to, look at the broader social, community and legal issues that come up with surrogacy issues. I think that is a more appropriate issue for a much broader review, such as is being conducted by this Committee, and also I think that is being undertaken at a national level through the Standing Committee of Attorneys General.

That said, there is a degree of background that we have from what we have done with assisted reproductive technology [ART]. We are more than happy to assist the Committee in any way we can. In that regard we have Iain Martin, who is our Manager—Legislation, and who has had a very strong role in the development of the assisted reproductive technology [ART] legislation. He can take you through a lot of the detail in that as well.

CHAIR: We are aware that the Assisted Reproductive Technology Act 2007 will be proclaimed and will commence when New South Wales Health has completed its implementation program, which includes consultation with stakeholders on the regulations. Can you let us know where that is up to?

Mr MARTIN: The regulation has been the subject of consultation with the stakeholders. We are now in the process of finalising the last few minor amendments that came out of the consultation process. Depending upon the Minister's views, we would be looking hopefully to commence the legislation on about 1 July, so it will be sometime within the next three or four months.

Ms O'SHANNESSY: I think we are also hoping to put the proclamation date out quite soon so that people have a three-month period in which to prepare. Some of the provisions will not apply.

Mr MARTIN: Some of the offence provisions will not apply for a short period to allow the industry time to get its registration in order.

CHAIR: Can you let us know who the stakeholders are?

Mr MARTIN: Obviously they are the assisted reproductive technology providers, the industry; the donor conception support group; groups that represent donor-conceived children; and, more broadly, the medical profession. That would largely be the stakeholder group. The regulations themselves, most importantly, impact on the industry in terms of information that they will have to collect and keep, and information that they will then have to provide to the donor register.

CHAIR: You have just touched on it now, but can you let us know what implications the changes have, and what the changes are from the previous situation?

Mr MARTIN: The current arrangements for the regulation of assisted reproductive technology are largely industry self-regulation within the context of the National Health and Medical Research Council's guidelines and the Fertility Society of Australia's accreditation program. Many of the matters incorporated in the legislation reflect those guidelines and the accreditation program. The important changes are that assisted reproductive technology providers now will have to be registered and that they will be required to collect and retain and provide information to the central register. That information will then be available to the offspring and the participants at certain points in time of the process.

CHAIR: To match the processes within the adoption law in relation to genes?

Mr MARTIN: To a certain extent. The adoption law is probably the closest analogy.

CHAIR: I am not bringing it in on purpose.

Mr MARTIN: Donor-conceived children will be entitled to access information about their donors when they become adults, and that will be identifying information. Their parents will be able to access non-identifying information at an earlier stage, and there will be circumstances in which—

The Hon. GREG DONNELLY: I am sorry to interrupt, but is that the biological parents?

Mr MARTIN: Their social parents. The birth parents of the children will be able to access information about the donor or donors, the biological parents, at certain points in the child's upbringing.

The Hon. GREG DONNELLY: And this is actually in the Act itself, is it?

Mr MARTIN: Yes. Non-identifying information, while the child is still a child, and identifying information in the event of certain medical conditions and life-threatening circumstances requiring that information for the child's protection.

CHAIR: Such as the possibility of an inherited disease process?

Mr MARTIN: Yes. Where there is a medical crisis that may require that information to be available. Of course, the donors also will be able to access information about the offspring, if the offspring give their consent, once they become adults.

CHAIR: The Committee has been advised that people using assisted reproductive technology to facilitate a surrogacy arrangement in New South Wales will be treated the same as any other assisted reproductive technology [ART] user. I am asking you whether there will actually be any difference.

Mr MARTIN: No, there is no distinction at all. The use of assisted reproductive technology [ART] procedures is just the use of assisted reproductive technology procedures [ART]. There is no distinction drawn on the reason for accessing those assisted reproductive technology [ART] procedures.

CHAIR: So your rules and regulations relate to the actual practice of assisted reproductive technology [ART]?

Mr MARTIN: Yes.

The Hon. GREG DONNELLY: Before looking at what is before us today, in relation to the set of interest groups that have been consulted over the regulations for the legislation before it gets underway on or

around 1 July this year, subject to finalising the details, you mentioned the ART providers, which you would broadly refer to as the industry, I suppose?

Mr MARTIN: Yes.

The Hon. GREG DONNELLY: Could you give some examples of the donor conception support groups?

Mr MARTIN: There is an organisation called the Donor Conception Support Group, which is a New South Wales based organisation. There are also a number of others that you would be aware of, including TangledWebs and I suppose other more loosely based organisations. We did not necessarily access those organisations directly and sought to access them through our contact with the Donor Conception Support Group. I am afraid I cannot tell you which of those organisations have made submissions. I can get that information for you and provide it to you if you would like.

The Hon. GREG DONNELLY: That would be good, thank you. So that I understand the process, was there, for want of a better term, a mail-out to some of these groups to inform them that the regulations were being developed and they were invited to contribute?

Ms O'SHANNESSY: Yes, it was a normal regulatory impact statement process, so there was an ad, it was published and people were invited to make submissions.

Mr MARTIN: But we did write directly to many of the key stakeholders.

Ms O'SHANNESSY: The ones we knew we wrote to, but there was the normal broad process.

The Hon. GREG DONNELLY: That is fine, I was just trying to understand the process, and there is the medical profession—that would be the peak body, I suppose?

Mr MARTIN: The medical profession would have been consulted by, first of all, the Australian Medical Association [AMA], the Fertility Society of Australia and the individual ART providers that we are aware of. I must admit that we did not sit down and trawl through the phone book, but the ones we had had contact with in the past we certainly sent a copy of the discussion paper to directly, and anyone else would have been contacted by the Fertility Society of Australia.

The Hon. DAVID CLARKE: Can you provide us with a list of those that you did contact directly?

Mr MARTIN: Yes.

The Hon. DAVID CLARKE: You placed an advertisement and then you wrote to various organisations that you thought would be interested. Is that right?

Mr MARTIN: Yes.

The Hon. DAVID CLARKE: Can you provide us with a list of those that you did write to?

Mr MARTIN: Yes.

The Hon. GREG DONNELLY: In terms of this specific inquiry, on the question of looking into the future and the regulation of surrogacy, can you help me to understand the process of the Commonwealth and State and Territory jurisdictions working through the consultation process? Looking at the material we have been presented with, there is obviously ongoing dialogue through the SCAG process, but it seems that some States have already passed legislation or may well be in the throes of developing legislation and/or regulation and passing it. Taking New South Wales as an example, which only has very minimal provisions by virtue of this Act, we are going to go through a process and end up with States and Territories having different legislative outcomes, which seems to be inconsistent with the intention of the SCAG process, that is, to the extent that it can, to try to create commonality across the Commonwealth. Am I misunderstanding this? I would have thought there would be the SCAG process, an outcome of the SCAG process and then an invitation to the States and Territories to go forward, but that does not seem to be the way it is playing out.

Mr MARTIN: I think that is probably a fair summary of the situation, yes.

Ms O'SHANNESSY: Yes. To some degree you would need to talk to the Attorney General's Department about how the SCAG process is working, but I think it is just a reflection of Commonwealth-State, of the Federation, that this is often the way things go and it obviously depends on all the other governments and their commitment to the SCAG process. I can just speak in passing of our own experience recently in national registration where there is a substantial commitment to national registration of health professionals, but some of these issues are coming up of how you coordinate across all the different jurisdictions.

The Hon. GREG DONNELLY: I am not being naïve, I am just referring to the good intentions in the discussion papers and the material presented to us about what this was designed to achieve and it seems that the outcome hoped for may not be achieved because some States have already gone down the track and legislated.

Mr MARTIN: In defence of some of those other States, of course, the ACT had its arrangements in place before the SCAG process commenced; Western Australia was well down the path of developing its legislation and probably felt it could not pull back.

The Hon. GREG DONNELLY: So it is a timing issue.

Mr MARTIN: Yes, and the Victorians had the referral to the Victorian Law Reform Commission and its report before the SCAG process commenced, so they probably also felt that they were in a situation where it was very difficult to stop halfway. Whether they should have is not for us to comment on.

The Hon. DAVID CLARKE: Difficult but possible?

Mr MARTIN: Yes.

The Hon. DAVID CLARKE: They considered it difficult, but it is possible that they could have stopped in an endeavour to get a national model?

Mr MARTIN: I would imagine so, yes.

The Hon. DAVID CLARKE: They made the decision not to stop and try to get a national model, they made the decision to go down the pathway and not wait for a national model to be devised?

Mr MARTIN: I would agree that that is probably the case. They have gone down the path of making their own arrangements possibly with the intention of modifying those arrangements in line with any national model that is agreed to.

Ms O'SHANNESSY: I think if you do go into a national model you will have situations where some jurisdictions have already legislated. It is not that they do not wish to participate but, as Iain said, they have got to the starting gate first, and I would expect that as part of the national process it is probably quite valuable that those States and jurisdictions can bring their experience to the national table about what has and has not worked. I would anticipate the Attorneys General working to some sort of cooperative model that will accommodate the experience from the other States as well.

The Hon. DAVID CLARKE: You say that the States that have already gone down this path and have not waited for there to be a national model can always modify, but when you have a situation where they have extended to new boundaries, as it were, in practical terms it is very difficult if it is modified to withdraw those boundaries, is it not? They would be looking to everybody else to extend to the same boundaries as they have taken. There is very little likelihood of them pulling back from boundaries that they have staked out. Would that be a fair assessment?

Mr MARTIN: Yes.

Ms O'SHANNESSY: I am not sure you could actually say that. I suggest you ask the Attorney General's Department more because they will know specifically where the other States are in this. I do not think we could say they will or they won't. I think it depends on the overall process.

The Hon. GREG DONNELLY: But there is no argument between us that there are other States and Territories that have already legislated.

Ms O'SHANNESSY: Yes.

The Hon. GREG DONNELLY: As Mr Martin explained, there is the ACT, which had the legislation before the SCAG process; Western Australia I think he said was well down the path; and the Victorian context was the law reform commission report and what that was agitating in terms of consideration in that State.

Mr MARTIN: Yes.

The Hon. DAVID CLARKE: Could I ask another question? I am quite happy for the Hon. Greg Donnelly to take my time.

CHAIR: I am watching the times of both of you today.

The Hon. DAVID CLARKE: When did the process of SCAG commence?

Mr MARTIN: Our first involvement in it would have been probably in January last year. We were asked to contribute to the officers working group put together by SCAG to provide our experience with the ART legislation.

The Hon. DAVID CLARKE: When did the legislation take effect in Western Australia?

Mr MARTIN: I am not sure that the Western Australian legislation has in fact commenced, or if it has commenced it is only very recently. We could certainly find that out and let you know. I was not aware that it had actually commenced. It has certainly passed the Parliament.

The Hon. GREG DONNELLY: Has it been proclaimed?

CHAIR: As at 1 March 2009.

The Hon. DAVID CLARKE: They have proceeded down the path knowing that there is a SCAG process. They have made the unilateral decision to proceed down their pathway regardless of any outcome of SCAG.

Mr MARTIN: Yes.

The Hon. GREG DONNELLY: The next question is broad, but I want to get your thoughts on it. The essential position in New South Wales at the moment is that there is what you would call light touch regulation, for want of using a better phrase.

Mr MARTIN: Yes.

The Hon. GREG DONNELLY: You explained to us the parameters of that light touch and, if we put aside the two conditions that are specifically mentioned in the legislation, it gives focus to the industry and how the industry conducts itself and operates. In effect we have an industry that is operating and functioning and people who are obviously utilising the industry, with a couple of small conditions that apply, namely, as you said, no commercial, and unenforceability or voidness of arrangements. When one moves beyond that as a principle what one seems to start to do in terms of a legislative framework is to place conditions on what is the practice that operates. At the moment it would be fair to say that the arrangements are fairly broad and open. In effect, from this point we are moving towards a greater regulation of the practice of surrogacy. Would you agree with that general statement? As we move from the point where we are, if we put in new conditions, we are further regulating it, are we not?

Mr MARTIN: There is that option, of course. If the Government decides to legislate in this area, it does not necessarily have to legislate for the practice of surrogacy and can restrict its actions to regulating for the parenting arrangements of a child born as a result of a surrogacy arrangement. So the Government can choose to leave the practice alone and in the hands of the medical professionals who conduct it, but then simply

legislate to regularise the familial arrangements that arise as a result. There are a number of options that the Government does have available.

The Hon. GREG DONNELLY: Using a hypothetical example, if the Committee came up with a recommendation that the surrogate mother should not be below 18 years of age, that is starting to regulate the practice, is it not, of who could be a surrogate mother in the State of New South Wales?

Mr MARTIN: We already regulate that, strangely enough. The ART legislation provides that a provider is not to give ART treatment to a child. So we already have that; that is the floor, if you like.

The Hon. JOHN AJAKA: It does not use the term "surrogacy".

Mr MARTIN: No, it is assisted reproductive technology [ART] treatment.

The Hon. GREG DONNELLY: I am sorry; I am showing my ignorance. I should have known that. Let me use another hypothetical: Say we made a collective decision that the practise of surrogacy should be available only to a woman who has already had at least one child. In other words she has had the experience of carrying a child and giving birth. That is starting to regulate in an area where there is no regulation at the moment, is there?

Mr MARTIN: Yes.

The Hon. GREG DONNELLY: If I use that example, one can then come up with a number of other examples and what we as a Committee would be doing is exercising value judgements over who should or should not be a surrogate and/or who the surrogate parents should be. Would you agree—as we start to move towards looking closer at the relationship between the surrogate and the commissioning parents?

Mr MARTIN: That is certainly one of the possible outcomes, yes. You will be aware that to a certain extent that is the path that has been travelled in Victoria with the legislation that has not yet commenced. The Victorian legislation makes some of those value judgements and says it is only available to certain people and certain people are presumed to be excluded from access to surrogacy arrangements.

The Hon. GREG DONNELLY: Just out of interest, do you recall what they are?

Mr MARTIN: My recollection is the presumptions are people with criminal records for violence offences, offences against children, and child neglect-type offences. They are presumed not to be entitled to access surrogacy arrangements.

The Hon. GREG DONNELLY: Invariably though if we decide to go down this path we are starting to make value judgements about the suitability of people to be either surrogate mothers and/or commissioning parents.

Mr MARTIN: Yes. I would have thought Parliament does that on a daily basis.

Ms SYLVIA HALE: I was interested that you talked about the value judgements that are made because in the submission you suggest that parts of the adoption regulatory framework are relevant to the regulation of surrogacy.

Mr MARTIN: That is the Government's overall submission. I am not sure that the Department of Health had any particular involvement in that.

Ms SYLVIA HALE: Sorry, it is Premier and Cabinet. The issue arises of criminal records, so I assume that currently when an adoption decision is made those issues are taken into account.

Mr MARTIN: Yes.

Ms SYLVIA HALE: Are the types of crimes that would render one ineligible spelled out in the adoption procedures or is it left to the discretion of the—

Mr MARTIN: I could not answer that question.

CHAIR: We might have to direct that as a question on notice to DOCS.

Mr MARTIN: I think it is a matter for DOCS.

Ms SYLVIA HALE: That is the thing in which I was most interested. Since this is a submission from the Department of Premier and Cabinet are you familiar with it?

Mr MARTIN: I have certainly read it.

Ms SYLVIA HALE: From that second paragraph in the submission it certainly appears that if we fail to regulate surrogacy or at least fail to introduce laws there will be a considerable lack of clarity. It leaves a whole series of questions that can be raised about the legal status of the child and the parents. For us not to seek to legislate in that regard would probably be unfair to all parties. That is a value judgement!

Ms O'SHANNESSY: I think this does get into the area of DOCS in relation to adoption and the Attorney General's Department in relation to the legal status of the child, which we are not in a position to comment on. It is more a matter for those agencies.

Mr MARTIN: The entire Standing Committee of Attorneys General [SCAG] review of surrogacy arrangements really started from the point of whether there is a need to regularise the familial arrangements post-surrogacy. That was the initial focus of the SCAG process.

Ms SYLVIA HALE: Amongst the submissions we received was one from TangledWebs Inc.—we are to hear evidence from them later this morning—to whom you referred earlier. The import of their submission is one of complete opposition to any proposed regulation of surrogacy. They seem to think it has had disastrous consequences for children who are conceived as a result of artificial insemination or whatever. Is the Department of Health aware or are you aware—I suppose you are acting in your legal capacity rather than in a Health capacity—of any cases that might have involved the Department of Health where these sorts of adverse outcomes have been brought to your attention?

Ms O'SHANNESSY: No. But that does not necessarily mean they have not happened. It is probably more likely they would come to our attention through some public hospital situation. I am not sure what types of adverse events they are talking about. It is not necessarily likely that it would come to our attention.

The Hon. DAVID CLARKE: You are not aware one way or the other?

Ms O'SHANNESSY: No.

Ms SYLVIA HALE: The sorts of events they talk about are identity confusion, genealogical dislocation, complexity of family relationships and things like that. They appear to be more social problems rather than specifically legal problems.

Ms O'SHANNESSY: Again, possibly if there has been a suggestion of children at risk it might have been something for DOCS, but I doubt whether those sorts of issues would be sufficient to bring in DOCS.

The Hon. JOHN AJAKA: We are all aware, and we have heard it said on many occasions, that the best interests of the children are the paramount consideration. I am trying to fathom this: We know surrogacy exists in one form or another; we have not made it illegal, other than commercial surrogacy. If we were to leave the status quo, is it working in the best interests of the child?

Ms O'SHANNESSY: Again, I think it is difficult for me to say whether it is or is not.

The Hon. JOHN AJAKA: From your area of involvement and your area of expertise, is it working?

Ms O'SHANNESSY: As I said to Sylvia, we do not have much information about what is happening or much feedback, so it is very difficult. I think that is why the process you are going through here is very good, as is the SCAG process, because often these matters are private arrangements in homes and it is very difficult to get a picture of what is happening. This is a good process for doing that.

The Hon. JOHN AJAKA: If you were to make a recommendation—you mentioned earlier that either the Act could be changed or a surrogacy Act created, if I can call it that, or one could start playing with the Assisted Reproductive Technology Act, whether using the term "surrogacy" or not—what would you recommend: The creation of a specific surrogacy Act so that the intention and requirements are clear, or is your preferred option to amend or insert provisions in associated Acts?

Ms O'SHANNESSY: I would make a broad statement about how you approach legislation generally. I would say that we always take the approach that we need to identify the exact nature of the problem. Are there a number of minor issues arising and each needs to be addressed individually or are the social and economic benefits—I am not saying necessarily there are economic benefits in surrogacy—across the board, so legislation would justify a larger regime? We would also factor in the need, particularly when looking at personal issues, to minimise bureaucracy and the impact on individuals. So I would be saying to you, with all the evidence you have before you, to examine carefully what are the key problems and the best way to deal with them in a minimalist fashion and in such a way that you look at the consequences. In some ways if a regulation regime is too extreme it can stop the process. If you think the process is okay and it should proceed, you need to factor in those things. Again we would be watching the SCAG process as it develops, and the outcome of this Committee. They would be some of the rules that we would apply when we are asked, "Should X or Y be legislated for?"

CHAIR: Have there been any legal issues in relation to assisted reproductive technology?

Mr MARTIN: Can you give me a little more information?

CHAIR: You have just put together the Act and it is being implemented. Have there been any court cases or legal questions in relation to assisted reproductive technology in the past?

Mr MARTIN: There have obviously been a number of matters that have gone through the Family Court and child support-type arrangements, both here and overseas—

CHAIR: Childcare issues.

Mr MARTIN: Yes. In terms of the liability of a gamete donor for support and the access or contact that a gamete donor may or may not be able to have with a donor conceived child. Those matters have arisen from time to time.

CHAIR: That is right. We have had evidence on those issues. I am asking more about the medical service and the technical service.

Mr MARTIN: No, not that I am aware of.

Ms O'SHANNESSY: I am not aware of any. We are not a major provider of IVF services, so in relation to our medico-legal portfolio and claims that something went wrong with the process I am not aware specifically of any substantive cases.

Mr MARTIN: As you would be aware, there have been cases involving applications to the court to take gametes from a deceased spouse, cases involving the disposal of excess embryos, and cases relating to gametes in storage. Those sorts of matters crop up from time to time.

CHAIR: What piece of the legislation do they come under?

Mr MARTIN: They are not legislated for.

CHAIR: So the judge just makes a decision without legislation?

Mr MARTIN: When the ART legislation commences it will put time limits on storage. When people provide gametes or create embryos they have to give their consent for the storage of those gametes or embryos and to their use or disposal at the end of the time period. Other than that we really do not go there.

CHAIR: I am going to ask another question that we sent you. Under section 45 of the Assisted Reproductive Technology Act all surrogacy arrangements including altruistic surrogacy will be void.

Mr MARTIN: Yes.

CHAIR: What is the current status of altruistic surrogacy arrangements? Can they be enforced?

Mr MARTIN: We understand that a court would generally not enforce such an agreement on the grounds of public policy and also in light of the irrebuttable presumption in section 14 of the Status of Children Act. The birth mother of a child is the mother and that is the end of the story until some other court process is undertaken. We understand that they would generally not be enforced by a court. I am not sure it has ever been tested in New South Wales.

CHAIR: So that is what void actually means?

Mr MARTIN: Yes.

CHAIR: Will surrogacy agreements have any status under the new Act or are they not covered because of the other Act?

Mr MARTIN: If parties choose to enter into an agreement for an altruistic surrogacy arrangement I suppose that is a valuable exercise in terms of clarifying in their minds exactly what they are doing and as an aide memoir for resolving any matters that might crop up between them.

CHAIR: But it has no legal status?

Mr MARTIN: In terms of legal status, no, nothing at all.

CHAIR: You have answered the next section about whether there is any recourse if the birth mother decides not to—

Mr MARTIN: And, again, we would understand that that is not the case, the courts would decline to consider those agreements.

Ms SYLVIA HALE: Even if there were an agreement which stipulated that the surrogate was to receive reasonable expenses and they subsequently failed to do so, there would be no basis in any legal action to use that written agreement to say that the expenses should be met?

Mr MARTIN: If that is in a surrogacy agreement, then yes, that would be the case.

Ms SYLVIA HALE: Is there any way you could have an agreement that was not in a surrogacy agreement in that—

Mr MARTIN: I am sure clever lawyers could turn their minds to those matters.

Ms O'SHANNESSY: I think it would be very difficult if the court is taking a view on public policy issues. I think it would be tricky. I think they would look at the whole picture. I think there are public policy issues in this issue that there perhaps are not in taxation law.

Ms SYLVIA HALE: Yet.

The Hon. JOHN AJAKA: Would it not be more of a responsibility on our part to ensure that there is sufficient legislation for judges determining matters to have an appropriate criteria to work from, rather than putting judges in a position where they are looking at various pieces of legislation, various sections and in a sense compelling them to try to put the picture together? I guess I am coming back to my question: Are we better off with one clear Act that deals with all the issues as opposed to a piecemeal fashion?

Ms O'SHANNESSY: Judges do that all the time.

The Hon. JOHN AJAKA: I know that.

Ms O'SHANNESSY: And you would be aware that some judges—

The Hon. JOHN AJAKA: Sometimes they are compelled to; they have no choice.

Ms O'SHANNESSY: Yes, but the development of the common law is as it is developed, and there are no doubt areas where judges would look for guidance, particularly where community attitudes are on the move. I think that is where it is probably difficult for them, but I guess I am making a personal statement more than anything else.

CHAIR: Can you comment on the retrospective application of section 45 and what implications this has for existing surrogacy agreements?

Mr MARTIN: Section 45 of the Act is retrospective in its application. It applies to all surrogacy agreements, whether made before or after the commencement of the Act. But as our understanding is that all such agreements would be void in any event, it makes no difference. They are already void. Section 45 simply clarifies that.

CHAIR: Makes sure they are.

Mr MARTIN: And for the wont of anything else, one would hope, ensure that people in this situation are not dragged through an unpleasant and difficult court process to confirm that matter. Other than that, I do not think it would have any effect whatsoever.

CHAIR: I am asking these questions so that they are ready for our reporting and deliberative process. Are there currently any other legal avenues available to remedy disputes in relation to altruistic surrogacy arrangements? For example, could an action in negligence be taken if the actions of the birth mother damaged the health of the child? Does that fit into your—

Mr MARTIN: It certainly does not fit into the ART legislation and it is certainly not within our area of expertise. Someone is always able to go to the court and seek to take an action in tort for negligence.

Ms O'SHANNESSY: The main issue with negligence, the action would be, if there was injury or loss to the child, it would have to be action taken on behalf of the child or by the child. And, obviously, negligence is limited to recovery of financial compensation.

The Hon. JOHN AJAKA: You say by the child only, not by the contracting parent.

Ms O'SHANNESSY: The way the law of negligence works is you have breached your duty. You had a duty, you breached it and I suffered loss. Therefore I take the action. The issue is the loss of the child and the action. If the child suffered some psychological or social harm—

The Hon. JOHN AJAKA: I understand that.

Ms O'SHANNESSY: —the action would have to be taken by the child or someone on their behalf.

The Hon. JOHN AJAKA: But you do not see that there would be a duty of care to the contracting parents? Yes, the contract is voidable that we have, but would there not be a duty of care to the contracting parents?

Ms O'SHANNESSY: No, I am not saying whether there would or not. For example even if there was, they would have to show that they have suffered loss.

The Hon. JOHN AJAKA: They have suffered some damage, stress, et cetera. I understand that.

Ms O'SHANNESSY: Yes. I hate to be a real lawyer but it all depends on the specifics of the case.

The Hon. JOHN AJAKA: I can understand that.

CHAIR: We have a few lawyers in the room.

Ms O'SHANNESSY: Good. Then you know what I mean. As Mr Martin said, anybody can take an action, and it may well be that the circumstances of a particular matter could be so novel as to warrant payment. But it would be a very novel action. It would be very interesting to see how it went. As you would know, it would be a very expensive enterprise.

CHAIR: So this issue would include perhaps a clinical deficit in the child.

Ms O'SHANNESSY: Sorry?

Mr MARTIN: Some genetic disability.

CHAIR: No, not genetic. Something like low birth weight or some actual physical—

The Hon. JOHN AJAKA: Smoking, taking drugs, that sort of thing.

CHAIR: Head injury, bruises, whatever.

Mr MARTIN: It is an interesting question. I am just wondering off the topic a bit, but it suggests a rather poor choice of surrogate by the commissioning parents if those sorts of issues are going to arise.

Ms SYLVIA HALE: It also raises issues of the child—

The Hon. GREG DONNELLY: I think it is prescient to the whole discussion. I think Ms O'Shannessy said—she did not acknowledge it was a private view—that community values are moving on. Let us take the example of a couple who commission a young woman to be the surrogate, thinking that everything was fine, but then discovered, because they were unaware of this before they commissioned her, that in fact she had a bit of a drinking habit—

The Hon. JOHN AJAKA: Or drugs.

The Hon. GREG DONNELLY: —or drugs. Then the child is born and the child suffers from some outcome associated with in utero being affected by the use of alcohol by the mother. Sure, these are areas that perhaps the courts have not started to test yet because they are novel, but they are prescient to this discussion because, at the end of the day, there are relationships there. They may or may not be legalised under some sort of recommendations we might put forward, but in any event they are very real hypothetical examples. That is why I think this whole thing is such a challenge.

Ms SYLVIA HALE: But they are issues in any pregnancy, are they not? They are not just for surrogates.

CHAIR: Yes.

Ms O'SHANNESSY: Yes.

The Hon. GREG DONNELLY: But this is very different because you are commissioning a third party.

CHAIR: The question is about the dispute.

The Hon. JOHN AJAKA: That is why I was asking you these questions. That is why, in my view, it would be different when you are commissioning a third person because, although we have a voidable contract, you have a party, a parent, coming to that contract, expecting the other party to act in a certain way. That is why I used the words "duty of care". Surely there should be a duty of care on the surrogate to do the appropriate thing.

The Hon. GREG DONNELLY: The surrogate is carrying the genetic material of the commissioning parents.

Mr MARTIN: In some instances, yes.

The Hon. GREG DONNELLY: Probably in a number of instances, yes.

The Hon. JOHN AJAKA: It is an interesting area that maybe we need to look at purely from an expert in negligence to give a bit of advice on that.

The Hon. DAVID CLARKE: In the department's submission you invite us to look at the position with regard to same-sex couples. You say "further issues to consider". You point out that as a result of amendments to the Status of Children Act the presumption has been extended to lesbian couples for children arising out of the use of a fertilisation procedure but only where the birth mother is a member of the couple. Do you follow me so far on that?

Mr MARTIN: Yes.

The Hon. DAVID CLARKE: So would it therefore not follow that if we did make recommendations we should make them in a way that surrogacy arrangements for commissioning lesbian couples would not apply unless one party of the couple has a biological relationship to the child? Because there would be a contradiction there, would there not?

Mr MARTIN: I must say I am not sure the Department of Health would have a position on that at all.

The Hon. DAVID CLARKE: I am not asking what the department's position is, but there would be a conflict, would there not? You pointed out in your submission that this presumption under the Status of Children Act only operates in situations where the birth mother is a member of the lesbian couple.

Mr MARTIN: The Status of Children Act, until the recent amendments of which you speak, provided that the birth mother was conclusively the mother and there was a presumption that the birth mother's male partner was the father of the child. The recent amendments to the Act now provide that that presumption also extends to the birth mother's female partner in appropriate cases. That is the extent of those amendments and I do not think there is any particular—other than that, I am not exactly sure where your question takes us.

The Hon. DAVID CLARKE: Except that you have pointed out in your submission to us that the presumption that arises as a result of those amendments to the Status of Children Act only operates in situations where the birth mother is a member of the couple. What I am pointing out is that to be consistent with that presumption that would necessarily follow that we would not be legalising surrogacy arrangements for commissioning lesbian couples unless one had a biological relationship to the child. Do you think that that logically follows?

CHAIR: I think the problem is that it is outside their portfolio.

Ms O'SHANNESSY: There are two issues. This is the Department of Premier and Cabinet's submission on behalf of whole of government, so it is not actually a submission we made. The second issue is I think yes, there obviously needs to be a degree of consistency unless there are specific issues in surrogacy that suggest there should be a difference, which is what no doubt you will be looking at.

The Hon. DAVID CLARKE: But on the face of it, to be consistent with those recent amendments to the Status of Children Act it would follow that we would not allow surrogacy arrangements in a situation where one of the commissioning lesbian couples was biologically related to the child.

Mr MARTIN: I think the Status of Children Act at the moment has nothing whatsoever to say about surrogacy arrangements, and that is consistent, whether they are a married heterosexual couple, a de facto heterosexual couple or a same-sex couple.

The Hon. DAVID CLARKE: But there is a principle that is laid down there that could well follow and relate to surrogacy arrangements.

Mr MARTIN: As I said, my understanding would be that the Status of Children Act has nothing to say about surrogacy arrangements at this point in time.

The Hon. DAVID CLARKE: Except that, I mean, you saw that there was a relationship by making mention of the fact in the submission that you put to our Committee on the question of surrogacy.

Mr MARTIN: Again, that is the whole of government submission, and I am not aware—

Ms O'SHANNESSY: The Status of Children Act is the Attorney General's Department legislation, so they are probably in a better position to give you an informed view of the subtleties that might arise in that position.

CHAIR: There has been a big issue during this inquiry in relation to conscientious objection. During the inquiry we have had quite a lot of information about this issue. If the Government acts to regulate altruistic surrogacy agreements, medical practitioners and ART clinic staff should be able to conscientiously object to facilitating such agreements—we have actually heard. Are medical practitioners and staff currently able to conscientiously object to participating in ART practises they find unethical, including surrogacy?

Mr MARTIN: There is generally no obligation on medical practitioners to participate, in a broad sense, in practises they object to. The medical board's code of conduct for medical practitioners expressly provides that medical practitioners, where they have a particular objection to a certain type of procedure, should not be involved in that procedure, should not seek to influence a patient, and should, where appropriate, refer them on to another practitioner.

CHAIR: That Act already exists?

Mr MARTIN: That is a code of conduct for the medical profession.

CHAIR: If we do move towards a regulatory process which means that surrogacy is no longer void, we will have to think carefully about the issue of conscientious objection?

Mr MARTIN: We are also in a situation where surrogacy treatment is highly specialised and a service that is offered in limited settings. It is unlikely that there would be medical practitioners, nurses and other health care workers working in those settings if they in fact object to what is going on in those settings.

The Hon. DAVID CLARKE: But it is possible?

Mr MARTIN: All these things are possible.

Hon. DAVID CLARKE: If it is possible, does if follow that conscientious objection should be allowed, consistent with the principle that you referred to earlier?

Ms O'SHANNESSY: Can I just comment broadly on the whole concept of conscientious objection? There will be a number of procedures done in many hospitals regularly at the moment that individual practitioners will have issues and problems with. It is, to my knowledge and experience, managed quite well. People are not required to do it. I would be very concerned about heading down a path of regularising and legislating a conscientious objection process unless there is very strong evidence to that effect because the general rule applies, as Iain has said: Health professionals are not obliged to provide treatment they do not wish to participate in. They are only obliged to offer people an alternative and to pass them on. There are issues about emergency situations where you would draw the line. So it is not something we have ever legislated for in relation to any procedure, notwithstanding there are a large number of procedures people will have a strong objection to and professionals will have a strong objection to providing. So I think I would find it quite problematic to head in that direction.

The Hon. DAVID CLARKE: Except that the issue has arisen with recent legislation in Victoria.

Ms O'SHANNESSY: Yes, it has.

The Hon. DAVID CLARKE: You would be aware of that?

Ms O'SHANNESSY: Yes.

The Hon. DAVID CLARKE: Would you agree that we would not want to have a similar situation in New South Wales where doctors are forced to act against their conscience and participate?

CHAIR: In relation to what?

The Hon. DAVID CLARKE: In relation to any procedure.

Ms O'SHANNESSY: I think that is an entirely different debate about Victoria and abortion law, which is quite different from the surrogacy issues we are talking about.

The Hon. DAVID CLARKE: I am talking about the principle of conscientious objection.

Ms O'SHANNESSY: Yes.

The Hon. DAVID CLARKE: Do you believe that conscientious objection, whether it is written into law or not, should be preserved?

Ms O'SHANNESSY: It is quite a leading question about heading down a legislative path. I think that conscientious objection is recognised in the medical ethics that professionals currently work under.

The Hon. DAVID CLARKE: And it should continue?

Ms O'SHANNESSY: As it currently is.

CHAIR: Do you have any views on the option of establishing a review panel to consider applications for surrogacy arrangements, as has been established in Victoria?

Mr MARTIN: No, not really.

CHAIR: Because it is outside—

Mr MARTIN: It is really outside our area. It is probably one of those matters that would be best addressed either by yourself or by the Standing Committee of Attorneys General.

The Hon. GREG DONNELLY: On the issue of commercial surrogacy and the provisions within the Assisted Reproductive Technology Act 2007, section 43 provides:

> A person must not:
>
> (a) enter into a commercial surrogacy agreement, or
>
> (b) arrange a commercial surrogacy agreement, or
>
> (c) accept any benefit under a commercial surrogacy agreement

In relation to this notion of "accept any benefit", obviously a brown paper bag full of $50 notes is a crass example of receiving a benefit. If, for example, a commissioning couple said, "To help you with your pregnancy, would it assist you to have a room put on your unit with a spa in it?", and the person said, "That sounds quite a reasonable proposition. It would help me. It would be therapeutic." I am deliberately using this example to be provocative. Is that a benefit? How do we discern a benefit? We can talk about this dichotomy between altruistic and commercial, but really are we playing a big game? In terms of what goes on, and we have talked about examples in the real world, in fact it is potentially a false dichotomy except in the very obscene example of the brown paper bag and the cash.

Mr MARTIN: We generally work on the proposition that a commercial arrangement or a benefit to a surrogate involves placing that person, the birth mother, in a financially or materially better position than she would have been but for the arrangement.

The Hon. GREG DONNELLY: That would be the payment of money?

Mr MARTIN: The payment of money.

The Hon. GREG DONNELLY: Or kind?

Mr MARTIN: The provision of a lovely big flat screen television for her to watch while at home. Anything that benefits her, as opposed to the reimbursement of expenses she necessarily incurs directly related to the pregnancy. I am not setting out a scheme about what is allowed and what is not allowed, but one would ordinarily understand obstetric fees and the like are a necessary expense. The purchase of a maternity wardrobe, which is of no use after the pregnancy, again is probably a reasonable expense. The provision or the payment of taxi fares to and from appointments at the hospital, again no financial material benefit to the mother. But anything that puts her in a better position or makes it look like being a surrogate is now her occupation for which she is remunerated may fall foul of that concept.

CHAIR: I thank both of you very much for your attendance today. I recognise that our questions have diverted, partly because the Premier's Department's submission muddles all the departments together. We have had access to the others and will ask more questions of them. We have some questions on notice to be answered by 3 April. The secretariat will inform you about those questions on notice. Thank you very much for appearing today.

(**The witnesses withdrew**)

(**Short adjournment**)

LINDA MARGARET WRIGHT, Lawyer, affirmed and examined:

CHAIR: Welcome to the third public hearing of the Standing Committee on Law and Justice inquiry into legislation on altruistic surrogacy in New South Wales. Thank you for your submission, Ms Wright. We are hearing evidence from a number of persons today. We have some regulations, which I will not read out. In relation to rules about adverse mention, Committee hearings are not intended to provide a forum for people to make adverse reflections about others. The protection afforded to Committee witnesses under parliamentary privilege should not be abused during these hearings. Therefore, I request that witnesses avoid the mention of other individuals unless it is absolutely essential to address the terms of reference. There is a problem with telephones interfering with our audio mechanisms, so I ask that telephones be turned off during the hearing.

Ms Wright, in what capacity are you appearing before the Committee? Are you appearing as an individual or a representative of an organisation?

Ms WRIGHT: I am appearing as an individual.

CHAIR: Are you conversant with the terms of reference of the inquiry?

Ms WRIGHT: Yes, I am, Madam Chair.

CHAIR: If you consider at any stage certain evidence you wish to give or documents you wish to tender should be heard or seen only by the Committee, please indicate that fact and the Committee will consider your request. If you take any questions on notice, the Committee would appreciate a response by Friday, 3 April 2009, if possible. Would you like to start by making a statement?

Ms WRIGHT: Yes, Madam Chair, I would. I have been asked to appear before the Committee in my role as a lawyer. For the past five years or so I have been providing advice to both intended parents and birth parents primarily before the embryo transfer occurs and, to a lesser extent, assisting intended parents following the birth to obtain parenting orders in the Federal Magistrate's Court. The advice I have been giving to people makes it clear that in New South Wales there is what could be described as either a legislative vacuum or a mishmash of legislation that impacts on surrogacy as it is currently practised. I am, therefore, of the view that there clearly is a role for government to play in putting in place properly thought through legislation that has been specifically designed to apply to the whole of the surrogacy procedure, rather than the current arrangements being caught by the various pieces of legislation.

I favour legislation that permits altruistic surrogacy to occur. I do not necessarily have a better view of the criteria that intending parents and birth parents should have to meet, although my views are somewhat coloured by the type of clients that I have been dealing with. My view is that at the very least there should be some medical basis for the surrogacy arrangement rather than just mere convenience. My primary concern is to see legislation put into place that covers the whole of the process, but particularly putting into place a procedure following the birth which will enable the birth certificate to issue showing the independent parents as the parents of the child. That is a major problem with the current procedure, and that is my primary concern.

The Hon. JOHN AJAKA: I have briefly gone through your submission. Thank you very much for providing it. I know there are blackouts in the submission for obvious reasons, but I would be extremely grateful if each of the blackouts showed "CC" for "commissioning couple", "S" for "surrogate" and "P" for "partner". I assumed as I read through it that I was getting the right parties, but it would help enormously if you could do that and provide it to the secretariat, if it is not too much inconvenience.

Ms WRIGHT: I can certainly arrange for that to be done.

The Hon. JOHN AJAKA: In your opinion would you believe it to be more appropriate to have one specific Act dealing with all aspects of surrogacy as opposed to what we appear to be doing, that is, modifying, adding or subtracting terms and provisions to and from a number of existing Acts?

Ms WRIGHT: Yes, I do indeed. You may see from my submission that I think the Australian Capital Territory Parentage Act is a very good model. It provides within it the procedure for the existence of the intended parentage transfers, the agreements, the procedure for getting a transfer of parentage order following

the birth. So, yes, I would be in favour of one Act. I think it would be simpler and far less likely to be the subject of dispute.

The Hon. JOHN AJAKA: Would you go to the extent of calling it the Surrogacy Act? It seems a few parties almost want to avoid the word "surrogacy" and use another term.

Ms WRIGHT: I do not have a view on that. A word is a word. It does not really matter what it is called as long as it puts into place an appropriate procedure.

The Hon. JOHN AJAKA: If we simply leave the status quo as is without making further amendments, do you believe it is not currently workable and, if so, for what reasons?

Ms WRIGHT: It is workable, but it is workable with some obvious difficulties, particularly post-birth. What it creates is a very odd situation where you have the non-rebuttable presumption that the birth mother is the mother of the child, the non-rebuttable presumption that her male partner, and after the recent amendments her female partner, is the other parent of the child where they have consented to that assisted reproductive procedure, regardless of the genetic make-up of the child. What that means is that where the agreement between the commissioning parents and their surrogate and her partner is followed through with the transfer of the care of the child following the birth, you have a very odd situation where the child who is usually genetically related to at least one of the commissioning parents is not regarded at law as their child. They then have to get an order from the Federal Magistrate's Court giving them some form of basis for the child being in their care and then they have to adopt their own child. Until recent amendments to the Adoption Act where the child was related, as is often the case, to the birth mother, that meant that they could not do anything about adoption for five years. So the child is in limbo, in fact. Where we are looking at what is in the best interests of the child, there has to be a focus on solving that problem.

The Hon. JOHN AJAKA: Do you see a difference between both gametes having been donated by the commissioning parents as opposed to a situation where neither gamete has been donated by the commissioning parents? As a lawyer, do you see that the legislation needs to differentiate in that situation?

Ms WRIGHT: I do not really have a firm view from a social perspective on it. As a lawyer I can see that there would be a reason for differentiating. However, it will probably go back to the question of what the Committee recommends and what the legislation, if any, says about the binding nature or otherwise of the preconception agreements. If you are going to create a situation where that agreement is, for example, binding and someone undertakes the surrogacy procedure, it would then be very unfair to discriminate at the end of the procedure between genetic relationship and non-genetic relationship. A lot of it may go back to the view that the Committee forms on whether or not those agreements should be binding. But I think overall if there is going to be a procedure, then there should not be a differentiation at the end of the procedure whether there is a genetic relationship or not.

The Hon. JOHN AJAKA: I want you to confirm if I have understood your submission correctly. I will try to summarise it in point form and please tell me if I have got it wrong. As I understand what you are saying, firstly, the commissioning mother should be fertile but unable to carry her own child. Further, one of the gametes should come from the commissioning couple. I assume in that situation you are saying that the female partner should provide the gamete?

Ms WRIGHT: Yes.

The Hon. JOHN AJAKA: Then you say that the other gamete should be from, I assume, an anonymous donor and not from the surrogate herself, is that correct?

Ms WRIGHT: Yes, that is right. It is my firm view that the birth mother should not be the donor.

The Hon. JOHN AJAKA: You even it up and take it one step further by stating that the surrogate should not even be related to the commissioning parents.

Ms WRIGHT: No, I think that is a misunderstanding. What I was saying in my submission was that the birth mother, the surrogate, should not be the genetic parent.

The Hon. JOHN AJAKA: So she should not be donating a gamete—full stop?

Ms WRIGHT: That is right. It is quite common for the surrogate to be related. Often she is a sister or a mother of either of the commissioning parents.

The Hon. JOHN AJAKA: I wanted to clear that up.

Ms WRIGHT: I think it is good that there is a relationship.

The Hon. JOHN AJAKA: You said that the surrogacy should be decriminalised. Do you simply mean in non-commercial surrogacy, or do you mean in both non-commercial and commercial surrogacy?

Ms WRIGHT: You have to read that submission in the context of it being a copy of a submission that I made to a Queensland parliamentary inquiry, and Queensland had all the essentials. The reference to decriminalisation obviously does not apply to the situation we are facing in New South Wales. I certainly do not support commercial surrogacy.

The Hon. JOHN AJAKA: Thank you; I wanted to confirm that. You also said that you do not recommend same-sex surrogacy; you believe that it should still be between a man and a woman?

Ms WRIGHT: Yes. Again, it is not a legal position. As I said, I think my views have been somewhat coloured by the couples with whom I have been dealing. Following recent amendments to the legislation it might not be possible to exclude same-sex couples. I have a personal rather than a legal view.

The Hon. JOHN AJAKA: Are you saying that surrogacy agreements should be enforceable, or should they remain voidable or void?

Ms WRIGHT: I think they should still be void, or voidable, but they should be taken into account in any application post-birth for the transfer of parentage, if that is where the legislation takes us.

The Hon. JOHN AJAKA: Rather than it being enforceable, the next step would be for a judge to look at that criterion when looking at all other criteria?

Ms WRIGHT: Yes, that is right.

Ms SYLVIA HALE: I am looking at your confidential material, which I find interesting. In what context was this letter or agreement drawn up?

Ms WRIGHT: It was developed probably over the past four or five years. Initially I was approached by Sydney IVF to see whether or not I would be interested in giving, and available to give, legal advice to couples—the proposed birth parent and her partner—in a form that was acceptable to its ethics committee. We had a meeting and nutted out the various criteria that the ethics committee was looking for, and we nutted out the various legal issues that it might need to consider. That report has been developed as a pro forma report that goes to Sydney IVF after I have had a meeting with the commissioning parents and the proposed birth parents. That has been modified over a number of years as the legislation has changed, and obviously it is tailored to each set of circumstances as it applies to the two couples.

Ms SYLVIA HALE: I notice, for example, that the general provisions at the end of this document refer to whether the commissioning parents will be present at the birth, and whether that birth will be by Caesarean section or a natural birth. It is more or less a standardised agreement that would then be amended to take into account the agreement to which all the parties had come.

Ms WRIGHT: Yes. The report should not necessarily be read as an agreement. It is a report of a discussion that I have had with clients and advice that I have given to clients. Obviously there is a checklist that I follow in taking them through the various things that they need to think about. Part of the reason for including things such as whether they will be present at the birth, and whether it will be by Caesarean, is not so much from the legal perspective of a legal agreement on that. Part of what I am required to do by Sydney IVF is to comment on the legal capacity of the parties to enter into the arrangement. After having those discussions it opens up a conversation for me to form that view.

Ms SYLVIA HALE: Would all parties receive a copy of this document?

Ms WRIGHT: They do, yes.

Ms SYLVIA HALE: And they would have an opportunity to come back to you and say, "I have had second thoughts about a particular issue"?

Ms WRIGHT: Yes. As you will see from that letter, I make it clear to people that if there is a change of view or they want to ask other questions, I cannot then deal with them on an individual basis. That has to be forwarded to all the parties I met with because they are all my clients. If a dispute arises I cannot then advise or act in relation to that dispute.

CHAIR: Do you have many disputes?

Ms WRIGHT: I am not aware of any, but that is not to say that there have not been any. Obviously I cannot be involved in them if there are disputes. To my knowledge there have been no disputes. I often receive emails from people after the birth to say, "Thank you very much. The baby has been born and here is a photograph or the details." I am not aware whether there have been any disputes.

Ms SYLVIA HALE: You referred in section 5 of this document to complications. This morning we had a discussion about the responsibilities of the surrogate mother to the foetus. I think an example was given of foetal alcohol syndrome, if the mother drinks excessively and things like that. Because of the blanks in the document it is difficult to work out where it goes. Would you mind walking Committee members through the complication section so that we have some idea of how it is dealt with?

Ms WRIGHT: I suppose that the complications are really legislative complications. They start from a premise of: What happens if the birth mother, or the partner for that matter, refuses to surrender the child? What happens if the commissioning parents refuse to accept the child? Assuming that something goes wrong with the arrangement, the complications could be that the birth parents might have a child that they do not necessarily want to raise, or the complications could be that the commissioning parents might not be given the care of the child. I then talk them through what they would need to do in relation to getting some order from the Federal Magistrates Court. Given *Re Evelyn*, the likely result is that they would not have the full-time care of the child.

My view is that they most likely would be given time—the new term for access or contact—with the child. Other complications include things such as child support. If a child remains with the birth parents and those birth parents separate, you have an irrebuttable presumption under the Status of Children Act that the male partner of the birth parents is the father. But under the Child Support Act that assumption is not irrebuttable; it is rebuttable. The birth mother may then be left with a child for whom she cannot get child support from her former partner and she may then have to make an application to have the genetic father declared the father of the child. There are all those sorts of complications. That is really what I mean by a mishmash of legislation that impacts on surrogacy when you do not have a specific surrogacy Act.

You might also have the complications of the inheritance laws. If a child is living with the birth parents and that child is deemed to be a child of theirs, they would have a claim on the inheritance, despite the fact that the child is not a genetic child of the birth mother or the partner. Those sorts of issues need to be thought through as well. What about wills and those sorts of issues? How do you provide for the child in your will? You cannot say, "I leave my estate to my child", because the genetic parents might not necessarily be the legal parents, so you have to name the child. You cannot call him or her "my son", or, "my daughter". If you want to make provision in your will you specifically have to name the child.

Ms SYLVIA HALE: There would be additional complications if, for example, the donor of the sperm was not known or could not be traced? There would be no-one then from whom you could seek child support?

Ms WRIGHT: From whom you could seek child support.

Ms SYLVIA HALE: From the point of view of the child's future stability it is important for the identity of the donor be known.

Ms WRIGHT: Not if you have a transfer of parentage from birth. That solves the problem.

Ms SYLVIA HALE: Except for the problem of inheriting genetic diseases or some such thing.

Ms WRIGHT: That is right, but that is a different issue.

Ms SYLVIA HALE: I agree; that is a different issue. Let us say, for example, that there are two men, one infertile and one fertile. The fertile man, in a generous act, donates his sperm to the infertile man, a woman conceives a child and the child becomes a pregnancy, but for some reason the commissioning father then wants nothing to do with the child. The legal responsibility for the support of that child would go back to the donor of the sperm, even though at the outset he had generously donated his sperm as a gift rather than with the intention of having any long-term relationship with or commitment to that child?

Ms WRIGHT: That question has nothing to do with surrogacy. You are not talking about a surrogate arrangement; you are simply talking about a sperm donor and a child being born in a relationship because the male partner in that relationship is infertile. Is that right? You are not necessarily talking about—

Ms SYLVIA HALE: It is not necessarily confined, but such a situation could arise in the context of surrogacy.

Ms WRIGHT: It could, yes, if you are talking about both commissioning parents being infertile.

Ms SYLVIA HALE: Thank you.

CHAIR: To extend on that, if a transferral of parenting scheme were implemented those complications would go?

Ms WRIGHT: A lot of the complications would go because you would then have created a legal relationship, just as you do in adoption.

CHAIR: Reference has been made in some of the submissions to a joint certificate process—hidden information and birth certificates that come forward later?

Ms WRIGHT: Are you asking me for my view on what should be shown on a birth certificate?

CHAIR: Yes. How are they doing it?

Ms WRIGHT: I state at the outset that I do not practise in the Australian Capital Territory, so I am not familiar with the procedure other than what I have read in the legislation. Just as in adoption, a new birth certificate shows as the parents not the birth parents but the commissioning parents. However, the original information is always available; it is not destroyed. If there were to be a transfer of parentage and a new birth certificate was issued, that certificate should not show both sets of parents, as that would be discriminatory for the child. As children go through life they have to produce birth certificates, so that would pre-empt a lot of unnecessary questions and possibly ridicule. Once that transfer of parentage occurs it is important for the birth certificate to reflect that transfer and nothing else.

The Hon. JOHN AJAKA: Could a child have two birth certificates—an extract that shows one set of parents and that can be provided to everyone and, if the child so wants, a birth certificate showing his or her entire history?

Ms WRIGHT: I think the child should be able to obtain the information. I do not have a view on whether it should be in the form of a birth certificate as such, but the information should be available in some form or another.

The Hon. JOHN AJAKA: If we are looking at the best interests of the child he or she should have a choice—a birth certificate showing only the parents, or a birth certificate showing all four people because that is the nature of the child. It would not hurt a child if he or she did not have a choice.

Ms WRIGHT: You are talking about a choice being made when a child has almost reached adulthood, or has reached adulthood. That would then mean the issue of a different birth certificate. You would need to check with the Registrar, Births Deaths and Marriages. However, a certified copy of a birth certificate is just that: a certified copy of a certificate. You do not go and create a new certificate.

The Hon. DAVID CLARKE: Ms Wright, you said that you do not support surrogacy involving commissioning same-sex couples. You then referred to your experience with commissioning couples. Did your experience with some commissioning couples help you to come to that view, or were the two unconnected?

Ms WRIGHT: No, they are not unconnected. As I said at the outset, I think my view has been coloured by the type of couples that I have been dealing with, and they have been heterosexual couples who are either married or in a long-term de facto relationship. At the time I started to give this advice, obviously, the legislation had not been amended; it was not possible for the partner of a lesbian birth mother to be shown on the birth certificate and Sydney IVF's ethics committee was only dealing with heterosexual couples. So, I think my view has been coloured by that. Also in my submission, and it is still the case here in New South Wales, what I am concerned to see is some legislation in place that regulates what is happening, and I would not want to see that legislation fail because it is too far to one side.

In Queensland they were coming from a position of decriminalising surrogacy and I thought it was a big leap to take it from there to open slather, if you like, in a very colloquial sense. It is not quite the position here, but it almost is. My preference would be to see legislation pass and not fail because it is too radical for some members. Now, your Committee would know better than I what the chances are of legislation like that passing. From a social perspective I suppose I am reasonably conservative—that is a personal view. So, yes, my preference overall is to restrict it to heterosexual couples.

The Hon. AMANDA FAZIO: I am interested in the issue of reasonable expenses. In your submission you talk about the impact of the baby bonus and how it might be construed as bringing in an element of commercial surrogacy. Could you expand on what you think reasonable expenses should entail and also explain the reference to the baby bonus?

Ms WRIGHT: Okay. I heard the tail end of the gentleman from the Department of Health, I think it was. I actually agree with what he said about what reimbursement and what reasonable expenses are. The sort of things that we talk about when I speak to my clients are things like the obvious, the medical expenses; the legal expenses associated with their consultation with me; the travel expenses; lost wages in some circumstances—a birth mother may be in an occupation where she does not get paid maternity leave, so she may have to have six weeks off following the birth to recover; the maternity clothes. Those sort of obvious things I think are legitimate reimbursement of expenses. They are not putting the birth mother or her partner in a financial position better than they would have been in had they not undergone the surrogacy.

The question of the baby bonus is interesting. It is not something that I had actually thought about until it was raised by one of my clients. It was raised not long before I did a submission to the Queensland parliamentary inquiry. So I put it in there because I thought it was an interesting dilemma. The ART legislation in New South Wales talks about commercial surrogacy, I think it is section 43(c), where there is an acceptance of a benefit. The fact that the birth mother may be entitled to the baby bonus does not necessarily mean that she has to accept it. But I think a lot of my clients, what they are doing is they are getting the baby bonus but they are then passing it on to the commissioning parents. My concern was that that was getting a little bit close to the realm of commercial surrogacy and it was something that a committee might need to look at and clarify. But to my knowledge no birth mother of the couples that I have been dealing with is actually accepting the baby bonus and keeping it. If she is accepting it, it is a fleeting acceptance before it is then passed on to the commissioning parents.

CHAIR: Where would we find information for clarity on that issue? Do you think we should go to the Federal Government?

Ms WRIGHT: I do not necessarily think you will get clarity on it. At the moment the Status of Children Act says that the birth mother is irrevocably presumed to be the mother of the child and, therefore, she is entitled to the bonus. It may be that if we are talking about some nationally consistent legislation, the baby bonus legislation may have to be amended at a Federal level. Alternatively, it could be dealt with at the State level, perhaps by saying that she is not entitled to keep it, but then you would have competing pieces of legislation. So, that may be something that you need to talk to the Federal Government about.

The Hon. AMANDA FAZIO: I was interested also in your comments about parentage after the baby is born and that if there was a legal dispute, who was going to raise the child after it was born; the surrogate mother may have some time granted to spend with the child. You said that you have not had any disputes with the families you have dealt with. Apart from the court case to which we keep being referred, are you aware of

any other cases where there has been a dispute? Do you think there should be some form of mediation mechanism or something set up as part of a surrogacy legislation?

Ms WRIGHT: I am not aware of any cases where there have been or has been a dispute. As to mediation, I do not think it necessarily needs to be specifically in the surrogacy legislation. If a dispute does arise and if an application is made under the Family Law Act for some sort of parenting order, then as a matter of procedure under the Family Law Act there has to be alternative dispute resolution either before the application can be made to the court or, in some circumstances where that is not required, as part of the court process. So, you already have a process there of mediation or alternative dispute resolution or counselling, whatever you want to call it, built into that process. I would not have an objection, I do not think, to making alternative dispute resolution compulsory in the event that there is a dispute; but if there is a dispute and there is therefore going to be no parentage transfer, then the fallback position has got to be for the commissioning parents to the Family Law Act and, as I said, there is already in built into that the dispute resolution process.

The Hon. GREG DONNELLY: Your evidence is very enlightening because for me it is really connecting the broad conceptual issues with the reality of dealing with surrogacy as it operates. On the question of your personal view about homosexuals not having access to surrogacy, what about the issue of a single person having a surrogacy arrangement with someone, in other words, for the commissioning of a child, is that something about which you have a view?

Ms WRIGHT: Well, again, that is a creation through government sanction if you like of non-traditional family. I think we have moved a long way from the concept of there being any negativity about a single parent, but it is still, in some sense, a non-traditional family. Our traditional view is mother, father, child: that is the ideal. I think that society generally accepts that is probably the ideal way to raise a child. I suppose the risk would be that if legislatively you permit a single person to commission a surrogacy, you are in effect creating a situation where single sex couples could utilise that. For all intents and purposes they may say they are not a couple, one is a single, surrogacy is created, then the couple resumes its relationship. They have created a family in that way. So, I think my personal view still is that it should be restricted to heterosexual couples married or in a long-term de facto relationship.

The Hon. GREG DONNELLY: On the question of the nature of the agreements that exist in New South Wales at the moment between commissioning parents and their surrogates to the extent that they actually are written agreements of some form, they are actually void, are they not?

Ms WRIGHT: They are; that is right.

The Hon. GREG DONNELLY: You may deal with this next matter in your submission, so forgive me if it is and I have not quite picked it up. In your submission do you deal with the voidability of arrangements and about changing that position?

Ms WRIGHT: My view is that the agreements, whether they are written or verbal, should be voidable. I think it is very dangerous to think about legislation that makes those agreements enforceable. What you are creating is the situation where a child may then be seen as a commodity that is subject to a contract, and that is something that I struggle with. It is also very difficult to foresee and foreshadow how the birth mother is going to feel. It is one thing to enter into an agreement pre-conception and another to then actually have to surrender the child; circumstances will change or could change dramatically in the 9 to 12 months, whatever the period is going to be. So my view is that they still should be voidable and I think I said earlier that they should just be one of the criteria that are looked at in terms of whether or not a transfer of parenting should be made.

The Hon. GREG DONNELLY: I think paragraph 5A on page 3 of your submission is specifically the point we are talking about. The paragraph concludes:

> This would be particularly important if partial surrogacy was to be permitted.

Could you explain "partial surrogacy" as you mean in that particular circumstance?

Ms WRIGHT: Can I just have a look at our submission?

The Hon. GREG DONNELLY: Yes. I am sorry; I do not mean to put you on the spot.

Ms WRIGHT: No, that is all right. I will just grab it. I think that was probably in relation to a specific question from the Queensland inquiry.

The Hon. GREG DONNELLY: Yes, I think it was.

Ms WRIGHT: I think that was in reference to both of the commissioning parents not necessarily being the genetic parents.

The Hon. GREG DONNELLY: Yes, that makes sense. If I could now take you to this issue of what are, as I understand it, the National Health and Medical Research Council [NHMRC] guidelines and the ethical guidelines for the industry, how the two are linked and in some sense operate as a bit of a de facto flaw or de facto guide to conditions that apply or are to be considered appropriate to apply in the context of surrogacy in New South Wales. Do you have a familiarity with the NHMRC guidelines?

Ms WRIGHT: I do.

The Hon. GREG DONNELLY: With respect to the NHMRC guidelines and the ethical guidelines that apply to the industry, do you have a view that there are aspects of those guidelines that the industry, for want of a better word, is not picking up and applying, which you think should meet an appropriate flaw for surrogacy arrangements? Have I made myself clear with the question?

Ms WRIGHT: I think so. What you are asking me I think is, am I aware of situations where the guidelines perhaps have not been followed as closely as they might be?

The Hon. GREG DONNELLY: Or may have been deliberately chosen not to in fact be utilised because it might be a bit sticky or bit difficult, yes?

Ms WRIGHT: My primary experience is with Sydney IVF, and I would have to say that since dealing with the clinic, there has not been a problem. I have had experience of dealing with two couples who conceived utilising another clinic. I was concerned that they had not been asked to get legal advice. They came to me through referral from a psychologist who was concerned about some of their understanding of what was going on.

The Hon. GREG DONNELLY: I hate to interrupt, but without breaking your train of thought can you tell me if you think it is important for commissioning couples to get legal advice in terms of dealing with a range of matters associated with the decision they are considering?

Ms WRIGHT: As things stand at the moment, definitely, because there are so many issues, particularly concerning the parenting of the child. If legislation is put into place within one Act, which is clear and sets out the procedure from beginning to end, it may be less necessary. But certainly as things stand at the moment, it is very important. A lot of the couples I see have already done a lot of research before they get to me and they are aware of some of the pitfalls, but the two specific ones to which I was referring before did not even know that the commissioning father's name could not go on the birth certificate. I can see why the psychologist was concerned.

I have some concerns about the particular clinic involved. I do not even know if in the end that surrogacy preceded; I suspect it did not. But there are some circumstances out there where, although the guidelines are quite clear, obviously one of the difficulties is the commercial aspect. You call it an industry, and that is not necessarily a pejorative term. The clinics are commercial clinics and they are there to make a profit. Therefore there may be some case for the legislation itself to at least have the basic criteria set out, so that at least in terms of that basic criteria there can be no rubbery-ness.

The Hon. GREG DONNELLY: I think you must have been reading my mind because that is where I was taking this line of questioning. The guidelines, to the extent to which they exist and operate, function as a flaw. In the end, they are and will continue to be guidelines, and therefore are subject to change. What is exercising our minds as a Committee is the extent to which we decide or recommend that surrogacy legislation in a general sense will be introduced into New South Wales, and what ought to be considered to be within that legislation.

Ms WRIGHT: Yes.

CHAIR: A lot that would be regulation in relation to the guidelines.

Ms WRIGHT: Whether it is regulation and legislation, it remains the same.

The Hon. GREG DONNELLY: I have gone through the National Health and Medical Research Council guidelines, which are quite voluminous, but I have not read the industry guidelines. There is a whole range of issues and it would be a challenge to work out which ones should go in, and which ones should stay out. In point 6F of your statement, you refer to brokering and advertising. It picks up an answer to an earlier questioned by either Ms Hale or the Hon. John Ajaka. How did you come to your view about the surrogates being related to or having a long-term friendship with the commissioning parents?

Ms WRIGHT: Again, it has been coloured by the nature of the people I have been dealing with. That is one of the ethical requirements that Sydney IVF imposes.

The Hon. GREG DONNELLY: Is that right?

Ms WRIGHT: Yes. They want to see that there will be a long-term involvement of the birth parents in the child's life, and that is obviously fostered by either a biological relationship, such as an aunt, cousin, or whatever, or a long-term friendship. One of the things that we talk about is what is proposed in terms of keeping the child involved in the life of the birth parents. I think it probably goes without saying that from the child's perspective, that would be in the best interests of the child. If a child has questions, the birth parents are there to answer them. It is an open arrangement.

The child will be told as soon as he or she is able to understand the circumstances of their birth. I think that is very important for the long-term wellbeing of the child. If you had a situation in which a surrogate was brokered, the chances are that that surrogate would not be a part of the child's long-term life. I think that is why it has been coloured by that, but I think that is very important. It is the same sort of concept as in the Family Law Act. It is very important for a child to have an ongoing relationship with both the mother and the father in the event of a marital breakdown.

The Hon. GREG DONNELLY: If I may press you a bit further on this issue, I think you said that that is one of the guidelines that Sydney IVF operates under, but to the best of your knowledge that is not an industry guideline or a National Health and Medical Research Council guideline.

Ms WRIGHT: No.

The Hon. GREG DONNELLY: It is a specific company guideline.

Ms WRIGHT: It is genetics question that they have thought about.

The Hon. GREG DONNELLY: And they have decided that they would apply it in those terms.

Ms WRIGHT: Yes.

The Hon. GREG DONNELLY: If a couple went along to Sydney IVF with the intention of entering into such an arrangement and they said that they had someone in mind who was not related, they would be screened out. It is that what would happen?

Ms WRIGHT: It is not so much that they are not related.

The Hon. GREG DONNELLY: I am sorry; I meant that they are not part of a long-term relationship.

Ms WRIGHT: That is right. They need to have at least a long-term friendship.

The Hon. GREG DONNELLY: What does that mean?

Ms WRIGHT: That long-term friendship is not defined in the sense that it would be subject to individual circumstances, but I am aware of at least one matter where the ethics committee had some doubts and

refused the application because they thought that the relationship between the commissioning parents and the proposed birth mother was not good enough or close enough.

The Hon. GREG DONNELLY: This is a question that perhaps is better directed to Sydney IVF and whose representatives, as you probably know, are coming along later today to give testimony. But surely there would be an argument that that commissioning couple is being discriminated against in terms of being able to access a commercial service.

Ms WRIGHT: Yes, of course, but the question is whether there should be some commercial aspect to it, and that is a matter for the Committee.

The Hon. GREG DONNELLY: I am sorry, but you have misunderstood me. It is commercial in the sense that Sydney IVF offers a service. I do not think anyone would doubt that that is what it is. The couple go along and say that they have a woman who has agreed to be a surrogate and to carry and bear the child, and they wish Sydney IVF to provide the service. They say, "No, thanks. We have these guidelines. You must understand." Surely that is discrimination.

Ms WRIGHT: Does that not go back to one of the questions I heard at the end of the last witness? It is about whether there are ethical or moral considerations of medical personnel.

The Hon. GREG DONNELLY: I am being devil's advocate, but they are real practical issues.

Ms SYLVIA HALE: Can I ask one follow-up question?

The Hon. GREG DONNELLY: Yes.

Ms SYLVIA HALE: Are you aware of any instance in which Sydney IVF may have refused to proceed with the surrogacy arrangement, and the commissioning parents and the surrogates have gone elsewhere?

Ms WRIGHT: I am not aware, no.

Ms SYLVIA HALE: But that option would be open?

Ms WRIGHT: It could be open to them, yes.

The Hon. GREG DONNELLY: This is pressing right down into the minutiae of what could be in legislation, but questions, for example, relating to the number of eggs or sperm that are, to put it rather crassly, in circulation, by which I mean that are available for utilisation of surrogacy—

CHAIR: I think it is in the assisted reproductive technology legislation.

The Hon. GREG DONNELLY: That is not my question. My question is that that sort of really detailed prescription that in a sense starts to enter into this debate about prescription and guidelines, do you have a view that overarching legislation, such as you recommend we should be considering, needs to get down to that level?

Ms WRIGHT: My view is that it does not. While I am supportive of our overarching legislation, I also have a view that governments should not interfere in too much detail in what is an intensely personal and private matter. So, no: I think the answer to your question is no. I do not think it needs to get into that much detail. If the recommendation is that at least one of the commissioning parents must be a genetic parent, to some extent that gets around that issue anyway.

The Hon. JOHN AJAKA: Thank you for your letter of advice, the pro forma. I notice that in 4C you state:

> That Act provides that for the adoption of a child by relatives of the child the child must have been in a relationship with the adopting parents for five years.

Ms WRIGHT: It is now two years. It was amended in December. You will notice that that is dated November. When I became aware of the amendment, I clarified that with that particular set of parents.

The Hon. JOHN AJAKA: That was my question. Even at two years, the reality is, in a surrogacy situation even if the gametes have been donated by both commissioning parents, the situation still is that they are unable to adopt a child for a minimum of two years.

Ms WRIGHT: That is right. So the child will be in legal limbo for that time where the birth mother is the sister or the mother of a commissioning couple.

The Hon. JOHN AJAKA: I have practised a little bit in family law. My best guess is that even to obtain parental orders, in a best case scenario you are looking at between two and four months.

Ms WRIGHT: About two and a half, according to the last one I did.

The Hon. JOHN AJAKA: There is an even worse limbo for the first two and a half months.

Ms WRIGHT: That is right.

The Hon. JOHN AJAKA: And then there is a clear limbo up to two years. If you get it exactly in two years time, it would still probably be two and a half in real terms.

Ms WRIGHT: That is right. One of the problems with it and getting a parenting order is that, because technically it is an order being made in favour of non-parents, the Family Law Act specifies that there should be some mediation and counselling. That causes delay, even if there is consent by both parties.

The Hon. JOHN AJAKA: And going back to parental orders under section 61B I must say that I had not realised that just because you obtain a parental order under section 61B there could still be certain areas that you cannot cover. One of the areas you mentioned is getting a passport and travelling overseas.

Ms WRIGHT: One of my concerns was that is to get an order for parental responsibility, from a Department of Foreign Affairs and Trade perspective that may not be sufficiently detailed. I recommend to people that they get some specific orders from the Federal Magistrates Court as well, dealing with that passport issue.

The Hon. JOHN AJAKA: We are not looking at one Act, but we are continuing to look at modifying an existing Act. Should this Committee look at reducing it to three months instead of having two years for adoption when you have a situation of surrogacy and gametes donated by commissioning parents?

Ms WRIGHT: That is one option, certainly.

Ms SYLVIA HALE: The letter that is provided to the parties seems to be a mixture of confirming their ability to understand the nature of the legal obligations and other things, notification of what the advice is that you have given to them, whether the parties are able to agree on particular issues, and a report to that effect.

Ms WRIGHT: Yes.

Ms SYLVIA HALE: Can I take it, for example, that if there was a foetal abnormality and there was no agreement on whether the pregnancy should be terminated, in that case the application for surrogacy would not proceed?

Ms WRIGHT: That is something you would have to talk to Sydney IVF or any other fertility clinic about. I would imagine that that would cause some consternation on the part of the ethics committee if there was no agreement. I note it is something that the psychologists go into in a lot more detail.

Ms SYLVIA HALE: In a submission from the Government there was a suggestion that, as is the case for adoption orders, there be an investigation of criminal history. Does Sydney IVF venture down that path at all?

Ms WRIGHT: Not to my knowledge, but again you have to talk to the ethics committee. It may be that the parties had to supply some sort of a criminal background check. I do not know. I have not been asked to be involved in that, so I am unaware as to whether or not that is one of the guidelines.

CHAIR: I wish to go back to the issue of the transfer of parentage and the birth certificate process. Is it your idea that parents should go through the Family Court for that to occur?

Ms WRIGHT: No, it would be a State-based thing, like it is in the ACT. It would be an application to the Supreme Court.

The Hon. JOHN AJAKA: Under the Adoption Act?

Ms WRIGHT: That is right, or some other piece of legislation, but akin to an adoption application.

The Hon. JOHN AJAKA: Thank you very much, and I look forward to receiving the identifiers.

Ms WRIGHT: I will identify it as female commissioner, male commissioner, birth mother and birth father, so I will put a little code on it and do that.

CHAIR: Thank you very much for appearing before us today. Thank you for the work you have put in, which is very good and obviously useful to the Committee. Would you mind getting that information back to us by 4 April? The secretariat will contact you before then about anything we might have asked you for or add to the questions. Thank you very much indeed.

Ms WRIGHT: You are welcome.

(The witness withdrew)

MYFANWY KATHLEEN WALKER, Student, before the Committee via teleconference, affirmed and examined:

CHAIR: Welcome to the third public hearing of the Standing Committee on Law and Justice inquiry into legislation on altruistic surrogacy in New South Wales. We are hearing evidence today from a number of individuals and two witnesses are via teleconference. Although we are hearing evidence from these two witnesses, it remains a public proceeding and the same procedural rules apply as with witnesses who are present in this room. As usual, Hansard will produce a transcript of evidence, which will be published and placed on the Committee's website. Committee hearings are not intended to provide a forum for people to make adverse reflections about others. The protection afforded to Committee witnesses under parliamentary privilege should not be abused during these hearings. I therefore request that witnesses avoid the mention of other individuals unless it is absolutely essential to address the terms of reference.

In what capacity are you appearing before the Committee—that is, are you appearing as an individual or a representative of an organisation?

Ms WALKER: As an individual and also as a representative of TangledWebs.

CHAIR: Are you conversant with the terms of reference for this inquiry?

Ms WALKER: Yes, I am.

CHAIR: If you should consider at any stage certain evidence you wish to give or documents you may wish to tender should be heard or seen only by the Committee, please indicate that fact and the Committee will consider your request. Despite the fact that we are in teleconference, we can clear the room and make it private if it should be necessary and the Committee decides to do that. If you take any questions on notice, the Committee would appreciate getting them back by Friday 3 April, that is even considering your busy time as a student.

Ms WALKER: That is not a problem; that is fine.

CHAIR: Would you like to start by making a statement?

Ms WALKER: What was that last bit? I didn't hear.

CHAIR: Would you like to start by making a statement?

Ms WALKER: No, that is fine, I would just like to thank the Committee for hearing me today. That is all I have to say really.

CHAIR: Can you describe the role of TangledWebs and its interest in the issue of surrogacy?

Ms WALKER: Sure. TangledWebs started off as an informal group of mostly donor-conceived adults, and by "donor-conceived" I mean conceived by donor sperm, so sperm donor conceived adults, from Australia and internationally. We felt that we needed to be able to share with each other within the group views that at the time we thought were unacceptable for discussion in the wider donor conception community. Our membership now also includes a number of people who were adopted, parents who conceived their children using donor gametes, biological parents who were gamete donors and also a few professionals within the field of infertility. For the most part I would say that our focus has been on traditional forms of donor conception, specifically the use of donor sperm, but as time has gone on we have had to begin to consider practices of using donor egg or embryos as well as surrogacy. We think that all the assisted reproductive technology practices involving the use of donor gametes share pretty much the same issues, so our concern extends to surrogacy for that reason.

CHAIR: Do you have any surrogate children within your membership?

Ms WALKER: Not at the moment. Membership to TangledWebs is open to anyone who is concerned about ART practices. Membership is certainly open to anyone conceived by surrogacy, should they wish to join. Given that as far as we know there have only been a few surrogacy cases in Australia and the majority of those

children are very young, I think it will be some time before we start to see them speaking out, and possibly their membership.

CHAIR: So the organisation actually works for persons who have a concern?

Ms WALKER: Yes. Most of those people who are members are actually conceived by donor conception, but we also include membership of people who have concerns about the practice.

CHAIR: The Hon. Greg Donnelly?

The Hon. GREG DONNELLY: Thank you, Madam Chair.

Ms WALKER: I am sorry, I can't hear you very well.

The Hon. GREG DONNELLY: Can you hear me now?

Ms WALKER: You sound very far away.

The Hon. GREG DONNELLY: I will pass over to someone else and use another microphone.

The Hon. JOHN AJAKA: Can you hear me?

Ms WALKER: Yes, that is better.

The Hon. JOHN AJAKA: I think if we put the volume down in the room it works better; with the volume up I think it echoes. Can you indicate to me, going on from what the Chair was asking you, how large is the membership of TangledWebs?

Ms WALKER: I could not tell you, off the top of my head. I think somewhere between 20 and 30 at the moment, but we have international members as well and because of incorporation rules they cannot sort of be included in our membership.

The Hon. JOHN AJAKA: It would be fair to say that it is under 50?

Ms WALKER: Yes, I would think so.

The Hon. JOHN AJAKA: Thank you for your submission, and I have read parts of your article again and thank you for that. Do you not feel it would be better for there to be strict regulation in relation to surrogacy rather than simply leaving the status quo as it is, if one takes the position, "Well, we can't abolish surrogacy, it exists today and it is continuing to exist." What would be your views on that?

Ms WALKER: I will say I think regulation is a double-edged sword. I think the danger in legislation to regulate the practice is that it appears that in doing so the Government is sanctioning the practice as a legitimate choice. I think that once this happens, even if it is only in very limited circumstances, the door is open for future reform and ultimately wider availability. I think that ART facilities should only be accessed as a last resort. I think we tend to move towards a system becoming more about reproductive choice and I think that once that happens there tends to be little room for consideration of the effects of the practice on the person created. In saying that, I think the danger in not regulating is that there are no guidelines on how to deal with issues that arise when people go ahead anyway. Amongst other things, for example, the fact that the birth certificate will not reflect the real truth of the child's parentage. However, these types of issues can be overcome without sanctioning. It is a tough one to answer, but they are my thoughts.

The Hon. JOHN AJAKA: What I am hearing in this Committee is that by leaving the status quo we have serious issues in relation to intestacy if no specific will is made; there is a two-year plus wait in relation to adoption and parenting orders for at least a three or four month situation, and there are defects with that. They are the concerns in relation to that.

Ms WALKER: Yes.

The Hon. JOHN AJAKA: Would it not be obligatory on our part, rather than leaving the status quo, to at least bring some regulation in, the paramount consideration being what is in the best interests of a child, to eliminate some of those problems?

Ms WALKER: Yes, I would definitely be agreeable with that. I think there was a question that asked me about legal identity and I elaborate my thoughts on that question, so I can go on with that now or wait until we get to it.

CHAIR: It would be fine to pick that up now.

The Hon. JOHN AJAKA: Yes, we would appreciate that.

Ms WALKER: I think the question was about the legal recognition of parents and I think there was some suggestion that one of the problems with gestational surrogacy is the genetic parents having to adopt their own child. Am I correct?

The Hon. AMANDA FAZIO: Yes.

Ms WALKER: I think one of the main problems that we have is the system of presumption of legal parenting as to the status of the child. I have thought about this particular issue quite a lot and I am making it a focus of my legal studies actually. I think the presumption as to the legal status of children relating to ART procedures is one of the main causes of a lot of the problems that end up being brought to committees like this for consideration. I think that originally the Parliament made a mistake when they decided to treat children conceived by donor sperm no differently from children conceived naturally by presuming that the man married to the mother is the father. I think this is why we have ended up with the tangled issues that we have.

I think something similar to the adoption system is much more appropriate where the genetic parents are the legal parents of the child and then legal parenting is transferred to the intended parents when the child is born, and there are many advantages in doing this. The first, which is particularly relevant to gestational surrogacy, is that they do not need to worry about genetic parents having to adopt their own child. I still think there needs to be some provision for and recognition of the surrogate mother's involvement. I think a cooling-off period, for example, is necessary. With this type of system the surrogate mother and her partner would no longer be presumed to be the legal parents.

I do not think it makes sense for the surrogate and her partner to be presumed to be the parents when they are not actually related to the child. Secondly, I think such a system is vitally important in going some way to protecting the best interests of the child. If legal parentage is transferred from genetic parents to intended parents by a formal process the transfer is recorded and the birth certification can reflect the truth of what took place and that child's parentage is reflected in a sense that it had genetic parents and the surrogate parents are legal parents. I think this is much better than the current system of presumption, which is no longer able to cope with the increasing complexity of family types that the law has to grapple with. Does that make sense?

The Hon. GREG DONNELLY: Do you have a copy of the submission you provided to the Committee in front of you or near you?

Ms WALKER: Yes.

The Hon. GREG DONNELLY: You made a couple of points that I would like you to elaborate on because I found them interesting. In the fourth paragraph you say that, "A child's best interests are served when it is conceived and gestated by, born to and nurtured by one mother. To fragment maternal roles through ova donation/gestational surrogacy (or straight commercial or altruistic surrogacy) and relinquish the birth is to deny a child its entitlement to a whole mother." That is a pretty profound statement if you think about it for a moment. Can you explain to us how you have come to that view?

Ms WALKER: Yes, I can. Our view, and it is my personal experience and view as well because this has happened to me, is that when you have ART procedures not involving donor gametes, or surrogacy, you end up with the parental relationship to the child being fractured. In surrogacy this can occur in a number of ways. There can be a genetic mother, a gestational mother, a legal mother, a genetic father and a legal father. In my personal experience I have a genetic father and a legal father, so my paternity is split in two. The problem with this from the child's perspective lies in how within the ART community you view each of those people. I think

gestational surrogacy is a really good example. If, for example, the child is not going to be raised by the genetic parents, the attitude is invariably that the genetic parents do not matter and it is more important that the child receives love and a stable family environment, which is fair enough.

With gestational surrogacy the attitude is reversed and it is the genetic parents who are considered to be the most important to the child and the legal parents, the surrogate and her partner, are seen as a legal impediment to that child belonging to its natural family. I think it is kind of crazy that we decide before this child is even conceived who its parents are going to be on the basis of who wants to be the parent, not who is actually the parent. We give little regard to the fact that when this child it matures may have a very different view of who it considers the parents to be, and that was certainly the case for me. That ties into what I said about legal parentage before and needing a formal process for transferring parentage from genetic parents to legal parents, and making it very clear that that is what has occurred. I think it makes things clearer for the child and also legally.

The Hon. GREG DONNELLY: Can I make the link to a point you made earlier? With respect to adoption legislation in New South Wales—I cannot speak for Victoria where you reside—the paramountcy principle applies. That is, the best interest of the child is required to be exercised when looking at the adoption arrangements being considered for the child. That has paramountcy over any interests that adults or potential parents might have. It is very much a child-centred piece of legislation. In the context of surrogacy and ART it is not clear, certainly in New South Wales because we do not in effect have legislation that deals with this, that this paramountcy is enunciated by the law. I think it flows from that that if you do not have a law that enunciates that principle you potentially end up with a situation like we have now where it appears—I think this is the point you made—that adults are asserting their rights to have a child and once the child is born and grows up and matures it then starts to face issues that you in TangledWebs Inc. are trying to advocate about.

Ms WALKER: I think it is absolutely vital that legislation contains wording about acting in the best interests of the child. I do not necessarily think that in practice it is possible to discharge that burden of responsibility. For example, in Victoria the adoption legislation also talks about the paramountcy of the child but a court has to be satisfied it is in the best interests of the child for it to be adopted. The court has to be satisfied that it is in the child's best interests for its parentage to be transferred from its biological parents to its legal parents. We do not have that or anything like that in our ART legislation. I would like to see those things implemented in legislation. Does that answer your question?

The Hon. GREG DONNELLY: Yes, I think it does. Victoria passed surrogacy legislation last year, did it not?

Ms WALKER: Yes it did.

The Hon. GREG DONNELLY: Can I take you back to your submission two paragraphs down where you say, "The lifelong consequences of surrogacy in the life of the child may not be immediately recognised. Identity confusion, genealogical dislocation and complex family relationships characterise adoption and, we believe, surrogacy outcomes." That is a pretty strong statement. On what basis are you making that?

Ms WALKER: That statement is a group statement so it comes from the experience of different members of being adopted and also being donor conceived, and our views as a result of that experience. I can say from my personal experience that being donor conceived has created a lot of issues, not just for me but also for my wider family. Given that with surrogacy you are also using donor gametes a lot of the issues are going to be the same. That is where that statement comes from.

The Hon. GREG DONNELLY: I have in front of me an article that you wrote for a magazine called *Australian Rationalist* a year or two ago in which you argue the case that is pretty much the focus of this inquiry about surrogacy and rights. In the first column—this is a conceptual discussion, so bear with me—you articulate that your views are not based on religious ideals or views; it is something other than that. Can you elaborate on what you are getting at there because I am not perfectly clear about the point you are trying to make? You talk about a secular culture.

Ms WALKER: I would say that my views come more from a human rights basis but also clearly from my personal experience and how I feel about being donor conceived. If we look at how we generally deal with this sort of issue quite apart from assisted reproductive technology—how we deal with children and parentage within foster care, for example, within the Family Court system—and how we almost invariably put the interests

of the child first, and then look at ART practices, it is my view that it almost operates in the reverse. With adoption the child is conceived and then provisions need to be made for the care of the child and the focus is always on the best interests and wellbeing of the child in relation to who is going to be the parent. With ART there are parents who want to be parents and the child is conceived because those people want to be parents. It is kind of a reverse ethic in that sense. That is the way I see it.

The Hon. GREG DONNELLY: My final question is related to that. I am sure you do not have your article in front of you but on the last page you say towards the end, "My argument is against the practice itself." That is the position you are asserting: you have difficulty with the practice itself.

Ms WALKER: Yes, not the people seeking to use it.

The Hon. GREG DONNELLY: No. If I go back to the earlier line of questioning by the Hon. John Ajaka where he explained that the Committee is looking at the reality of what exists—the reality of surrogacy being commissioned in New South Wales and what should be the legislative framework around it—do you venture forward to try to break from your principal opposition and say that if it does go on, notwithstanding the fact that TangledWebs and I, Myfanwy Walker, do not accept the practice, certain conditions should apply? Do you take that step and compromise your position by saying these are the conditions that should apply if it does go on?

Ms WALKER: Yes. I am not an idiot and I recognise that these practices are going to occur regardless of what I think. My position is that if practices like surrogacy are going to happen we should be very careful about how we legislate for them and regulate them. The focus should always be on the best interests of the child. That has always been my position. My position first and foremost is that I do not necessarily believe that these practices can be carried out in the best interests of the child. My position after that is that if we are going to do this we need to try, as far as possible, to focus on serving the best interests of the child.

The Hon. GREG DONNELLY: Forgive me for pressing you, but that is a bit like a get out of jail pass, is it not, because we all agree that the best interests of the child should be served. I do not think anyone around this table would disagree with that. What is exercising our minds is how we settle on the conditions or the parameters around which the best interests of a child are protected in the context of surrogacy.

Ms WALKER: Okay, I see what you are saying.

The Hon. GREG DONNELLY: I am not trying to trip you up; I am pressing you about what it means to go from the general statement to the specifics.

Ms WALKER: I would say that I am least opposed to limiting surrogacy to gestational surrogacy where the parents who will be raising the child are the genetic parents. In saying that though I think there are significant and complex issues for the surrogate mother. It is really hard for me to say—I do not think this is as black and white as being able to say that I do not think this should happen and then to say I compromise my position by saying that we should be regulating it.

The Hon. GREG DONNELLY: I think you have given me some insight into your position. Thank you.

The Hon. AMANDA FAZIO: Can you hear me all right, Ms Walker?

Ms WALKER: No, we have the same problem. You are very distant.

The Hon. AMANDA FAZIO: I am just swapping microphones.

Ms SYLVIA HALE: In the article in the *Australian Rationalist* at the beginning it suggests that your biological father, Michael Linden, had also written on this topic. Did he share your views?

Ms WALKER: Not to begin with, no, but I did not share my views with him when we first met. I cannot speak for him, but his views have developed over time.

Ms SYLVIA HALE: Perhaps in the article that he wrote, which I assume you have read—

Ms WALKER: Yes.

Ms SYLVIA HALE: You do not have a copy of it. Are they similar to your views there—

Ms WALKER: Yes.

Ms SYLVIA HALE: —or different?

Ms WALKER: Yes.

Ms SYLVIA HALE: Yours is an organisation comprised of people who exist as a result of donor conceptions.

Ms WALKER: That is right.

Ms SYLVIA HALE: Do you know of organisations for similar people who are the result of donor conception but who support the practice?

Ms WALKER: Not in terms of an organisation that is—are you asking about an organisation as such that—

Ms SYLVIA HALE: They would advocate it. They would say, "Look, we are here because of these practices and we think they are a good thing."

Ms WALKER: No. I mean, there are groups that consist of parents who conceived their children by donor conception, but I would not say there is an organisation that consists solely of donor-conceived adults that exists for that purpose.

Ms SYLVIA HALE: As I understand it from a very brief scan of your article, one of the things that concerns you is the feeling that you do not belong to any particular family, that you have connections with one grouping and yet another. Would you not agree, particularly in today's culture, that this a very common experience for children as families—the original family divide, divorce, separate and the parents remarry and the children then obviously enter into blended families and have fairly complex relationships with other people? Would you say that this is an aspect of contemporary life and it is not just a problem for donor-conceived children?

Ms WALKER: I know what you are saying. I get asked that question quite a lot. I am also a member of a step-family. I have to say that it is very, very different. The dynamics are very, very different.

Ms SYLVIA HALE: What makes them different?

Ms WALKER: I think mainly because of infertility. You are dealing with a lot of sensitivity and subjects that are quite often taboo, not often talked about. I do not, for example, know, or I did not know too many other people who had been conceived like I was, so it was an isolating experience to be donor conceived. For a person conceived by surrogacy, that is going to occur much less frequently. It is very difficult to articulate and I do not know if I can do it justice over the phone. I can certainly take it on notice and attempt to outline it a little more clearly for you.

Ms SYLVIA HALE: What I am interested in is in what way do you think the problems confronting children, say, of blended families or separated families are inherently different to the problems that face children who have been conceived as a result of a donor.

Ms WALKER: To give a practical example, if you are in a step-family you are not legally denied the opportunity to know who your half-siblings are. I know that I have a number of half-siblings out there somewhere but I am legally not allowed to know anything about them and they are not legally allowed to know anything about me.

Ms SYLVIA HALE: I do not wish to interrupt but can I say if those obstacles were removed, because that seems to me that it is a deficiency perhaps in the law rather than a fundamental difference between the experiences of the two types of children.

Ms WALKER: I am sorry, I do not mean to interrupt you but the fundamental difference is that the Government regulates and clinics provide this as a service. It is not something that is just occurring in the community like step-families without any involvement by third-party agencies. Does that sort of—

Ms SYLVIA HALE: No, but presumably if the process were regulated by the law so that the child was entitled to receive access to that information, would that overcome your reservations about the process?

Ms WALKER: I do not think so. I can use an example of a family that I know; I do not wish to name them because I am talking about them. They have a donor-conceived son and their arrangement is that the donor is very involved in that family. It is almost like a co-parenting arrangement. They still experience difficulties where their son just goes, "I just want to be a normal kid." We can try to do the best we can with legislation and try to make it the best situation that we possibly can, but there is something inherently and fundamentally problematic with the way that we try to grapple with these types of practices and I just do not know that we can sufficiently achieve what we would all like to be the ideal. I just do not know that it is possible.

Ms SYLVIA HALE: Certainly in the case of children who are adopted and possibly more so in the past than at the moment, those adopted children have often been made fun of by other children—"Ya, ya, you're adopted", sort of thing—yet we do not argue that that is a reason to prevent adoption because we say that that is a practice that could possibly be of benefit to the child. Can I suggest to you that there would certainly be a number of children who would argue, "I wish I'd never been born. I wish I'd never been conceived"? It might possibly be possible in those circumstances to say that indeed if one were acting in the best interests of that child, that child should never have been conceived.

So that puts you back in the position where you are, and if you are arguing from the best interests of the child, then the only way you could prevent the conception of that child is by the institution of a particularly rigorous system of eugenics where you said only children who meet certain requirements will ever be born or will ever go through from conception to pregnancy. You do not think the human condition is such that it is almost impossible for a child to be born into such perfect circumstances that it can always be argued it was in the best interests of that child to be born.

Ms WALKER: I get that statement quite a lot. I do not know. I certainly am not of the view—I mean, I am quite grateful for my life. I am not of the view that I should never have been born. I do not know any donor-conceived person who would express that view. I think that it is quite possible—and it is certainly my personal experience—that you can be very happy, lead a very well balanced life and still have concerns about the way in which you were conceived and concern about the practice that created you and be able to speak out and try to inform others about the concerns that you have about the practice. I do not know if I am doing a particularly good job today, but I do not think the ends justify the means, which is what I think the bottom line of that statement that if we do not have these practices then these people would never have been born. I think we need to be more open-minded than that and actually look at what people are saying and being more considerate of how they feel about the way they were created.

We do not have enough evidence to say whether or not something is or is not in the best interests of the child. My primary position is that you need to be able to say that if you are going to deliberately take this child and transfer the parentage from the genetic parents to the legal parents, then you need to be able to say that that is in the best interests of the child, and the onus is on you as a government to be able to prove that if you are regulating it and sanctioning this practice. Obviously that is what you are doing by having this inquiry, trying to ascertain that, but that is my position.

CHAIR: Thank you for participating today. You suggested that you might be able to enlighten us a bit further on some questions at a later time.

Ms WALKER: Yes.

CHAIR: And also some of the questions you were sent that we were obviously interested in, we have not got to because we have changed our tack a bit. We would be grateful if they could come back by 4 April. The secretariat will be in contact with you on those specific questions.

Ms WALKER: No problem.

(The witness withdrew)

(Luncheon adjournment)

MIRANDA ELEANOR EVANS MONTRONE, Psychologist and Family Therapist and Infertility Counsellor, sworn and examined:

CHAIR: Welcome to the third public hearing of the Standing Committee on Law and Justice inquiry into legislation on altruistic surrogacy in New South Wales. Several people have appeared today, some by teleconference. The media understand the broadcasting guidelines, which are available. Any messages or documents to be provided to Committee members are to be delivered through the secretariat. Committee hearings are not intended to provide a forum for people to make adverse reflections about others. The protection afforded to Committee witnesses under parliamentary privilege should not be abused during this hearing. Therefore, I request that witnesses avoid the mention of other individuals unless it is essential to address the terms of reference. Mobile phones are to be turned off, as they interfere with the audio equipment.

Ms Montrone, in what capacity are you appearing before the Committee? Are you appearing as an individual or a representative of an organisation?

Ms MONTRONE: As an individual.

CHAIR: Are you conversant with the terms of reference of the inquiry?

Ms MONTRONE: I am.

CHAIR: If you should consider at any stage that certain evidence you wish to give or documents you wish to tender should be heard or seen only by the Committee, please indicate that fact and the Committee will consider your request. If you take any questions on notice, which this Committee is famous for asking, we request that you provide answers by Friday 3 April 2009. The secretariat will contact you about the questions and the date for responses. Would you like to start by making a statement?

Ms MONTRONE: Yes. My name is Miranda Montrone. I am a psychologist with 30 years' experience in many areas, including community worker and individual, couple and family therapy, and 25 years' experience in infertility and assisted reproduction. For nine of those years I was the clinic infertility counsellor at an assisted reproductive technology [ART] clinic in western Sydney. During that period I also established a counselling service based at Relationships Australia, which was set up to serve the needs of those people who were medically treated up to the late 1980s with human pituitary hormone and with increased risk of iatrogenic CJD. Since 2002 I worked exclusively in a private psychological practice, with about 40 per cent of my work being infertility related, including providing independent psychological assessments for patients planning to undergo surrogacy treatment at clinics.

The first surrogacy with which I was involved was in 1996 when I was a clinic counsellor and I have since been involved in 65 cases, most of which were gestational surrogacy arrangements. From my experience most surrogacy cases involve people of Anglo-Celtic background, but have also included, with me, Indian, eastern European, Chinese, Vietnamese, Filipino, Slovenian, Maltese, Lebanese, Italian and Portuguese. Mostly they have had Christian religion, including Anglican and Uniting, as well as a number of Catholics. There were also people of Jewish, Buddhist, Hindu and Muslim faiths. Mostly, people have been from New South Wales, metropolitan and country, but also other States and New Zealand and a few from other countries. Psychological assessment is always done in the context of relationships, background, culture and religion, and these issues are discussed as they relate to the surrogacy proposal.

Sometimes those outside assisted reproduction can assume that ethical and moral aspects are not given consideration. These are issues that I have discussed many, many times in many different ways with many different people, including colleagues and patients. In the context of this inquiry I can assure you that the 250 people presenting for surrogacy proposals over that period of time with whom I have had contact have given serious thought to the implications of their actions in the context of their relationships—couple, family and, most importantly, any children of the surrogate and any hoped-for children of the surrogacy proposal—and in the context of their community and their own religious, moral and ethical beliefs. I believe that an independent psychological assessment is an essential part of the informed consent process in altruistic surrogacy. It is important to make a distinction between the different types of counselling in infertility, which can often get blurred. There is information and support, implications for treatment, counselling for decision-making, and therapeutic, and their assessment, which is separate again.

Some of the former ones are done routinely by people in assisted reproductive clinics. But when I do the independent assessment it is very clear to everyone involved that it is a formal assessment and whilst I am not unsupportive, and I am really very happy when people ask questions and I am happy to inform, anything they say is part of the assessment and anything I see is part of the assessment and open for discussion. Surrogacy is a big thing. It is not just another small step in treatment. Preliminary processes in surrogacy are essential, I believe, for thorough consideration by all involved. I believe that the comprehensive pre-treatment assessment processes, which have also, in the past, included legal, psychiatric and independent gynaecological consultations, have been instrumental in surrogacy being well managed so far. I would recommend that these processes be continued if legislation is to be introduced.

CHAIR: That is very interesting, thank you. You have given an overview of the independent psychological assessments that are involved in your work. Can you describe the psychological assessment that is required? You have given an outline of four different requirements. I am interested in the pre-treatment assessment.

Ms MONTRONE: I see people before they are approved for treatment by the clinic, amongst others. We write reports for the clinic and they then make a decision about whether or not they will proceed with treatment. In my submission in part of the answer to (b), there are 17 criteria that I am required to consider to write my report, ranging from things like the relationship between the people involved. Are they longstanding? Is there any imbalance of power? Do the needs of one group, particularly, for example, the commissioning couple or intended parents—it can be very difficult; they have been through a lot and are dealing with a lot of issues. The emotional pain can sometimes be very strong. Does that implicitly dominate anyone else's normal human needs? I also have to look at things like prenatal testing, implications of treatment, risks to health, including the surrogate, particularly in that she is going to go through treatment that she would not otherwise and she is going to go through a pregnancy and there are risks in that. What if someone changes their mind? Is there informed consent? The implications for all involved, all of those issues.

CHAIR: Do you do your assessments on the commissioning couple and the surrogates?

Ms MONTRONE: Separately?

CHAIR: Yes.

Ms MONTRONE: No, I think it is necessary to see them together. If you are talking about creating a human life that has had connections and could continue to have connections, and I would recommend some connection so they do not have to be intense necessarily in the future, I think it is important that the relationship between the people are considered. I am always conscious of relationships and issues, and warrant further exploration. So I see people as part of my assessment as couples, as individuals and as a group and they also do an objective measure of psychopathology. So it takes quite some time. The total time I would see all four of them would be up to eight hours, and then I write a comprehensive report that I check them. I check the essence of it, not the final report, but I discuss any recommendations that I have.

CHAIR: Does your work inform the role of the ethics committees?

Ms MONTRONE: Yes, it does. The report goes to the clinic and the clinic ethics committee uses that information to make its decision. I believe that the process is very effective. Sometimes I say to them, "This is a matter of concern". They will not get the report and be surprised about what is there because they will know that I have a concern and they will have a chance to discuss it. On the few occasions that I am concerned I will say, "This is really concerning me." During the assessment there have been times that people have withdrawn from continuing the process themselves. I consider that to be a good outcome, as it does not rupture any relationships. People can offer things from the goodness of their hearts without deeply considering the implications of their actions. I think the pre-assessment process leaves room for people to change their minds without the dreadful rupturing of relationships.

The Hon. GREG DONNELLY: I found your submission to be thorough and detailed. It is interesting to have evidence from a practitioner who has been dealing in the field. Referring to the counselling that you provide you would be aware that the current surrogacy framework in New South Wales is very bare-boned, which is why we are having this inquiry. To the extent that counselling is occurring, is it happening because the key providers of ART mandate that counselling is a prerequisite before applicants are considered for surrogacy?

Ms MONTRONE: So far as I know, one large clinic in New South Wales has done surrogacy and I assess those people who come from New South Wales. If people live in other States the clinic gets someone else to assess them. I also do assessments for another smaller clinic. So far as I know, at the moment those are the only two clinics doing surrogacy. There may be other people and other clinics, but I am not aware of them. I also do Australian Capital Territory assessments when they are New South Wales based.

The Hon. GREG DONNELLY: I again refer to the issue of counselling. From what you have said, in your view it is important in that it enables a whole plethora of issues to be discussed and considered. That is not mandated under the law in New South Wales, so it is occurring. Is it occurring because the clinics require it?

Ms MONTRONE: Absolutely.

The Hon. GREG DONNELLY: Essentially, it is an ethical guideline under which the clinics are operating.

Ms MONTRONE: Yes. I remember when surrogacy first started. At first it was not done and then there was talk that it could be done. Canberra then started and not long before that there was the Baby M case in the United States of America involving a commercial surrogate. However, commercial surrogacy is different and the laws in the United States are different from those in Australia. Then there was the Baby Evelyn case in Australia and that went to the High Court. Again, that was a very different case. From my understanding it was a home insemination surrogacy, which is very different.

When the clinics started they wanted to be very careful, as there were no guidelines. They developed cautious and considerate guidelines and they were very careful. In the beginning I was concerned about how to do it and which way to proceed. I was very careful. I think that care has resulted in a good outcome. So far as I know, there are no comprehensive guidelines such as this in the National Health and Medical Research Council [NHMRC] guidelines. Clinics have set a best practice standard. I think it works in that context because there was nothing within which to operate.

The Hon. GREG DONNELLY: From the evidence of previous witnesses we have gathered that, to the extent to which the State and Territory legislative framework exists, we have the NHMRC guidelines and we have the industry guidelines. I am referring to that broadly as I am not sure what the industry guidelines are called. We then have individual service provider guidelines, under which company X operates, as corporate guidelines for this ART service. We have a conglomeration of those three layers of guidelines and we then have the legislative framework, to the extent that it exists.

One thing has been exercising my mind: How far should this Committee go in saying that some of these guidelines, a portion of these guidelines, or all of these guidelines should become incorporated into legislation? When should a decision be made to go down a legislative framework path? I think you said that clinics operate under these guidelines. I have seen the NHMRC guidelines, but I have not seen the industry or individual corporate guidelines. This presents the Committee with a dilemma. There is a light touch approach in relation to the possibility of a legislative framework, and there is a prescriptive approach. At one end we have complete opposition to outlawing it and at the other end we have complex guidelines. We are on the spectrum.

Ms MONTRONE: The industry one is known as the Reproductive Technology Accreditation Committee, or RTAC, which involves self-regulation. There has been a lot of self-regulation in assisted reproductive technology.

CHAIR: Does the accreditation group work across all the organisations that practice ART?

Ms MONTRONE: To my understanding, yes. If you want RTAC accreditation you have to follow its self-regulation guidelines. Traditionally, the cases that have been presenting for surrogacy have been extremely good proposals. Mostly, they are gestational surrogacy, or the egg and the sperm of the couple. Usually it involves a relation—a sister, a sister-in-law, or a longstanding friend. There are significant and serious health concerns about genital problems or cancer if a woman does not have a uterus. In that sense it has involved conservative treatment. I imagine that if there were a more open situation, pressure could be placed on clinics to consider it. Let us say, for example, that a couple that does not have a uterus problem has a couple of goes at IVF. Some people have said to me, "I have a friend who will be a surrogate." I do not think that is an option.

We are moving further and further from the guidelines and people are starting to do things on their own. If a relationship is tenuous it introduces another level of concern. I think the answer is that the legislation must be enacted. We require a review by an external patient review tribunal. I know that some of the clinics will be unhappy about that. Surrogacy has become more commonplace. Last year I saw 12 cases but all up I have seen 65. I saw a lot of cases last year, but this year I have seen two cases. There is an increased awareness of surrogacy. In some instances it can become a case of someone saying, "I will do that." Cases such as that put a lot of pressure on the clinics and they can experience difficulty in holding off. Patients who are hurting tend to push the clinics.

We need legislation that covers situations in between. We need to set up a framework rather than have just one layer. Each case is reviewed and considered externally by the State. Surrogacy is a big issue. It is not just a question of taking one more step; it is a big thing to ask a woman to carry a baby and then to relinquish that baby. Most of my work has involved gestational surrogacy, which does not involve the egg of the surrogate. Essentially, the surrogates have said that they have had no problems relinquishing the children and they have relationships with the intending parents so they will see those children. However, I am aware of some situations in which people are making arrangements via the Internet and money is involved. That was a long-winded answer.

The Hon. GREG DONNELLY: It is leading into an area in which I am particularly interested. Some witnesses asserted that we need a legislative framework essentially because there is nothing other than bare bones at the moment. At the moment commercial surrogacy is outlawed and it is void, or voidable.

Ms MONTRONE: It is not enforceable.

The Hon. GREG DONNELLY: Those are the two conditions. Other than that the legislation is pretty broad. It has been argued that we should try to come up with a framework for this piece of legislation. If you look at the industry itself—and I do not use that phrase in a pejorative way—you find that surrogacy is done in a way that involves people such as you and mainstream providers. Obviously that accounts for the guidelines that have been developed and that have evolved over time, and children are being born as a result. Again, I do not use this phrase in a pejorative way, but there are also non-traditional or informal arrangements. For example, a couple might decide that they know someone who is prepared to be a surrogate and a child is born. The reality is that a child is born.

The question I am wrestling with is whether one can reasonably create a piece of legislation that deals with both those scenarios, if they can be described in that way. One is done in the context of a regulated industry. At the end of the day a guideline can be changed. It could be argued that a guideline was deficient, to the extent that it could be unilaterally changed, compared to a law or regulation that has to go through Parliament. We have to account for the more informal and non-traditional scenarios, for example, a single woman or a single man saying, "I would like a child and I have found a person who will act as a surrogate for my child" A homosexual couple might say, "We desperately want a child." Two gay men might say, "We have a woman who is prepared to carry and provide a child for us." However, that does not fit and operate within the framework. Would you like to comment on that?

Ms MONTRONE: As I said in my submission, there are other sorts of treatments. Paragraph (d) of my submission refers to genetic relationships. Currently, clinics do not perform traditional insemination surrogacy, which sometimes is called partial surrogacy. The use of the word "partial" concerns me because it implies less when, in fact, it is more from a psychological perspective because it is the surrogate's egg. I would like that to be done through clinics. I believe that the pre-assessment process is effective in slowing it down, intensifying the discussion, and people have time to change their minds. People say that they have considered it, and they have, but I am good at intensifying debate, increasing the heat, and picking up issues that need further consideration. That is when things are picked up.

If they do this themselves it is inherently risky and it introduces all sorts of other problems. If it is done through a clinic you separate the sexual connotations, you have universal health precautions, and you freeze the sperm so that it minimises the risk of transmitting infectious diseases. People will not say, "I really should not do this because I am not quite sure what my husband or my partner is doing sexually." In those circumstances people do not say anything, so it leaves it very open. If this is done through the clinics and a review panel approves the whole assessment process, when a child is born he or she becomes the child of the intending parents relatively smoothly. The parents can have the child immunised with no trouble and their names can be put on the birth certificate. We need an option available so that people can do it properly through a clinic, for

want of a better term, rather than doing it outside these clinics. We cannot compel people to do things. But I think you give them an option that is a good option so they can.

The Hon. GREG DONNELLY: I do not know the guidelines of Sydney IVF—we will hear from them this afternoon so I guess we will have the chance to ask them—but let us assume that the guideline under which they operate is that the child must have a mother and father as opposed to any other arrangement, that is, single or homosexual. With respect to that condition that is a guideline, ultimately a same-sex couple that wants a child will, presumably if they are determined enough, seek ways and means outside the framework to do that. So that is a reality.

Ms MONTRONE: Same-sex couples are currently being treated, but it is not surrogacy because one of the women would carry the child; they use anonymous or known donor sperm. Surrogacy is only if neither of them have a uterus or, as you said, gay male couples. My understanding is that in Victoria, because I saw a television program, which is the fount of all knowledge—

The Hon. GREG DONNELLY: Especially commercial television.

Ms MONTRONE: No, it was SBS. It was a documentary about a gay couple in Victoria who went to the United States and used a commercial surrogate. There is a website, Gay Dads I think, that has a link. I think legislation makes reasonable behaviour reasonable without telling the legislators how to do it. I think you make it possible for people to do the right thing and you do it as best you can. Then if things go wrong, like if things were to go wrong in any of the surrogate cases with which I have been involved, well, we would have talked about it beforehand, that is a potential, because we do an awful lot of what-if scenarios.

The Hon. GREG DONNELLY: No matter how hard we try to come up with a piece of legislation to provide for a framework for this to operate within the State of New South Wales, there will always be the likely possibility that if people could not fit within that framework, as you say, they will do it themselves in some other way. That is the reality, is it not?

Ms MONTRONE: That is.

The Hon. JOHN AJAKA: In your experience have there been situations where serious problems have occurred with, firstly, the surrogate?

Ms MONTRONE: Not relinquishing the child? I know that is a concern everyone has. I have not heard of anywhere the surrogate has not relinquished the child, and I think I would have because it would have become legally problematical, I would think. With the assessments I do not always find out what happens.

The Hon. JOHN AJAKA: At the end? You are at the pre-stage?

Ms MONTRONE: I am at the beginning. They see me, they go to the clinic and they always say they are going to contact me. I sometimes do.

The Hon. JOHN AJAKA: But realistically, if there had been quite a number of problems—

Ms MONTRONE: I would have known.

The Hon. JOHN AJAKA: —it would be very unusual for you not to know?

Ms MONTRONE: I would know. There have been some health problems.

The Hon. JOHN AJAKA: That was my next question. If we take one person at a time and again with the surrogate, have you had situations where the surrogate has had some serious health issue problems?

Ms MONTRONE: Normal having-a-baby problems, things like pre-eclampsia, having to have the baby early and there being a consequence of that, normal prenatal testing problems, picking up a potential problem in the baby, all of those sort of issues.

The Hon. JOHN AJAKA: Baby blues?

Ms MONTRONE: I have not heard significant problems but, again, it is a what-if scenario that I have talked about with people about after the delivery and managing of that.

The Hon. JOHN AJAKA: In most situations the surrogate has a relationship with the commissioning couple?

Ms MONTRONE: Exactly.

The Hon. JOHN AJAKA: So you have not had a situation where the surrogate is a complete stranger, if I can use that term?

Ms MONTRONE: Very casual connection in one or two cases, but very largely a close relationship. In one of those two cases that were a casual connection, I had concerns about the surrogacy. It was one of the very few that I was very uncomfortable with and said so in my report. Canberra fertility does it. In adding to that question, they have a requirement—again I do not think it is an enforceable one—they ask their patients when they get pregnant to have counselling during pregnancy and after the pregnancy.

The Hon. JOHN AJAKA: That was my next question. On the whole in New South Wales there does not appear to be as many requirements or obligations post-birth?

Ms MONTRONE: That is the only difference, as far as I know, between the major one, Sydney IVF, and Canberra. I do not know how you can enforce that, but I have seen a couple of scenarios where people have done that. I actually think it is very helpful because it is not potential situations; it is real situations. I have seen, for example, a couple of situations over the years where there were problems during the pregnancy found at, say, routine ultrasound and then discussed, "What are you going to do" and "How are you thinking through that?" Just to finish, Canberra requires it is with either the assessing person or the clinic counsellor. The clinic counsellors are very involved and very good, particularly Canberra. Sydney has excellent internal clinic counsellors who sort of coordinate it all and do a lot of work.

The Hon. JOHN AJAKA: If we can move now to the commissioning parents and basically the same questions. Are you aware of situations where problems have occurred with commissioning parents, one or two of them, not wanting the child or other complications?

Ms MONTRONE: I have not heard anything like that.

The Hon. JOHN AJAKA: Now as far as the child is concerned, if you can remind me, how far back are we going? How old would the oldest surrogate baby be?

Ms MONTRONE: The oldest I would know would be maybe early high school, and I have no contact. I have not had any contact with any.

The Hon. JOHN AJAKA: But again you have not heard through the industry, to use the Hon. Greg Donnelly's term?

Ms MONTRONE: I have not heard of major problems.

The Hon. JOHN AJAKA: You have not heard of any problems through the industry?

Ms MONTRONE: No. These are very transparent arrangements, particularly now. At the very beginning there was a concern that society would be frowning on it and people were more concerned, say, 15 years ago, but over the last year the relationships are very transparent; everybody knows. I just did one where the intending people are in Victoria, the surrogate and her husband are in Queensland and they are planning, because the law is not there in Victoria, to do it in New South Wales. The commissioning woman had to have an emergency hysterectomy while delivering a baby. It was on the front page of the local paper that they needed surrogacy. So, a lot of people know. I always ask, "Who knows" and "What do they say in your family?" Is there anyone uncomfortable with it religiously? So, that is more the situation whereas the people in their immediate environs know. I am sorry; I have lost the question.

The Hon. JOHN AJAKA: No, you have answered most of it.

Ms MONTRONE: Does that answer it?

The Hon. JOHN AJAKA: Yes. Following the line of questions from the Hon. Greg Donnelly, I put it in two simplistic forms. We seem to have a situation where we keep the status quo. I think realistically we are not going to take it back to where it was 20 years ago; surrogacy is occurring and it is going to occur. So, if we accept the fact that we now have the status quo, we have the choice of leaving it alone or of bringing in one piece of legislation, so to speak, that covers the area of surrogacy where we set down the criteria pre-, during and post, what is required, look at the best of the Australian Capital Territory example, look at the best of the private clinics examples and all of the work that has been done over the years and come up with a policy that we say should apply, and whether you then include no same-sex couples or you put in that gametes must be donated by one party or both parties, or whether you put in that there needs to be close relationship counselling et cetera. Is it my understanding that you would prefer the latter, leaving it at the status quo; that you would prefer to see a situation of regulations?

Ms MONTRONE: I think it would help. One of the things that really concerns a commissioning couple or intending people, and concerns the surrogate and her partner—I know Linda Wright, who is so good and spoke this morning—as far as I know, the partner of the surrogate's name has to go on the birth certificate. It would be really good if it was possible that they could put down what their intention was and that the parents of the child's name goes on the birth certificate.

The Hon. JOHN AJAKA: From day one?

Ms MONTRONE: And they can get immunisation. One couple I remember I did see them after and they were telling me it was their GP. They could not do immunisation because the surrogate was living a fair way away, still close, and so the GP just did the immunisation but did not do the billing until they got the parenting order.

The Hon. JOHN AJAKA: From your experience as a psychologist, we have heard different views that maybe the birth certificate should be left as is and by the time you finish the adoption you change the birth certificate. The other view is that all four parties should be put on the birth certificate. In reality one can counter the surrogacy in situation where our there could be almost six parties involved in one form or another and you suddenly put six names. Then we hear another view that says look, from a child's point of view, going to school the last thing a child wants to do is hand up a birth certificate saying I have three dads and three mums or two dads and two mums or whatever.

Ms MONTRONE: It is too complicated.

The Hon. JOHN AJAKA: From the birth certificate point of view what do you think is in the best interests of the child?

Ms MONTRONE: I actually just had to go to the Registry of Births Deaths and Marriages to get a birth certificate and a marriage certificate for something else. I was really impressed with their efficiency. When I got it I sat in the car and I thought, "Now what if you just went and got this information and like the ART Bill that has been coming in, I think there should be a tiny little section on the birth certificate. I think it should be the parents.

The Hon. JOHN AJAKA: The commissioning parents?

Ms MONTRONE: The commissioning parents. And if it is a donor gametes, donor sperm, it looks like everybody else's except there is a little bit somewhere that says "There is further information available about this birth under section XYZ of the Births Deaths and Marriages Act" not the ART Bill or surrogacy bill. So, that just sort of is just indicated that it is there.

The Hon. JOHN AJAKA: Do you restrict who has access to that, for example, the child?

Ms MONTRONE: Yes.

The Hon. JOHN AJAKA: Or the commissioning parents?

Ms MONTRONE: Yes, along the lines of the ART Bill and the surrogacy bill. You make a decision about who has access. It looks the same except for that tiny little bit.

The Hon. JOHN AJAKA: To the world and sundry, the football coach, the swimming carnival et cetera, we are handing them a standard birth certificate?

Ms MONTRONE: They are not going to look at it. The birth certificate has—

The Hon. DAVID CLARKE: Except to a discerning eye, they will pick up that little addition, will they not?

Ms MONTRONE: Yes, but—

The Hon. DAVID CLARKE: And that could be an embarrassment to the child in some circumstances, could it not, because there may be some people who will learn to know what that little difference represents? What do you say about that?

Ms MONTRONE: Taking my donor gametes hat on to counselling for implications using donor gametes or donor embryos, now everything is discussed with openness and transparency, which I have seen people do. If it is so terrible that it has to be a super secret, then they really should seriously think about whether they should do it or not.

The Hon. DAVID CLARKE: I am thinking about the child. This is the birth certificate of the child. They do not have a choice in the matter?

Ms MONTRONE: No, they do not.

The Hon. DAVID CLARKE: That is who I am talking about.

Ms MONTRONE: I do not foresee a problem because there are children in so many family situations nowadays and so many ways that they have been born. There are so few children, the percentage I do not know but it is a low percentage, with the same mum and dad who have never been married and never had children before and no other children. It is so unusual to have that. People have to explain.

The Hon. DAVID CLARKE: You may not foresee it but it is something that can happen. We have heard of situations where children are embarrassed. They might be subject to some comments and so forth, as do children who are adopted. So, while this information needs to be made available to surrogate children, how do you get around this so it is not showing on the birth certificate in a way that to some it could cause embarrassment?

Ms MONTRONE: I do not know how. Somebody was talking to me the other day about it and they say there is something available about two sorts of birth certificates, which I would think would get very confusing. I know the extract of births, for example, does not have it on it whereas the full birth certificate does. Now that would get around that. But the people I see it is not the surrogacy; it is not a secret; everybody knows. It is not like the whole world; it is private but not secret. So, their family knows, but then the question is do they have to tell the teachers when the child goes to school? Well, no because the child has lived with them for the whole of its 5½ years life. They do not have to tell the football coach. It is not relevant. So that is a valid point; and if it was possible to have the two sorts of birth certificates, great.

The Hon. DAVID CLARKE: You state in your submission:

> 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.

Then you go on to state something else, and then you state:

> Thus I do not believe it to be essential for there to be a genetic relationship to the commissioning parents.

Do I take it that you rely solely upon comparing it to adoption to come to that view—

Ms MONTRONE: No.

The Hon. DAVID CLARKE: —or are there other arguments that you have taken into account to come to the view that it is not essential to have a genetic relationship to the commissioning parents?

Ms MONTRONE: I am sorry; I did not make it clear. Also with adoption, there are a lot of interfamily adoptions where there is a genetic relationship. I think it comes from having worked in clinics and counselled people such as single women with donor sperm, which may be anonymous donor sperm, in which case the child does not have a genetic relationship. In clinics there are gay women and gay couples who are treated, and the child does not have a genetic relationship to both of those parents.

Donor embryos are used in some clinics. If you just keep going, I do not say that I recommend it, but I am saying that it is in that same continuum of treatment, as in a clinic that will treat all of those bits and it can be not the rearing parents of the child. In that case, not having had a uterus and being part of the rearing parents, it is just on the same sort of step in terms of information.

The Hon. JOHN AJAKA: I am sorry; I am confused. I am sorry, I realise that I left the room for a while. I do not quite understand the point you are making.

Ms MONTRONE: The question is: Should the issue on the issues paper, which was should at least one of the commissioning or intended parents have a genetic relationship with the child—

The Hon. JOHN AJAKA: That was the question.

Ms MONTRONE: And the answer is that traditionally—

The Hon. JOHN AJAKA: And your view is?

Ms MONTRONE: Oh golly.

The Hon. GREG DONNELLY: Can I just say that you gave a list on a continuum? The situation is that there is only such a continuum on the basis that, from a legal point of view in New South Wales, it is not regulated. In other words, if there were a law that said that surrogacy is to be made available only as a service commercially through service providers to heterosexual couples who are married or who are in a long-term de facto relationship, that is a very clear position.

Ms MONTRONE: Yes.

The Hon. GREG DONNELLY: That is not to say that these other arrangements would not be entered into de facto, outside the industry, but the line would be very clear, would it not?

Ms MONTRONE: It would be. I have seen a number of lesbian couples where they have male friends offering to donate. Again I think the pre-process works extremely well. But back to my saying about why I like there being something that is inclusive rather than exclusive. The sperm can be frozen for six months and minimise risks and everything. I would prefer inclusive rather than exclusive so that you make it that people do not have to be deceitful—not "deceitful"; that is the wrong word. They are included. Can I just answer that before I forget the question?

The Hon. JOHN AJAKA: Yes.

Ms MONTRONE: My opinion is that it is about relationships and it is about transparency. To me, that is the essence of what it is all about. It is not about the type of relationship.

The Hon. DAVID CLARKE: It is also about what is paramount, which is the interests of the child.

Ms MONTRONE: Exactly.

The Hon. DAVID CLARKE: That is what is paramount.

Ms MONTRONE: But, for example, there is no evidence as far as I know of any problems in relationships of children growing up with donor gamete parents. They are born of different gametes from their parents. For donor sperm, there have been a lot of studies, but the best and very thorough studies were done by Golombok and everybody in Europe with information from four different countries over a number of years. There is no indication in terms of the donor material.

My personal opinion is that it is about relationships. For example, if I saw significant problems in a married heterosexual couple, I would be talking to them about that. If I see a single woman who was presenting for treatment, I always ask about support networks. Who are you going to call in the middle of the night if your child has colic and you, like any normal parent, want to pick your child up and throw it to the other side of the room? Who are you going to phone—anyone? That is the sort of question I would ask of a single woman presenting for donor sperm. It is about relationships and care of the child.

The Hon. DAVID CLARKE: Let us take the issue of relationship a bit further. What is your view on surrogacy for same-sex commissioning couples when neither party in the relationship has any biological relationship to the child?

Ms MONTRONE: Surrogacy as in neither has a womb that they can use?

The Hon. DAVID CLARKE: That is right. There is no genetic connection—

Ms MONTRONE: No, I am sorry.

The Hon. DAVID CLARKE: —of either one of the commissioning couple to the child in a same-sex relationship.

Ms MONTRONE: But it would mean that neither of the surrogate people, the intending parents, had a womb, so they have to have surrogacy.

The Hon. DAVID CLARKE: Yes.

Ms MONTRONE: For me, no uterus is a reason for surrogacy. That is what traditionally the position has been.

The Hon. DAVID CLARKE: Take a same-sex male couple.

Ms MONTRONE: It is not currently done.

The Hon. DAVID CLARKE: It is done when the couple goes overseas.

Ms MONTRONE: I know.

The Hon. DAVID CLARKE: We are talking about what will take place in New South Wales. Do you have a view on that issue?

Ms MONTRONE: I have no experience of that issue, except to have had some therapeutic work with gay men and gay relationships—not a lot, but some—and except to have had contact with gay men who have been donating sperm, most often for lesbian friends.

The Hon. DAVID CLARKE: Take the issue to which I have referred, keep in mind that you have had no experience or that it is uncharted waters, as it were, and keep in mind that we have to keep paramount what is in the best interests of the child. Do you have a view as to whether any legislation should allow such a legalisation or a pushing forward of the boundaries?

Ms MONTRONE: I think it is a decision the community needs to make. I am not sure why they would not have any genetic connection. It has taken me a while to get to that part of the question. Presumably they both have sperm, or one of them has, at least.

The Hon. DAVID CLARKE: Yes.

Ms MONTRONE: If we take that in terms of relationships, there are heterosexual couples who rare children to whom they have no genetic connection when they use donated embryos.

The Hon. DAVID CLARKE: But the difference there is that there will be a mother and a father figure.

Ms MONTRONE: Absolutely.

The Hon. DAVID CLARKE: That is the difference.

Ms MONTRONE: There are two questions there, though.

The Hon. DAVID CLARKE: That is what I am putting to you.

Ms MONTRONE: I think that is something that the community decides. I do not think it is up to me. None of the gay men I have met would I automatically say would be terrible, terrible. Why would I say such a thing?

The Hon. DAVID CLARKE: But you could not recommend it on the record, based on your experience, could you?

Ms MONTRONE: I have not had any contact. There have been heterosexual couples. None of my 65 assessments have been gay women or gay men. They have been heterosexual couples. That is my experience.

The Hon. DAVID CLARKE: That is something that you could make a recommendation on?

Ms MONTRONE: I cannot make a recommendation.

The Hon. JOHN AJAKA: You mentioned earlier—

Ms MONTRONE: No, I cannot. It is not a non-recommendation either.

The Hon. DAVID CLARKE: I understand.

The Hon. JOHN AJAKA: Earlier you mentioned that you have counselled gay men who have been sperm donors. Have you come across difficulties for them? Has there been a situation where years have gone by and they have not been able to accept that they have been sperm donors or they have had conflicts about not rearing a child or having been part of the child's life, or anything of that nature? Have you experienced that opposite scenario? I am curious that you mentioned it.

Ms MONTRONE: I think one of the sadnesses for some of the gay men that I have met is that they are not going to be a dad like other people, and I have had donors who have liked the idea of helping to create a life. In terms of long-term problems or long-term battles with the lesbian women rearing a child, no. In terms of issues that are part of being human and understanding one's own frailties, yes, but normal issues.

Ms SYLVIA HALE: The report that you prepared, do you actually provide that to the couples?

Ms MONTRONE: I do.

Ms SYLVIA HALE: And they are able to comment on it before it goes to the ethics committee?

Ms MONTRONE: It is sort of a complicated process, but it sort of works. What I do is I see them at the first session or on the first occasion. I see them on two separate occasions. On the first occasion I see the couple first and I get them to do the personality assessment inventory. Before I see them the next time, I analyse the personality assessment inventory and, in the context of the couple interviews, I write the beginning essence of the report—the bulk of it.

On the second occasion I give them the individual feedback of their PAI, but I think that is private information. It is like taking a microscope and there may be information that comes up that they would prefer to keep private. I read what I have written after the first occasion. They do not give approval after that. If I have

something they do not agree with, we discuss it, but then they will know what I am writing. If I have problems they are concerned about, they will know that they are going to be in there. When I send out, as in the final report to the clinic in total—it is a bit complicated—each couple gets the joint information, but I take the PAI information out, put it in separate envelopes and send it to each person individually because I think that is private and it is their information.

The Hon. GREG DONNELLY: I am sorry to interrupt, but when you say "couple", what do you mean? You have used that expression a couple of times.

Ms MONTRONE: The commissioning couple.

The Hon. GREG DONNELLY: This is not the commissioning couple, but the other couple.

Ms MONTRONE: The surrogate and her partner, her husband.

The Hon. GREG DONNELLY: Yes, but there is nothing that mandates that in New South Wales so there has to be a partner.

Ms MONTRONE: No. Sometimes, on a few occasions, they have not had one, but they do not have to.

The Hon. GREG DONNELLY: That is what I thought.

CHAIR: But if they have one, they will come.

Ms MONTRONE: I said it because it is mostly that. They will come.

CHAIR: She is saying that if they have one, they will come to the counselling.

Ms MONTRONE: Yes, they come, and in fact I think they have an important role. I will just finish that thought.

The Hon. GREG DONNELLY: Yes.

Ms MONTRONE: Information comes up in the PAI. It does highlight, not psychopathology—although it is there for measuring that—but it highlights areas that could be of concern to the person. It is interesting that when I give them the feedback, I hear them go into the other room and say, "She said so-and-so", or, "She said I'm very bossy." I do that to keep them private, but they discuss. They get a copy, but it is in pieces.

Ms SYLVIA HALE: You said that after going through this psychological assessment process, people have withdrawn. Are there any common reasons for them to withdraw, or is each case very different from every other case? Is it down to parental styles, religious conviction, or attitude, or is it awareness of the potential legal ramifications?

Ms MONTRONE: Sometimes they do not actually want to discuss the things in depth. One came back via the intending father that he said that the surrogate had pulled out because I had asked the hard questions and it had made her stop, and think, and made her have concerns about something that was already there. They all knew about it, but it just got a bit hard. They were still friends afterwards, which I think is a good outcome. On occasions I have said that this to a surrogate, for example, on occasion—sometimes you can say, "Don't you think you have too much on your plate at the moment?" There are not many that I have said significantly against; very few and on very few occasions. Only on a couple of occasions have I said, "I really don't think it's a good idea."

Ms SYLVIA HALE: It has been posited that in fact the ideal family is a man, a woman and a child, but what I want to ask you about is apart from, say, two people of that gender—and that gender and maybe anywhere along a continuum—are families all of one mould, or are they so varied in terms of the way that men might respond and women might respond to situations that it is not really useful to talk about ideal stereotypes?

Ms MONTRONE: Yes, it is not. There are so many types of families. We have people from so many cultures and so many different families, I think that the essence is about—there are indications about what are good parenting styles. There is research on that, but that is not in the actual gender. It is the particular styles parenting.

Ms SYLVIA HALE: So it would not matter if you were male, female or transgender; it is the style you would adopt?

Ms MONTRONE: Yes. I cannot really deeply assess their parenting style because I do not see them. The only way you can really assess anyone's parenting style is to observe them parenting intensively, but in terms of people rearing children we have in our society children reared in an enormous number of diverse families. I do think that lack of conflict is very, very important; lack of aggression is very, very important. There are a lot of indicators of what type of behaviour, but in terms of individual people or individual cultures, no, there is no saying one is better than another.

The Hon. GREG DONNELLY: In terms of bringing into the world and raising a child through to adulthood—let's take the age of 18 years—your testimony is that there is nothing that a woman as the mother and a man as the father brings that is innately different in the raising of the child, that is, motherhood and fatherhood?

Ms MONTRONE: That is a nice, hard question.

The Hon. GREG DONNELLY: It is precisely the point that you just responded to by saying that you did not think there was much difference. The issue is relationships. In other words, it is not the structure but the form.

Ms MONTRONE: I think the evidence is that there is a range amongst women and amongst men, there is a range of everything, and the differences in between each are greater than the differences between. The differences between women and the differences between men are greater than the differences between men and women.

The Hon. GREG DONNELLY: Does that mean that on average a child in the ordinary situation is not going to get anything more out of a situation where there is a mother and a father?

Ms MONTRONE: I do not know. I am not an expert; I have not done lots of research in that area. I do know that the lack of conflict is very definitely important and I have seen heterosexual couples and counselled them on divorce and I have begged them, "Please don't use your children to fight each other", and they do it over and over again.

The Hon. DAVID CLARKE: Would you also include in that answer that you are not in a position to say whether or not there is an advantage or a disadvantage?

Ms MONTRONE: To?

The Hon. DAVID CLARKE: To a child being in a family situation where there is a mother and a father. You cannot say—

Ms MONTRONE: It is better or not?

The Hon. DAVID CLARKE: That is right.

Ms MONTRONE: None of my experience has indicated that.

The Hon. DAVID CLARKE: One way or the other?

Ms MONTRONE: No.

The Hon. DAVID CLARKE: So it is not something you can really comment on.

CHAIR: I do not think she said that.

The Hon. DAVID CLARKE: No, and I am not saying that she did, I am putting that as a proposition to get a response to it.

Ms MONTRONE: I have had quite a bit of experience with gay women who have raised children and I have seen them with their children later and I have seen no greater love in a heterosexual couple than I have seen amongst other gay couples I have seen. The difference in situations is greater than the difference with the genders. That is my opinion.

The Hon. DAVID CLARKE: But you are taking that on individual situations that you have seen; you are not taking it on the basis of any in-depth studies that have been taken over a wide range of situations?

Ms MONTRONE: No, I am a practitioner, not a researcher, although I am sure there is research. Golombok did find as part of her study that there was no difference with gay women in parenting children. She has done other studies with parenting by gay women and single women.

The Hon. DAVID CLARKE: But you would accept that there is a whole range of research that would give different views on that?

Ms MONTRONE: I am not an expert on the range of research in that area, although I do know that Golombok found no differences.

CHAIR: Some questions were sent to you and we would require answers back to us by 3 April, if possible.

The Hon. GREG DONNELLY: I think you have answered a number of them.

CHAIR: The secretariat will contact you about specific things that perhaps we should have covered, but we were so intrigued with your topic that we did not allow that to occur.

Ms MONTRONE: Just one thing, madam Chair. At the very beginning you asked my full name and I just answered the name I use, but my full name is Miranda Eleanor Evans Montrone.

CHAIR: Thank you very much for coming.

(The witness withdrew)

MARK CHRISTIAN BOWMAN, specialist medical practitioner, and

KYLIE ANN DE BOER, General Manager, affirmed and examined:

CHAIR: Thank you very much for coming today. A while ago the Committee worked through who we needed to hear from and certainly your organisation was fairly high up on our list, so thank you for making the time today. This is the third public hearing of the Standing Committee on Law and Justice inquiry into legislation on altruistic surrogacy in New South Wales. We have some broadcasting guidelines, but the media understands those. If you have any messages or documents that you want the Committee to have, the secretariat will look after those for delivery to us. The hearing is not intended to provide a forum for people to make adverse reflections about others. The protection afforded to Committee witnesses under parliamentary privilege should not be abused during these hearings. I therefore request that witnesses avoid the mention of other individuals unless it is absolutely essential to address the terms of reference. If you have a mobile phone, it would be preferable if you turned it off because it interferes with the recording mechanisms.

Dr Bowman, in what capacity are you appearing before the Committee—that is, are you appearing as an individual or a representative of an organisation?

Dr BOWMAN: I would like to appear as a specialist gynaecologist and also I am appearing as Medical Director of Sydney IVF, that is, representing an organisation.

CHAIR: Are you conversant with the terms of reference of the inquiry?

Dr BOWMAN: Yes.

CHAIR: Dr de Boer, are you conversant with the terms of reference?

Dr DE BOER: I am.

CHAIR: If you should consider at any stage that certain evidence you wish to give or documents you may wish to tender should be heard or seen only by the Committee, please indicate that fact and the Committee will consider your request. If you take any questions on notice, could they be forwarded to the secretariat by Friday 3 April, but the secretariat would be in contact with you about specific issues. Do you wish to start by making a statement?

Dr BOWMAN: Perhaps I could make a brief statement. I am appearing today as a practitioner who has probably undertaken more cycles of genetic-based surrogacy involving IVF than any other practitioner in New South Wales over the last decade or so, and that has been with the assistance of Sydney IVF. That scenario has arisen because there are a very small number of couples who, without surrogacy, have no other way to have a baby that is truly genetically theirs, and that was the primary indication for us considering that, so we could use IVF technology to obtain eggs from a woman and sperm from her partner where, for example, that woman was unable to carry a pregnancy and, through transferring the embryo that resulted from those commissioned parents to a surrogate, with an appropriate completion of the surrogacy arrangement, those parents were then able to have a baby that was truly genetically theirs.

We recognised along the way, of course, that there was no legal pathway for the transfer of custody and we also recognised that there were a number of parties in that relationship—most importantly the future child whose needs need to be addressed and fulfilled. So to that end Sydney IVF, with the help of its clinicians, established what we believe was a fairly rigorous and appropriate sort of policy of review and work-up for each individual case so that we could ensure that this essentially clinically-driven process was completed appropriately from a social and legal perspective as best we could do under the circumstances, and it is with that hindsight that we have had that we have made an offer and request to give you further feedback about how well that process is run and how we have conducted that.

CHAIR: I understand you have a structured ethics committee. Can you talk about how you structured that, who you expect to be on it and how it works?

Dr DE BOER: We have an independent ethics committee. We have here to document the members of the ethics committee, what category they come under and their position in the community. We also have the members of the ethics committee who were involved in establishing our policy on surrogacy.

The Hon. JOHN AJAKA: Is it the same committee and committee members in relation to every case or do you have a panel of members that you choose for a particular committee for a particular case?

Dr BOWMAN: The committee is constructed under National Health and Medical Research Council [NHMRC] guidelines for ethics committees in terms of representation. The ethics committee has changed slightly in its composition over the years. The original policy was developed some years ago and part of that policy was to establish a secondary surrogacy review panel, which represents the ethics committee. So the ethics committee came up with a general framework and structure of how we undertake treatment and each individual case is reviewed by the surrogacy review panel representing the ethics committee.

Ms SYLVIA HALE: Could I ask what range of competencies are on the committee; would it be psychologists, lawyers—

Dr DE BOER: Yes, we have a chair, currently we have a layman and laywoman, two laymen, a doctor who is familiar with the field, a counsellor, a minister of religion and a lawyer.

The Hon. DAVID CLARKE: Who are the two laymen?

Ms SYLVIA HALE: How are the lay people selected?

Dr DE BOER: They are selected by the committee.

Ms SYLVIA HALE: But do you have to nominate or do you advertise and say, "We are looking for someone to serve on this committee"?

Dr BOWMAN: We do not advertise, but generally there has been interest generated from the community in what happens in assisted conception. Sometimes that representation has been through, for example, patient representation groups, and that has formed the representation of our ethics committee for some time.

Ms SYLVIA HALE: The Government's submission suggested that one of the aspects we needed to examine was the role of criminal checks, presumably on all parties involved but primarily on the commissioning couple. Do you undertake anything remotely resembling those checks?

Dr BOWMAN: No.

Ms SYLVIA HALE: Presumably the crimes or offences that might be of interest would involve things such as assault and abuse of children. Does your psychological profiling of the parties involved seek to identify those issues at all?

Dr BOWMAN: They certainly seek to identify appropriateness in its broadest sense. That involves not only a psychologist's review but also a psychiatric review, looking in particular at personality disorders. My personal view about this whole concept of who is fit to be a parent and who is fit to be participating in processes—those of us who have looked after infertile couples in all its respects for many years have difficulty dealing with why infertile couples should be selected for criminal checks while we do not take some sort of eugenic totalitarian approach to the whole of people trying to reproduce. I really have difficulty with that. Most of us as professionals were quite taken aback by the Victorian Government's recent proposals to conduct such criminal record checks. I appreciate that there are extra parties involved in the processes of surrogacy. All I can say is that we undertake as far as we can the most rigorous clinically based checks.

Ms SYLVIA HALE: There is not one person who comes before the Committee who does not maintain that the interests of the child should be paramount, but just what those interests are seems to be a moot point sometimes. Following on from what you have said about there being no criminal checks on the parents involved in more conventional pregnancies, would you say that the very fact that commissioning parents have to be subjected to the scrutiny of the ethics committees really goes a long way to ensuring the quality of parenting provided to the child, regardless of whether the family consists of a single person, a gay couple or the

conventional heterosexual arrangement? Does the process they have to go through in order to participate in some sort of surrogacy arrangement in effect have the potential to make them better parents than if it is just left to pot luck?

Dr BOWMAN: It is my understanding that our process is more determining about the strength of the relationships between the commissioning couple and the proposed surrogate because of the legal uncertainty and difficulty if that relationship were to break down. I do not know that we are assessing parents for their capacity to parent per se. It is simply saying that here is a unique scenario that has been proposed in a framework where if this relationship does not persevere or has not been thoroughly thought out, that has the potential to be harmful to all concerned. That is what our main focus is. That is my view of it as a clinician.

The Hon. JOHN AJAKA: I guess the reality is this: It is not a situation where someone walks into your rooms, hands over a Medicare card and you have only known them for five minutes and suddenly you are undertaking a surrogacy arrangement.

Dr BOWMAN: Absolutely not.

The Hon. JOHN AJAKA: The reality would be—please correct me if I am wrong—that in some cases it may have taken well over 12 months or longer for you to go through all the processes to get to a situation where a surrogate is pregnant and having the child. You as a doctor, and I suppose the people around you, would well and truly have got to know the patients, if I can use that term.

Dr BOWMAN: Definitely.

The Hon. JOHN AJAKA: So if a married couple walked in and the wife was three months pregnant and seeing you for the first time as a gynaecologist, as was the case for my wife and I when we had our first child, the gynaecologist is not going to know them as well as you would ultimately know your patients by the time you get to that final decision?

Dr BOWMAN: That is correct.

The Hon. JOHN AJAKA: You are probably one the leading doctors as far as numbers of surrogacies you have been involved in are concerned. Can you give us an indication—or take it on notice—of the percentage break-up where both commissioning parents had donated gametes, one commissioning parent only had donated a gamete, and where no gamete was donated by either commissioning parent?

Dr BOWMAN: I certainly have overall numbers here. In the seven years we have been undertaking gestational surrogacy we have had 69 applications, so we are not dealing with high numbers. There are only limited clinical indications that we will treat. Our two indications are where the commissioning mother does not have a uterus or the commissioning mother has a medical condition that precludes her from safely carrying pregnancy. Perhaps a third area is where a commissioning mother has a uterus that is incapable of carrying a pregnancy.

CHAIR: Excuse me for interrupting your train of thought. Do you perceive that this would be an important component of perhaps future legislation in relation to surrogacy?

Dr BOWMAN: That is my own view as a clinician. I personally have some concerns that people perceive surrogacy to be the answer for all manner of infertility problems, of which there is absolutely no evidence. We regularly have to go through those processes. The classic one is multiple failed cycles of IVF, which is almost invariably a problem of the hoped-to-be mother's eggs and almost never something to do with the woman's uterus. There is a perception, including within IVF but also in the community, that it must be the woman's body rejecting the embryos. There is absolutely no evidence for that except in very rare circumstances. We have sought from the start to very much limit the clinical indications of this to those areas I have mentioned.

Also we take a very firm stance that we do not undertake traditional surrogacy, in other words insemination of the surrogate such that the surrogate is then carrying a baby from her own egg. We do not undertake that. Therefore, all of these are cases of what you might call gestational surrogacy. Of those cases—I will have to take on notice the question about the exact numbers—the overall majority are where we are using the commissioning mother's eggs, the commissioning father's sperm and there is never a genetic relationship with the surrogate. A smaller number of cases are involved where the woman has lost both her ovaries and her

uterus, and a smaller number of cases involve third party out-of-sight donation, the commissioning father's sperm and surrogate but no genetic relationship to the embryo.

The Hon. JOHN AJAKA: My concern is this: We have a situation where we can retain the status quo or we can seriously look at recommending certain regulations where, for example, we end up with a surrogacy Act where all the checks and balances are put in, and the provisions of your guidelines and those in other States and the Australian Capital Territory, in what we hope would be a very workable framework. I want your opinion, given the experience of those you have dealt with, about what you believe they would prefer to see—the status quo or that stresses and balances are occurring as a result of some shortcomings in the current law?

Dr BOWMAN: My view, and I suggest it reflects the view of the people I have managed over the years, is that if there is a role for law it is in sorting out the legal aspects of custody of the child. Again as a clinician and having watched laws that seek to guide clinical practice in all sorts of areas over the years I think there is much less an argument for a role for law in clinical decision making. However, given there is legal ambiguity following the birth of the child that is where the processes, if there is a role for law, ought to be sorted. I am sure that would be the view of most if not all of the couples I have treated.

The Hon. JOHN AJAKA: In the 69 cases you have mentioned there have been no same-sex couples?

Dr BOWMAN: No.

The Hon. JOHN AJAKA: So we have a situation where there are 69 couples and there may be concerns or perceptions that whether or not the law is changed it may open the door to same-sex couples or to people who should not be granted surrogacy. I guess that again guidelines may assist in that respect.

Dr BOWMAN: I am just conscious that it is always very difficult to frame legislation that governs clinical practice because clinical practice changes. We already wonder if there are certain rare circumstances of immune rejection of embryos. It must be incredibly rare if it occurs but we do not yet have the technologies to declare those very well. We are just scratching the surface of that and legislation might emerge that makes future practice difficult. We have come to a very firm decision that we treat medical problems. For example, I have had one or two presentations of male same-sex relationships and I have told them that we do not treat that situation. I take a very personal decision about what you might call medical infertility and social childlessness. Those people then remove themselves internationally. I guess if there were legislation that governed some of those areas or sought to clarify them it might make life easier legally but I do not think it makes life easier medically.

CHAIR: But if there are clinical indicators in a same-sex couple would that fit your criteria—if neither of the women was able to have children?

Dr BOWMAN: I have not had that presentation but I guess, yes, if there were a lesbian couple where both have had a hysterectomy we would view that under medical indications.

Ms SYLVIA HALE: Does that not automatically exclude or discriminate against men who for medical or physiological reasons—

Dr BOWMAN: That is why I am suggesting it should be left to clinical circumstances.

Ms SYLVIA HALE: Yes, but the clinical circumstance is surely that a man cannot carry a child.

Dr BOWMAN: My own view is that that is not a disease process.

Ms SYLVIA HALE: So it has to be focused on the disease?

Dr BOWMAN: Yes. Having had your uterus removed or being born without it is in my opinion a clear clinical condition in a female.

CHAIR: Can I pick up a little more on the issue of possible legislation or regulation? We have had lots of evidence about parental rights and birth certificates, and the proposed changes in Victoria have brought in quite intensive regulations. What concerns us from the evidence is the issue of the agreements being void. They

are hanging in mid air. The surrogacy agreements are not endorsed. They do not have any legal right. I would like to hear what you think about changing that situation.

Dr BOWMAN: I should confess I am not completely au fait with all aspects of the Victorian legislation. I think this was a question provided ahead of time. We do not issue couples with a pre-formatted agreement. That is not our business. In fact we are conscious that the future New South Wales legislation says quite specifically that surrogacy agreements are not enforceable.

CHAIR: That is right.

Dr BOWMAN: We are simply saying that as part of the strengthening and examination, both internally and externally, of the relationship between the proposed surrogate and proposed commissioning couple that should have a very clear understanding of the roles and responsibilities and eventualities.

CHAIR: From the protocol?

Dr BOWMAN: We just raise the various issues that we believe are important and the parties go away. I have not been personally involved in whatever arrangement that actually draw up.

The Hon. GREG DONNELLY: I just noticed, just looking at the material we have in the actual submissions that have been made, Sydney IVF did not make a submission to this inquiry?

Dr BOWMAN: No. I wrote and offered to give some feedback as to how we conduct our practice, because I do not believe—and perhaps my colleague can speak too—Sydney IVF has an agenda here. I do not think we are particularly pushing barrows about what should or should not happen. On behalf of my patients, some legal clarify around custody would be of immense value to them. We are simply here to say this is how we did it.

The Hon. GREG DONNELLY: Sydney IVF is the largest provider of IVF services in this State, is it not?

Dr BOWMAN: Pretty close. There are two large units that operate, us and IVF Australia. In terms of infertility treatment, they go to those units in New South Wales.

The Hon. GREG DONNELLY: I thought you were by far the largest but that is not the case?

Dr BOWMAN: No, it is even, I think.

Dr DE BOER: It is fairly even.

Dr BOWMAN: Depends on how you look at it.

The Hon. GREG DONNELLY: Does Sydney IVF operate on a not-for-profit basis or a profit basis as an organisation?

Dr BOWMAN: Sydney IVF is a public but unlisted company. Its shares are jointly held by principally a number of doctors but also employees, past and present, of the unit, and it operates on a for-profit basis.

CHAIR: Is that the same process that a group of renal physicians would set up or cardiac? Is it the same sort of—

Dr BOWMAN: Potentially but it is much more sophisticated than that because you need a whole range of ancillary staff and services and equipment that make it a very large entity. It is like a private hospital.

CHAIR: With counsellors and nurses.

Dr BOWMAN: A private hospital would be a better analogy.

The Hon. GREG DONNELLY: The corporate governance is somewhat related to this so just forgive me for going down this track because I have some points to raise. Clearly, as an entity, as a for-profit business, it

operates in a commercial setting—in other words, there are competitors; you have just mentioned that there is one other. I presume you would consider there are competitors perhaps interstate or interterritory. For example, I understand there is a business in the Australian Capital Territory so they are competing for the market, if I can put it that way, the business.

Dr BOWMAN: That is one way of summarising it. Ultimately the patients finds specialists in the ways they have always traditionally found them.

The Hon. GREG DONNELLY: Sure, but obviously—forgive me for using such crude economic terms, but basically we are talking about people who are seeking a service and they are paying for the service. Is that correct?

Dr BOWMAN: That is correct.

The Hon. GREG DONNELLY: As I understand, there is no Medicare rebate for the service that you provide, is there? People basically pay for that service.

Dr BOWMAN: That is correct.

The Hon. GREG DONNELLY: That being the case that you are a for-profit business as opposed to a not-for-profit business, to the extent that New South Wales introduced legislation that placed restrictions on surrogacy, compared to the current regime, which is essentially without restriction, what effect would that have on your business and the profitability of your business?

Dr BOWMAN: It would have no effect on our business. It would have simply an effect on the clinical desires of the couples we aim to treat. For example, Sydney IVF currently undertakes 3,500 to 4,000 IVF cycles a year. In the 10 years we have done surrogacy—

The Hon. GREG DONNELLY: No, you are misunderstanding. When I am talking about in the context of surrogacy—

Dr BOWMAN: I just point out that we have had 69 applications for surrogacy in 10 years, of which 14 were withdrawn and we have had 15 babies born. Our agenda is not surrogacy as a business model. In fact, if surrogacy were banned outright in New South Wales tomorrow, it would make no difference to our business.

The Hon. GREG DONNELLY: I am not suggesting you have an ulterior motive. I am pressing you about the nature of the business of Sydney IVF and where surrogacy fits into the business model.

Dr BOWMAN: It is a tiny proportion of the business we do.

The Hon. GREG DONNELLY: It has been helpful that you have explained in those terms, so I appreciate that. Obviously surrogacy is such a small component of the business, as you have just described, but IVF is a much larger part of the business, if I can put it that way. The guidelines that Sydney IVF use, as the guidelines with respect to surrogacy arrangements that it conducts, and the guidelines—these are Sydney IVF guidelines; these are not NHMRC guidelines or industry guidelines—that you have with respect to IVF treatment, are they the same or different guidelines?

Dr BOWMAN: The fundamental guidelines are the same. Just to clarify, I am sure you are aware that IVF units undergo an accreditation process, which is federally based through the Reproductive Technology Accreditation Council [RTAC], and part of that accreditation is contingent upon you adhering to NHMRC ethical guidelines on assisted conception. So those guidelines travel through both IVF and cases of surrogacy. Our guidelines for surrogacy are principally geared around this unique circumstance of there being legal ambiguity around the child once born in terms of custody. I was just seeking to clarify and provide a stronger framework where the NHMRC guidelines did not provide that.

The Hon. GREG DONNELLY: Am I correct in identifying there are NHMRC guidelines and industry guidelines, in other words guidelines that are ethical guidelines for the industry itself which cover yourself and other operators in the industry?

Dr BOWMAN: Principally it revolves around the RTAC accreditation process, and there is a code of practice that we adhere to. Part of that code of practice states that we respect NHMRC guidelines.

The Hon. GREG DONNELLY: Is that what I am getting at? Is that the industry code that you—

Dr BOWMAN: Effectively, yes.

The Hon. GREG DONNELLY: Then there is Sydney IVF, which you have your own internal guidelines, is that right?

Dr BOWMAN: We have specific policies with regard to specific treatments such as surrogacy.

The Hon. GREG DONNELLY: Can you provide to the Committee a copy of those policies with respect to surrogacy and also IVF—the two separate policies?

Dr BOWMAN: We have just tabled the surrogacy policy.

The Hon. GREG DONNELLY: Can you provide a copy of the IVF policy to the Committee?

Dr BOWMAN: Perhaps you need to clarify exactly what you mean.

The Hon. GREG DONNELLY: I am trying to gather a clear understanding in my mind of the difference between—to the extent that there are differences—guidelines for surrogacy and guidelines for ART.

Dr BOWMAN: Do you mean the clinical indications for IVF?

The Hon. GREG DONNELLY: Forgive me because I am not a doctor, but let us use ART as the broad overarching framework. Obviously underneath that you have surrogacy that you offer as a service and you have guidelines associated with that. Then you have IVF as a discrete service you offer, and there are guidelines for IVF, I gather, with the patients you treat for IVF.

Dr BOWMAN: We have clinical indications. In other words, if a couple comes along with infertility they might have any number of diagnoses that are causing that infertility, and then a treatment arises as the cure of that problem. For example, one day it is IVF. So there are clinical indications–

The Hon. GREG DONNELLY: I am talking the policies because, to the extent that you have policies that apply with respect to surrogacy—I have not seen it but you have brought them along today. My question is: do you have different policies that apply to IVF?

Dr BOWMAN: I think it is simply that we have the RTAC code of practice that we adhere to, which is a national document that we are accredited against. Yes, that includes guidelines such as number of embryos for transfer, where circumstances might be appropriate or not appropriate.

The Hon. GREG DONNELLY: So you do not have a separate policy document that deals with IVF?

Dr BOWMAN: No. If you are referring to whether couples are suitable or not suitable for treatment socially, no, we have no document like that. But we have certain guidelines around things like gamete donation and what we might call unusual assisted conception requests as guides to clinicians because we have all encountered people who at times present very unusual requests that we believe fall outside what may be appropriate. So we have policies in that regard.

The Hon. GREG DONNELLY: Can you provide the Committee with a copy of those policies?

Dr BOWMAN: Sure.

CHAIR: It is outside the terms of reference.

The Hon. GREG DONNELLY: No, it is not because the two are directly related. I can join the two up, if you like.

CHAIR: You can join the two up but it is outside the terms of reference.

The Hon. GREG DONNELLY: No, it is not.

CHAIR: It is.

Dr BOWMAN: If there are guidelines, the guideline might be about who it is appropriate to treat or what is the appropriate treatment. How does one conduct IVF on the ground? That is no different. Eggs, sperm and embryos are cultured in the same way, whether it be for surrogacy or IVF. So that is no different. The only reason we have a specific policy for surrogacy is because of the fact that there is a third party involved and because of the legal—so I do not know that those other issues necessarily in any way relate to why we developed a policy for surrogacy.

The Hon. GREG DONNELLY: I am trying to take this along a particular line of argument because ultimately this Committee is considering that essentially we have a regime in this State which prohibits commercial surrogacy, as I understand it. With respect to all surrogacy arrangements they are void; they are voidable arrangements. They are the only conditions. So only two conditions operate in this State. Beyond that, it is pretty much free market. It is what people enter into subject to the NHMRC guidelines, the industry code that we mentioned earlier, and what are individual company policies or practices or guidelines. That forms the totality of the way in which surrogacy is conducted in this State. What is challenging this Committee is: Should we or should we not go down the path of further regulation? What is exercising my mind—I cannot speak for the other Committee members—is to the extent that we go down the path of further regulation, what clearly is possible in terms of what that regulation might be are what is in current guidelines that exist, either at the national, industry or company level.

We could say, "Leave those guidelines as they are in place." They have worked pretty well, so let us keep the minimum, as they are now, accept the guidelines have worked reasonably well and there have not been outcries and objections and complaints and that that is the best model for New South Wales, as opposed to opening up a new law which becomes quite prescriptive with regard to—and this is the point you were making earlier about the clinical decisions. If you start trying to be prescriptive about it, you have this collision between prescription in law and the position that the industry takes in terms of the clinicians operating in the industry and how that creates issues. Can you follow what I am arguing?

Dr BOWMAN: Yes I can. I guess the only other feedback I can give, and you are probably aware of the recently passed but yet to be proclaimed or enacted New South Wales legislation, specifically says that ART units are now to be registered, and you can only effectively gain registration by becoming an RTAC accredited unit. What they call Federal regulation under the Government means the Reproductive Technology Accreditation Council. So I can provide you with the document that we must adhere to, which is the RTAC code of practice, which effectively governs that. It is really that, plus the NHMRC guidelines, that are referred to now directly or indirectly in the proposed New South Wales law.

The Hon. GREG DONNELLY: These are not trick questions; I am trying to piece this together.

Dr BOWMAN: I am not sure, apart from the specifics. It is simply because the NHMRC guidelines are not very specific on surrogacy. In fact, in my opinion, they are woefully inadequate.

CHAIR: Participate in rewriting them!

The Hon. GREG DONNELLY: That is an issue for us.

Dr BOWMAN: We would love to contribute to NHMRC policy development. However, it has its own views on a lot of issues.

The Hon. GREG DONNELLY: You referred earlier to the importance of clinical decision-making, or clinical autonomy. Obviously, that is a matter for Sydney IVF. In other words, the medically trained experts who are working in this area must retain their clinical autonomy as trained professionals. We are being asked not so much to interfere in that part of the business, if I can put it that way, but to establish whether or not there should be regulation in a pre-clinical situation, in other words, whether or not there should be laws in this State that make it more restrictive or that retain the status quo with respect to surrogacy. That is the issue that we face. No-one has come before us and said, "We want you to place more restrictions on the clinical procedures of

individual enterprises." No-one has put forward such a suggestion. It is more to do with pre-clinical situations. Can you comment on that?

Dr BOWMAN: By pre-clinical, I guess you mean—

The Hon. GREG DONNELLY: I used a crude example. I am referring to those occasions before people come knocking on your door.

Dr BOWMAN: Is it the role of government or legislation to tell people who should and should not seek professional opinion? Let us examine that in the wider assisted conception sense. Pretty well since the inception of IVF, Victoria has had restrictive laws and independent bodies telling IVF clinicians what they can and cannot do in certain circumstances. They have to apply to the Infertility Treatment Authority to be told what they can and cannot do. Above the Murray River we have not experienced that. I would argue that both societies effectively are travelling along okay.

The Hon. GREG DONNELLY: Could we do with some more regulation in New South Wales?

Dr BOWMAN: IVF clinicians and IVF units are quite comfortable with the proposed legislation because it simply tags clinical and ethical performance within a framework of clinical autonomy.

CHAIR: Is this the New South Wales ART?

Dr BOWMAN: Yes, it is the New South Wales legislation. Barring one or two complicated regulations that we have sent back to the director general for more consideration, the framework states that IVF units will be registered and they will adhere to certain things. I suggest that most of us are comfortable with that, apart from individual minor workings and things. I think that simply represents that in New South Wales we have practised for the betterment of our citizens.

The Hon. GREG DONNELLY: If the law in New South Wales were changed to provide explicitly that, for the purposes of surrogacy, individuals and same-sex couples could access and utilise surrogacy arrangements, would Sydney IVF go down the path of offering services to those individuals—the individuals and same-sex couples—because the law now provided for it?

Dr BOWMAN: I doubt it. Currently those are the clinical decisions that we arrived at as recently as the past 18 months when that request was made to us.

The Hon. GREG DONNELLY: As an enterprise you would then face claims of discrimination if you did not provide that service, would you not?

Dr BOWMAN: We possibly could. We could also adopt the view that we are in the business of treating pure medical problems.

Ms SYLVIA HALE: Why do you support treatment for medical infertility but not social infertility? Is that because it narrows the potential for litigation?

The Hon. JOHN AJAKA: Because doctors are not social. That is the reason.

Ms SYLVIA HALE: Does it simplify matters for you?

Dr BOWMAN: It simplifies matters in some respects, but that is not the primary reason. Perhaps it is inherent conservatism, but traditionally we work in this area because we want to help families in the widest sense. I guess you could then get into the definition of what is a family. I have not seen long-term evidence to show that two men raising a child necessarily would be in the interests of a child. However, that is a personal view; that is not a company view. I have yet to see that evidence.

The Hon. DAVID CLARKE: I wish to ask a question arising out of what Ms Sylvia Hale said. She used the expression "social infertility".

Dr BOWMAN: Perhaps I used the wrong terminology.

The Hon. DAVID CLARKE: Is there any social infertility? I understand what medical infertility is, and I fully understand where you are coming from. However, this has been elevated to the concept of social infertility.

The Hon. GREG DONNELLY: Two blokes cannot have a kid.

The Hon. DAVID CLARKE: That is right. You are there to deal with medical problems, are you not?

Dr BOWMAN: Yes. All the time people are presenting in grey areas. If a single woman presents, having co-opted a friend, and it is unclear whether or not they are in a sexual relationship, it does not matter what they tell you because you do not know what is going on underneath.

The Hon. DAVID CLARKE: Are you happy to deal with medical infertility?

Dr BOWMAN: In that situation we say to the proposed father that fatherhood is not necessarily a legal definition. If he wants to kick a soccer ball around he will probably get rung up, no matter what he thought he was getting into at the start. That is a fairly trite way of putting it. There are all sorts of individual situations. A lesbian couple might co-opt a gay male friend in whatever capacity they might co-opt him. At the end of the day there is a chance that the child's needs would require drawing on the person who provided the sperm, beyond just being the provider of the sperm. I think we have a role in counselling people; I do not have a role in judging them. Right now there is no opportunity for two men to have a baby if female needs are to be drawn upon. It does not have to be in the same house or in the same street; I believe it will be there whether or not they intended it.

The Hon. DAVID CLARKE: Would you be upset if the law forced you to treat social infertility, as you are there to treat medical infertility? If some laws of discrimination required you to treat social infertility would you be upset about that?

CHAIR: By the way, I do not think we are plotting for that to occur.

Dr BOWMAN: I would have some difficulty, yes. I would have some difficulty if I felt that the child's needs were not being met in the widest respect. We have all sorts of definitions of the word "family" but at the end of the day there are male and female role models around. In all the other paradigms that I have treated those constructs exist. They might be different, blended or varied; nonetheless they are there.

The Hon. JOHN AJAKA: I was intrigued when you said earlier that of the 69 people who presented a certain number did not proceed. Ultimately you said that 14 children were born.

Dr BOWMAN: No, 15. There have been 15 births in 10 years.

The Hon. JOHN AJAKA: On the whole of the IVF scale we are not talking about hundreds of children being born each year through surrogacy.

Dr BOWMAN: No.

The Hon. JOHN AJAKA: Can you explain to me what occurs? Who makes the final decision if a mother's health is at risk compared to the health of the unborn child? What occurs in that situation? Who has the final say?

Dr BOWMAN: I am not an obstetrician, so that would be occurring away from my practice, and possibly even away from this State. I have seen more people than anyone else because I have attracted people from all over the country. Until recently it has been banned in every State other than the Australian Capital Territory. That is one of the issues that must be addressed. This is part of that pre-treatment process where those things are individually agreed on. Everybody needs to understand that that agreement, however couched, is not enforceable.

The Hon. JOHN AJAKA: You might not be able to answer my next question, but why were there only 15 births? Is that an average? Does that mean that 35 failed in one form or another?

Dr BOWMAN: No. I guess it means that we potentially helped a quarter of the people who presented.

The Hon. JOHN AJAKA: Did the others involve a miscarriage, or did they not proceed?

Dr BOWMAN: Potentially or, for example, the eggs of the commissioned mother might have been too old. We can create embryos but this is not about the fertility of the surrogate; it is about the person receiving the embryo.

Dr DE BOER: And some are still undergoing treatment; they have not yet completed their treatment and they have not yet become pregnant. We have one person who is pregnant but she has not yet had a live birth.

The Hon. JOHN AJAKA: A commissioning couple and a surrogate could go through this whole process, as in the case of standard IVF, if there were such a term. They could go through this process once or twice and if nothing eventuated they would still have to go through all the stress.

Dr BOWMAN: That is correct.

CHAIR: Thank you for appearing before the Committee this afternoon. It has been very informative for us. Does the Hon. John Ajaka require specific figures?

The Hon. JOHN AJAKA: I think we have a good indication. Basically, I wanted to know whether we were talking about thousands of people or whether we were talking about one in 50 people.

Dr BOWMAN: Our unit alone might result in close to 1,000 births. On average we have about one in three cycles leading to a baby in IVF. In any one year, if we are looking after 3,500 IVF cycles, that might lead to just under 1,000 babies a year. Multiply that figure by 10 and then compare it with the 50 cases of surrogacy that we have treated.

The Hon. JOHN AJAKA: I am a bit surprised at the low figure. I thought we were looking at much higher figures.

Dr BOWMAN: We have all been surprised at the level of interest amongst State attorneys general of something that from our point of view is a very small area of practice.

CHAIR: When you find out you might provide the Committee with the answer to that question.

Dr BOWMAN: I suspect that I know part of the answer.

CHAIR: Thank you very much for appearing before the Committee today. If the Committee requires further information from you members of the Committee secretariat will contact you and let you know. We would appreciate any answers to questions by 3 April. We have some questions that we did not ask you that we have already supplied to you on notice. Thank you for appearing before the Committee today.

(**The witnesses withdrew**)

SANDRA KAY DILL, Chief Executive Officer, Access Australia, sworn and examined:

CHAIR: Welcome to the third public hearing of the Standing Committee on Law and Justice inquiry into legislation on altruistic surrogacy in New South Wales. We have taken evidence from a number of witnesses today. The media who attend are aware of the broadcasting guidelines. Witnesses, members and their staff are advised that any messages should be delivered through the attendants or the Committee clerks. I advise pursuant to the standing orders of the Legislative Council that any documents presented to the Committee that have not yet been tabled in Parliament may not, except with permission of the Committee, be disclosed or published by any member of such Committee or by any other person. Committee hearings are not intended to provide a forum for people to make adverse reflections about others. The protection afforded to Committee witnesses under parliamentary privilege should not be abused during these hearings. Therefore, I request that witnesses avoid the mention of other individuals unless it is essential to address the terms of reference. Mobile phones should be turned off, as they interfere with audio equipment. Ms Dill, what is your occupation?

Ms DILL: I am the Chief Executive Officer of Access Australia, a support group for people who need medical help to have a family.

CHAIR: In what capacity are you appearing today before the Committee? Are you appearing as an individual or as a representative of the organisation?

Ms DILL: The information that I will give you about our views is representative of the view of Access. The information about the research relates to my PhD and masters research, which I am undertaking at the moment.

CHAIR: Are you conversant with the terms of reference of the inquiry?

Ms DILL: Yes.

CHAIR: If you should consider at any stage certain evidence you wish to give or documents you wish to tender should be heard or seen only by the Committee, please indicate that fact and the Committee will consider your request. If you take any questions, and this Committee does give questions on notice, we would appreciate it if you supply the information by Friday 3 April 2009. The secretariat will contact you about any such questions. Would you like to start by making a statement?

Ms DILL: Just to thank you, and I will leave you to ask questions so that I can direct information as you would like. I thank you very much for inviting a perspective from a group of people, some of whom may consider using the option of surrogacy to have a family. We appreciate your willingness to listen to people who will be most affected by the decisions that you make. I will leave it to you to ask questions.

The Hon. DAVID CLARKE: Ms Dill, the position of Access Australia is summed up as:

> Access Australia recommends that surrogacy be permitted in law because surrogacy in a controlled environment can provide a successful option for women who for medical reasons are unable to carry a pregnancy safely.

Is that a general overview?

Ms DILL: Yes, general.

The Hon. DAVID CLARKE: Would it also be in respect of men who have a medical problem?

Ms DILL: Yes.

The Hon. DAVID CLARKE: Do you have an attitude to the introduction of laws relating to surrogacy where we are talking about same-sex commissioning couples who have no biological genetic link to the child—for example, two male homosexuals who have no medical problems? Do you have a view about a change of law in respect of a situation like that?

Ms DILL: Does the law prevent them at the moment? The law does not prohibit surrogacy; it does prohibit surrogacy contracts.

The Hon. DAVID CLARKE: That is right.

Ms DILL: They are matters for an ethics committee, and they should be properly considered in that light by a duly constituted ethics committee. There are only a couple of clinics that will approach the area of surrogacy because it is problematic. It is especially important that it be done in a way where all of the parties are going to be able to be better off after the experience than not. So that is a matter for an ethics committee to make a decision about the child. I guess we could discuss—whatever our personal views may be—on what grounds we might prohibit access to anyone to medical treatment if there are no good grounds to refuse them on medical grounds or on other grounds.

The Hon. DAVID CLARKE: Do you think on the whole it is better for a child to have, where possible, a mother and a father?

Ms DILL: I have spent a number of years being involved. I am a very conservative, heterosexual, married woman who is a Christian. So I have had approaches about this from many different perspectives. C. Everett Koop, who was Reagan's Surgeon General, said at the time that we should not automatically enact personal moral views into laws enforced by the State. So I have come to the view that I would be reluctant if I had the power to deny anyone access to appropriate medical care if they needed it, with the understanding that there was no reason to do so based on the welfare of the child. When I look at our society we see more than 50 per cent of Australian marriages end in divorce and that can cause great distress to children. Our concern is that any child born into any relationship be one where the child is nurtured and the child is loved. That would be our concern. We are not much interested in the parties.

The Hon. DAVID CLARKE: I understand that, but I am asking a different question. Do you believe that there is a positive dimension, on average, that it is an advantage to a child where there is a mother and a father, all other things being equal? Do you believe there is something more to be gained from a child having a mother and father, if possible? I know there can be bad situations and there can be terrible mothers and fathers. But on the whole, all things being equal, is there something to be gained from a child having a mother and a father?

Ms DILL: I understand the question and it is an important one. I need to say that in Access there is going to be diversity of opinion about this. In my research at the moment one question that I will be exploring is: what is a family, how important is genetic connection and looking at the diversity of family. One response I might have as a researcher to a question like that would be: On what evidence would anyone propose that that is the case? I would try to stay objective and ask that question. Obviously, women carry children and to have a child you need input from the male and female. I think again, that is one issue.

The other question is whether or not, regardless of what our individual views may be, we would impose laws to basically enforce citizens in our community to have the same view that we might have, whichever view that happens to be. I am not so sure because I would need to see the evidence on that. I know of an IVF doctor who normally would not do IVF with lesbian couples, for example. I worked with my colleagues in Japan to set up appointments through Tokyo University when they came out here looking at women who had donor insemination, and several of those women were couples in a lesbian relationship. I was quite humbled by the way that without exception these families operated. The care of the children was very much the focus. In one family the donor was a family friend, who was a parent and was very clear and had been discussed. The children spend time with this male donor I think every other weekend.

So, there were situations where the female couple recognised that they wanted their child to have access to a range of people. They also seemed to have very strong family support from both males and females. I know the doctor I am thinking about said he was quite humbled because he had not realised that these couples that had approached him for IVF treatment were actually giving more thought to having their children than many of the heterosexual couples he met. So, in the absence of that I would prefer in a policy setting not to make a valued judgement. I mean, I would look at the evidence. As a researcher I would say let us look at the evidence because we want the children to be nurtured.

The Hon. DAVID CLARKE: So that could be a good situation, but one that involved a mother and a father figure could be a better situation?

Ms DILL: Yes, I hear what you are saying. I guess if I had a child that is probably how I would do it, but I have lived long enough to know that my choices are not necessarily the best ones always. I would again say, well, I need to examine the evidence on that. I have learned to withhold judgement. Part of the reason for that is that as a person who has undergone 12 years of infertility treatment, gone through a late miscarriage after nine years of trying to conceive and then become involved in policy issues, not necessarily very controversial ones but just sort of general access with the Commonwealth, I have listened to a lot of valued judgements people made about us and they are quite confronting. I guess I have learnt a lot about not judging people without having information or access to all the facts. So, I am not trying to avoid your question.

The Hon. DAVID CLARKE: No, I understand. You say you would be looking at the evidence, but would you agree with me that in looking at the evidence and keeping in mind that in a way one side of this would be pushing the parameters into uncharted waters, we need to be particularly careful that the evidence and the research is going to support us going in that direction that takes us into uncharted waters?

Ms DILL: Yes, but I would equally say we would need to look at the evidence that supports the idea—

The Hon. DAVID CLARKE: All the evidence.

Ms DILL: —that having children, and as I said as a heterosexual married woman, I would be a little nervous about that.

The Hon. DAVID CLARKE: So we do it with caution because we are moving into uncharted waters, but with all the evidence being considered?

Ms DILL: But before we move there to do that, it seems to me we are making a presumption that to have a child in a particular way is better for the child. We need to establish that first before we do this.

The Hon. DAVID CLARKE: I agree.

Ms DILL: As you will see later as we continue to speak together, people accessing surrogacy in Australia is a very different protocol than people accessing surrogacy in America. It just seems frivolous to me, but where people are saying for social reasons, "I don't really want to take time off to be pregnant, so I'll get a surrogate to carry my baby for me", that kind of thing is just not going to happen in Australia.

The Hon. DAVID CLARKE: But keeping in mind that we are dealing with what is in the best interests of the child, is it reasonable for me to put this: rather than making a decision to go down a pathway on the balance of probabilities, we would be looking at maybe a higher standard than on the balance of probabilities because we are dealing with the welfare of children and we are moving into an area which, as I have indicated, is taking us into uncharted waters? Maybe the standard of proof of evidence has to be higher than just on the balance of probabilities?

Ms DILL: I would hope that the standard of evidence would be very high and apply to everyone.

The Hon. AMANDA FAZIO: In your submission you recommend that surrogacy be permitted in law. Although altruistic surrogacy is not prohibited at the moment, can you tell us why you think there is a need for altruistic surrogacy to be expressly permitted in law?

Ms DILL: Thank you for the question. I am not a politician but it seems to me that obviously there are reasons why laws are framed in particular ways. It is true that altruistic surrogacy is not prohibited, but we are people who are trying to have a family. I guess I am just a little uncomfortable with the idea that for those who have children in this way, when they grow up it was not prohibited that they be born in this way, but it was not really permitted either. There is some sort of sense of reserve. It would be nice if children were very clear about the fact that there is no sense of shame in this; that maybe there was a better way they could have been born. You know, the Government has not really allowed it; it has just turned the other way and said, "Look, you can't undergo commercial surrogacy." So, I guess for the sake of the children it would be nice not to encourage it and certainly there are lots of ways that we will see and explore as we speak, but I think it would be nice for them to be clear and unequivocal that our Government does not view them in any way less than any other children born through the normal course of events.

The Hon. AMANDA FAZIO: Also in your submission you put forward a number of criteria you say should be established for an altruistic surrogacy arrangement. Can you tell us a little more about those issues and also if you think they should be set down in specific surrogacy legislation or left to the assisted reproductive technology clinics to develop their own criteria and apply them?

Ms DILL: I am not sure that we need to be very specific about this. Certainly, this is how it happens at the moment and it is proved to be very helpful, this preparation phase. The preparation phase is not for the faint-hearted. Even if we assume that the clinics have no interest in anyone, I guess we could crudely say it would be bad for business if a surrogate case went wrong because it would just completely ruin it for them, but that is a secondary matter. The issues in relation to the kinds of things that would happen are really part of the process to take people through when they first consider surrogacy. We receive calls from women sometimes when they see a program relating to surrogacy on television. They ring up, which is very sweet, and say, "Look, I would really like to help another woman have a child and I would love to do this."

Our first response to them is, "Well, these are the clinics that do surrogacy. What you need to do first is to make an appointment with a counsellor at the clinic, go and see that counsellor and find out whether or not you would be eligible under a range of conditions that each individual clinic might have. Then part of that is that you and your husband would need to go in and have separate and together counselling. If you have children old enough to understand what is happening, they would need to be spoken to by the clinic counsellor. Then if you proceeded, as a measure of distancing the process from the clinic, they would ask you to go to see someone outside the clinic, who is clearly independent, just to confirm that everyone feels that all the parties have explored all the possibilities."

The response I get invariably is, "Oh, we're not going to go through all that." One woman even said to me, "Oh, why would I need my husband's permission?" I said, "Look, I'm all for women's lib, but you're going to carry a baby for nine months. He is going to find out and this is going to impact on your family." So, no-one wants to go into something that is going to cause harm to your family just so that another can benefit. This is not good. This shows you how people can be very emotive and spontaneous but not giving a second thought to the outcome. So, I do not think so. One of the few things I like about Victorian legislation, forgive me, is that its introduction is fairly general: "In the circumstances that the commissioning"—I do not like that term; I prefer to use the word "intending"; it sounds like a sort of business agreement—"person cannot have a child any other way." An obvious example is a woman who is without a uterus, or she has a medical condition that may make it dangerous for her to carry a pregnancy to term. We think beyond that it is good to place that in law because it gives people a very clear idea that you do not just do this.

The other thing about surrogacy is that you ask those questions later, but I do not think so. I am basing that on the evidence. There are clinics that have been doing that for a number of years. They have a very rigorous process. These things must be adhered to, and one of them is that a surrogate cannot be someone whom you do not know. It has to be a family member or friend—and that is why there are not too many cases of this—and someone who will know the child, even at a distance. You need someone who will be very involved in the parenting—that is not what this is about—but just so that the child will always be aware of the circumstances about how he or she came into being, and part of what we do is that we support this rigorous process. There is absolutely no reason why a clinic would not do that because they want to be successful.

The Hon. AMANDA FAZIO: Do you think that it would ever be appropriate for a single woman who has not had children of their own to act as a surrogate?

Ms DILL: Again on the evidence, we would question that because firstly we do not know whether she is fertile, and 20 per cent of people of child-bearing age need medical help to have a family. Fertility cannot be presumed. It just seems not to be responsible to put someone through an IVF procedure when you do not even know if they have a fertility problem. The other thing is that we really encourage a situation in which a woman must have had at least one child and preferably has completed her family, but at least has been through a pregnancy so at least she knows what the process is about.

Again I would almost say that it would be good to have legislation to that in effect, but there might be an unusual circumstance. The inflexibility of the legislation is what concerned me in this instance. What if there was an unusual situation, an unusual family situation, where there was a sister who was willing to try to help her sister, and there was no-one else available? If that person was very carefully prepared and the tests that were able to be done were done, and she was able to give truly informed consent, would you then stick to the letter of the law and say, "No, you can't because you haven't had a child."

The Hon. JOHN AJAKA: What if she indicates that she never wants to have children, other than in this circumstance? That would have to be another criterion.

Ms DILL: Yes. I would not see a reason to ban that. Again I think it would be very important that her medical checks would be done, but also that she is very carefully prepared with a process in terms of implications counselling so that all the parties, including the medical team, were persuaded that she was very clear about what she was undertaking; and that there was no guarantee that she was even going to conceive. She will get very close supervision if she does become pregnant. I would see no reason to prohibit that, but ideally in that sort of situation the surrogacy itself is not very common, and that would be very rare. However, I would see no reason to ban it, again because it may be something that provides a happy outcome for everyone.

Ms SYLVIA HALE: If you say it is desirable to be flexible in relation to the surrogates, why should you not be equally flexible in relation to the intending family or parents? In your submission you suggest that it be available only for women who are without a uterus or who for medical reasons are unable to carry a pregnancy safely. Why would you be so inflexible in relation to them?

Ms DILL: It is not really intended to be inflexible, Ms Hale. It is about making people aware of the circumstances for surrogacy. My question would be: Why would anyone want to have surrogacy, unless there were very good reasons for doing so? In vitro fertilisation [IVF] is much more successful. Why would you do surrogacy? It is just a whole huge problem.

Ms SYLVIA HALE: Two men, for example, or homosexual couples?

Ms DILL: I am sorry?

Ms SYLVIA HALE: Two gay men who may want a family.

Ms DILL: As I said before, I do not think that should be prohibited. You could argue that gay men certainly are not able to carry a pregnancy.

Ms SYLVIA HALE: But it would seem on your criteria—

Ms DILL: I am not being facetious there.

Ms SYLVIA HALE: No.

Ms DILL: It is clear they are not doing it for frivolous reasons. If they were to do it, they would be doing it but they obviously cannot. I guess that is a benefit or a problem that certainly a lesbian couple does not have to face.

Ms SYLVIA HALE: Yes, that is right.

Ms DILL: When I say that, I would not see that as excluding homosexual men.

Ms SYLVIA HALE: It was just the way I was reading your first statement, "Access recommends the following criteria … "; and then you seem to suggest that it should be available for women who are without a uterus, but you do not suggest it should be available for men who cannot biologically carry a child. Do you see?

Ms DILL: Yes, okay, or I could say "people without a uterus". It was not intended to exclude men doing it. It was really to draw attention to the fact that it is not something that you do because you have had three in vitro fertilisation [IVF] attempts so you will do surrogacy now. It is just not medically appropriate. You have a much better chance of having another few IVF attempts than you will through surrogacy, and surrogacy is problematic. It is a very complex and draining process. Why would you do it unless there was a very good reason for doing it? It was not intended to exclude men but rather to draw attention to the fact that it was not for a great number of people.

Ms SYLVIA HALE: Sure.

The Hon. AMANDA FAZIO: In your work with the ethics committee, has the issue been raised about an upper age limit for surrogates? It used to be that you would say that a woman had reached menopause and therefore her child-bearing days were over, but now you have instances, mainly overseas, where you hear of women in their sixties and even older who are having children through IVF. Do you think that there should be an upper age limit on women acting as surrogates, or do you think it really should be left to their individual health circumstances?

Ms DILL: I think we are fortunate in Australia—all of us—that we have such medical facilities. I chair an international network of patients' leaders and I recently visited the largest public hospital in Uganda with very committed medical professionals. All I kept telling myself for the week I was there was, "Don't get sick, don't get sick, don't get sick." They just do not have access to good medical resources. I would not see a need to legislate for an upper age limit. I think the processes that are in place would address that. It is true that some mothers have carried children for their daughters, and they may be post-menopausal and in their fifties. It is relatively simple to give a woman oestrogen and to bring her back into cycle.

What a doctor would be concerned about from his own perspective at the very least, and we hope from the perspective of his care for his patient, is that the woman be able to carry the pregnancy safely. What a woman does not have to do, which is different for a woman who is having a child for herself, is that she does not have to raise the child. Most of the comments I have heard relate to that, such as, at her age, where will she be when she is 20 years older and will she still be around for the child? I cannot think of any reason why a doctor would risk allowing a woman in her fifties to carry a child unless he was very convinced that she was of adequate health, sufficient to be able to carry and gestate that child. For some families, that is what has happened, and it has worked very well.

The upper age limit is arbitrary. Where do we get that from? Based on what evidence? We can get women who are in their early forties and who are in quite poor health compared with women who may be in their fifties. Again I am trying to suspend judgement and say that the doctor has a duty of care to his or her patient, and if they make a bad decision they may find themselves the subject of litigation for professional negligence at worst. I think we have adequate protection in place in that scenario.

The Hon. JOHN AJAKA: Ms Dill, thank you for your submission. It really was very helpful and summarises many of the areas in quite a concise way. Rather than go through the submission point by point, because it speaks for itself I will do it this way: If we look at the situation of the status quo, in your opinion it is just not working. There is just not enough protection, in the best interests of the child. Would you agree with that statement?

Ms DILL: For surrogacy?

The Hon. JOHN AJAKA: Yes.

Ms DILL: I would say in one area that is the case, and that is the transfer of legal parentage of the children.

The Hon. JOHN AJAKA: With that, you have the birth certificates, getting a passport, and all of the ancillary matters that come with that one area.

Ms DILL: Yes, and taking your child to an emergency room and having to get a relative's approval to have medical treatment undertaken, both parties having to change their will so that the grandchild is not included in the surrogate's will, and the biological parents or the intending parents having to have wills re-done to include their children. It does not make a lot of sense. When the child goes to school, the child needs to have some certainty about his or her legal parentage.

The Hon. JOHN AJAKA: Accepting that surrogacy exists in New South Wales, and assuming we are not going to revert—

Ms DILL: Prohibit it.

The Hon. JOHN AJAKA: Leaving aside commercial surrogacy, the reality is that we need to look at some form of mechanism, perhaps by new legislation or otherwise, to try to resolve the issues that are occurring in respect of these children in the best interests of the child. Your belief is that we should be looking at either

legislation that covers surrogacy or existing legislation that we amend, such as the Status of Children Act or something of that nature. Is that your position?

Ms DILL: Yes. How that is framed is up to the legislators, but something to that effect, yes. You would be aware that there are the two positions, and I used to have this one, which would remove any uncertainty if there was some contractual agreement—which I do not agree with—by which the surrogates was committed to giving up the child at birth. I have had a few people say to me in the last few weeks, "What are you advocating this other position for? The surrogate needs to know what she has to do at the end of the day." My concern about not doing that was that the surrogate would always feel that she had an escape clause, and that if she was ambivalent, she might just enter into the agreement. That is what happened with Mary Beth Whitehead. It was not a good preparatory phase.

In order to give emphasis and to make everyone always aware of what they are about to undertake, I do not see any need to change the existing law which recognises the birth mother as the legal mother of the child, but this mechanism which we have suggested is a window. You would allow the surrogates to get over the birth, but when a child is between six weeks and six months of age, or whatever the time frame you wish to make—

The Hon. JOHN AJAKA: Just on that point, are you suggesting that maybe we should have a system whereby after the child is born, not before, the matter could be brought quickly before the Supreme Court, for example?

Ms DILL: For a judge to enter—

The Hon. JOHN AJAKA: For a judge to look at all the circumstances—

Ms DILL: Yes, and interview everyone.

The Hon. JOHN AJAKA: —including what is in the best interests of the child and including whether an agreement exists, albeit voidable but nevertheless still one of the criteria he takes into consideration, and the judge is able to say from a very early stage, "Look, everyone is happy. In the best interests of the child, I will immediately make an order that the parents are the commissioning parents. The birth certificate should be amended immediately. They now have a greater responsibility. The child is their child." That is what you are suggesting or recommending?

Ms DILL: Yes. I have spoken to some couples, and some couples in my research have said, "We would like this to happen at the birth." I understand why they have said that because they are in a situation that is very clear. It might be a family situation where it would make perfect sense to them, but I think that if we have laws, I have come to the view that we need to be clear and the community needs to be reassured that people are not undergoing something in a light way.

The Hon. JOHN AJAKA: Or rushing into it.

Ms DILL: Or rushing into something. I think women undergo a treatment that is a little unusual, and those of us who participate in it have that responsibility. I think it is worth just allowing that six weeks to elapse, and not adoption because—

The Hon. JOHN AJAKA: I understand. Today we discovered, to my not inconsiderable surprise, that we are not exactly talking about thousands of children being born into surrogate arrangements each year in Australia. I must say I was surprised at how small a number it in fact is. But if we were looking at a matter going before the Supreme Court and giving the judge the ultimate discretion to make a determination in the best interests of the child, why even have a time restriction? Why not allow the parties to put on the application as soon as they want? It is still open for the judge, exercising discretion, to say one of three things: "No, I reject it", "Look, I am almost satisfied, but I think it is too early, so I will adjourn the matter for six weeks and see the parties then with updated affidavits", or "I am absolutely satisfied; this is a situation where I am prepared to make the order immediately". Would that resolve the issue?

Ms DILL: I think you will find a lot of people saying that it sounds a little bit like unseemly haste. Again, taking a more conservative approach to that, we would not like the surrogate to feel that they were being rushed into something. In any case, they probably will not be, but others looking on might see that that is the case and say, "Why are you doing this?" Everyone was happy and now we want them to go down to the

Supreme Court. Maybe reduce it to four weeks, but at least allow for the sense of dignity of the surrogate—she has had to undergo gestating a child for nine months, which is no small thing to do, I imagine—and allow her some time to get over the birth. Just a little time and a little respect for the surrogate—I think that is not too much to ask. Then you will have a situation where judges are known for their conservative approach, so that is something that I feel most members of the community would be reassured by. It is that point, and I think you will find social scientists would really strongly say that, I guess just as a gesture of respect for the surrogate—"She does not want to have the baby this week; okay, let's rush her down to the Supreme Court." It just seems a little like, "Well, thanks, and see you later".

The Hon. JOHN AJAKA: What happens with the child at birth?

Ms DILL: Handed over immediately.

The Hon. JOHN AJAKA: So there is no breastfeeding—

Ms DILL: Well, the Kirkmans were an unusual case. The intending mother wanted to breastfeed. I do not know how this works, and I do not really want to go into the medical background, but they use a pump or something and she was able to have some sort of milk. It was not genuine milk—I do not know what it was—but she was able to at least have that experience.

The Hon. JOHN AJAKA: But the surrogate mother does not breastfeed the child?

Ms DILL: No, the surrogate gives the child up at birth. Some people who have concerns about a surrogate doing this will even say that it is not good for the existing children of the surrogate—you know, the mother is giving a child away—and people who are looking for good one-liners say, "I don't think we should ever be legislating to allow women to give away their children", but particularly when the woman is not biologically linked to the child, and if it is her choice to do that, why not respect that choice and allow a family member or a close friend the opportunity to support their friend or family member in that way?

The Hon. JOHN AJAKA: In your view the surrogate should never supply her own gamete?

Ms DILL: No. I would have thought that at one stage, but why would I do that? Obviously it is more problematic. I think that clinics would be very reluctant and they would make sure that there would be a lot more implications counselling. Infertility counsellors are very skilled at drawing out—in fact I even know that with egg donation the requirement is that the intending parents are interviewed separately, together, with the donor and without, and this would happen in surrogacy. When they are all together everyone says, "This is great, I want to help my sister"—it is usually a sister—"and I really want to do this". She gets the egg donor on her own and she says, "I feel really bad. I've got children; my sister hasn't. I feel so, so bad for her and I desperately want to help her, but I don't want to do this. I don't want to have an operation to do this." So what happens is that the counsellor becomes very unpopular for knocking the case back. I think that process is very important. Actually something like that would go back to an ethics committee.

The Hon. GREG DONNELLY: Is Access the main organisation in Australia that represents couples who are not able to—

Ms DILL: Have a child without medical assistance? Yes. We are the only national group. There are some local groups. The leash of those tends to roll over often because people have children, or not, and then tend to leave. There are those of us who are masochistic and just want to stay on. It is a way for us to find some way of having control over our infertility, to be honest, and see if we can make a difference—and being together, like any sort of support group network. We are a not-for-profit charity. We also now, to our delight and still to my dismay, have a group called IVFlings, which was self-titled by young adults in their mid-20s now who wanted to be part of Access. One of our patrons is Candice Reed, Australia's first IVF baby, who is 28. They actually want to be part of this because they see judgments being made and they feel that a lot of laws being made have an impact on how they are viewed one way or another, so they are interested in it. Frankly, I was surprised, but they are very interested in that. So Access has grown to encompass this as well and they are a delight to work with.

The Hon. GREG DONNELLY: What is the governance of Access, just so that I understand the organisation?

Ms DILL: We are a public but unlisted company and that is because we have to exist on donations. It provides a very high level of accountability and transparency. For those donations, which we take from a variety of sources, we adhere to the guidelines of Medicines Australia and Consumers Health Forum, of which we are a member. In our memorandum and articles of association we have a requirement that the majority of our board of directors and any advisory body we have shall be consumers, so we are consumer-controlled. That is important for us.

The Hon. GREG DONNELLY: In terms of the matters that we are canvassing today and specifically in the context of surrogacy, does Access have a policy document that outlines its position on this issue?

Ms DILL: Yes, it does, and in fact all of it is included in the document you have, it is just not on that page with the heading.

The Hon. GREG DONNELLY: Could I take you to page 2 of your submission? The introduction is on page 2 of 14 and halfway down it has "Comments on specific terms of reference follow".

Ms DILL: Yes.

The Hon. GREG DONNELLY: The second paragraph says that Access Australia recommends that surrogacy be permitted in law because surrogacy in a controlled environment can provide a successful option for women who, for medical reasons, are unable to carry a pregnancy safely. Is that the policy of Access Australia?

Ms DILL: Yes, but unintentionally. I think we would say to be more accurate, because that was our intention, "for people" who are unable to carry a pregnancy safely. We just assume that would be women, in thinking, but it is really for people who are unable to carry a pregnancy safely.

The Hon. GREG DONNELLY: If we move from women to people, at least from a policy point of view, the organisation would not argue against the right of an individual person—let's take a single male—saying, "I am in no relationship and I don't want to be in a relationship, but I dearly want to have a child of my own to look after. I really want that".

Ms DILL: He would not be accepted. Can you see why?

The Hon. GREG DONNELLY: Would not be accepted by whom?

Ms DILL: Any clinic.

The Hon. JOHN AJAKA: He wants to have a child, full stop.

CHAIR: Because he is talking about himself, not his kid?

The Hon. GREG DONNELLY: Tell us why.

Ms DILL: He would not be accepted—and I see what you are saying. It follows too if you have two men. I must confess I have not been asked that question before, it is more about single women, and single women who are wanting to have a child usually have it by donor insemination, but if a single woman did not have a uterus, say, she may want to go to the trouble of having a surrogate carry her child and having donor sperm create the embryo. I know what you are saying.

The Hon. GREG DONNELLY: I am just trying to develop the consistency in the argument that if you acknowledge, as you have done—

Ms DILL: I have not given this a lot of thought, but I think one question that the person would be asked is—and I do not think any man has ever really raised this—"Are you sure you do not want to be in any kind of relationship? Are you quite sure that you will remain single, but that you would like to be a parent?" In the implications counselling I think this man would be made very aware of what that might mean in terms of the impact that it might have on his lifestyle. A question would also be asked about the kind of support he would have to help him in that endeavour.

The Hon. GREG DONNELLY: Let us assume he meets the criteria.

Ms DILL: You mean he would be ruled out just on the grounds that he was male and single?

The Hon. GREG DONNELLY: What I am saying is that through the counselling process there was nothing identified that would lead to the conclusion that he was not in a position to properly look after a child who had been born through a surrogacy arrangement. There was nothing to indicate that he could not do that.

Ms DILL: Actually that is a question I would really like to take back. I do not feel that I should speak for people without checking with them. It is curious. I am researching this, but I have never had anyone ask me that. It is a very good point, if we are saying we would see two men as people who have established their own family and want as a natural extension of that to be parents, and for women who are single who would like to have a child, what they do is get donor sperm. May I take that and get back to you?

The Hon. GREG DONNELLY: Yes.

Ms DILL: And I need to get back to you by?

CHAIR: April 3.

The Hon. JOHN AJAKA: Could you add to that if you are aware of any male person actually going to a clinic and asking?

Ms DILL: That is an absolute no. To be honest, I am not aware of any single woman of any sexual persuasion going to a clinic to look for surrogacy. It has just never been raised. We have discussed this in ethics committees and with people broadly and it has never once come up, which is curious, but it is worth asking about.

The Hon. GREG DONNELLY: I guess logically it follows if there were three adults, and I suppose you could extend it to whatever you like in terms of a number. I am trying to conceptually come to terms with moving away from originally—and you would say now inadvertently—what your position was—

Ms DILL: It was not intended to exclude anyone.

The Hon. GREG DONNELLY: No, I appreciate the point you are making, but if you move away from that paradigm of providing surrogacy arrangements, where do you, to the extent you can, draw a line logically and say "yes" or "no" in terms of the provision of a surrogacy service?

Ms DILL: Where do you draw a line, and then the question will be why?

The Hon. GREG DONNELLY: What I am leading to is that we are looking at potentially creating a law in this State, which would be very black and white in terms of regulating surrogacy in this State. You rule things in or you rule things out, which in terms of some of your earlier evidence can obviously create some issues because I think in earlier evidence you were saying, "Well, you have to be mindful that they are individual cases and individual circumstances".

Ms DILL: Yes.

The Hon. GREG DONNELLY: I guess it becomes a challenge for a government and a parliament to produce what is, in effect, a law that deals with the common good across the State in terms of its provision and how does that interface with individual personal circumstances.

Ms DILL: Yes, the link between utilitarian and autonomous. That is a really good question, thank you. We will give some thought to that and get back to you.

The Hon. AMANDA FAZIO: Recently I saw a documentary about an English family where there were three sisters. One sister was not able to have a child and the other two sisters wished to help her, so one donated an egg, which was fertilised by the husband of the woman who could not have children and implanted in the other sister who carried it to term. In the documentary, it seemed to me that it worked fine, to the extent that they said they would be prepared to do it again if the younger sister wanted to have a second child. Do you think that that sort of arrangement is acceptable?

Ms DILL: That sort of carries the concern about the relationship between the brother-in-law and the surrogate. Is that the question—is that a healthy thing to do?

The Hon. AMANDA FAZIO: Yes. It seemed to me to work fine but from some of the evidence we have heard so far in the inquiry it seemed to be an unusual case and might have blurred the lines of what is acceptable under existing practice in New South Wales.

The Hon. JOHN AJAKA: Because so many parties are involved—three women?

The Hon. AMANDA FAZIO: Yes, because mostly there are only two women involved, but this was two elder sisters helping—

Ms DILL: One woman donated the egg and the other women gestated. That is probably a very good way to separate the connections because let us say they went to one sister and said they needed an egg and that sister said, "Okay, I'll donate the egg. It will be easy. I'll just get inseminated." Breaking it up seems to be a wiser way to go because everyone is a little more distanced from the child that will be there. Again it all comes down to the preparation. I think that is important. What underscores that for me is the Baby Evelyn case. It was an incredibly sad case in Australia where people with the very best of intentions and the highest motives wanted to help their friends have a child and it ended up having a huge and negative impact on both families. It has just destroyed them. Now we have a situation where the child is back with the surrogate and the relationship has broken down. The intended father visits every so often. You just cannot imagine what that is like for all the families. One has to hope that in time they will be able to come to understand each other's position.

In relation to the preparation, when I was speaking with the Kirkmans—I have their permission to mention this—I wanted to ask this question but it sounded really tacky. They said, "No, ask what you want." Maggie said to me, "We had already discussed what would happen if Linda gave birth to Alice and wanted to keep her and we decided if she did that I wouldn't be any worse off and I would just be an attentive aunt." My question was, "I think that's really wonderful and noble of you to have that view but honestly do you think that would not have created tensions in the family?" It just seemed to me to be fraught with potential anguish and tension. They were quite adamant. They said no. I asked Linda—I asked them together—and she said no. She was one of the people who persuaded me. She said, "If Maggie had said 'I really need you to commit to give up the child at birth' I would have felt the pressure of that."

These are very articulate know-themselves women. She said, "When Maggie said, 'No, you wait till the child is born'—they had explored endless options about possibilities—'you make the decision to give up the child or not' it freed me up. I did not feel at any time under pressure and curiously I never felt at any time connected to Alice more than I would be. Sure it was an unusual pregnancy but I never felt any more connected. I was free to do that. I didn't feel like I was being coerced or pushed in a direction." I did not really understand that but it worked. Maybe we need to allow for these things so that people feel respected in that process.

Ms SYLVIA HALE: I find that very interesting. I think you used the phrase "it is paradoxical and karma". You also say it is critical that the baby be removed from the birth mother as soon as possible.

Ms DILL: I do not think I said that.

Ms SYLVIA HALE: Sorry, I must say you did not use those words but I think you suggested that it possibly go to the intending parents as soon as possible.

Ms DILL: No, I would not even say that. That would seem presumptuous to me. I am the last one to be handing out advice on matters because if it went wrong everyone would be at me. In all of these arrangements the surrogate gives the baby to the parents at birth. The intending parents usually attend the birth. That arrangement is made with the surrogate. The hospital knows about it and they just give the child to the intending parents at birth.

Ms SYLVIA HALE: That is what I was interested in. If there is the assumption that the child will be handed to the intending parents at birth, does that not deprive the birth mother of the opportunity to bond with that child and is that a loss that the birth mother suffers?

Ms DILL: I think it is important to note that the decision about whether the child will be given up is solely the surrogate's.

Ms SYLVIA HALE: Sure. So provided that is totally understood by everybody that that is the essential pre-condition—

Ms DILL: Absolutely. Part of their assessment is to see a family law lawyer and the lawyer will make that very clear. It will be made clear to them in a number of different ways by the psychologists. That decision must clearly be the surrogate's. When people know this and they want to enter a surrogacy arrangement it is like, "Okay, this is not straightforward; we do one, two, three, four and five." It is a case of, "We will do this." At this point the surrogate has a decision to make and whichever decision she makes she is supported by the law. Interestingly, in my research about how nervous people were that the surrogate would not give up the child at birth the feedback I had from the parents was that they were not worried about that, because it is clearly the surrogate's decision. She has all the hospital staff around her at the time so she is not on her own. They felt they were well prepared and everyone understood the surrogate did not want to have another child. But a few surrogates said they were nervous that if the child was born the parents would not want to take it, even if it was healthy. The surrogates did not want to be a parent.

Ms SYLVIA HALE: That is interesting. On a somewhat different topic, we had evidence today from TangledWebs, which is an organisation predominantly of adults who have been created through donor conception practices. The view they expressed in their submission was that the lifelong consequences of surrogacy in the life of the child may not be immediately recognised. They say identity confusion, genealogical dislocation and complex family relationships characterise adoption and they suggest they also characterise surrogacy outcomes. Did I hear you say earlier that you had a similar organisation of young people who were the result of artificial reproduction techniques? What would their view be of this submission?

Ms DILL: I think they raise a very important point and it is no doubt informed by their particular circumstances. Thankfully donor insemination is now carried out in a much more open and responsible way and that has to be good for everyone. It is not perfect but it is a lot better. I found the Baby M case in the United States, which I am sure you are familiar with, fascinating. That is Melissa Stern. I had to hunt it down. "I love my family very much and I am very happy to be with them." She in fact formally terminated all parental rights of Mary Beth Whitehead when she was 21. That was a very sad case. But Alice Kirkman has to be a very good case. You can read it. "I have been around for 14 years. I am in year 9 at high school." I think what is important is this idea that the surrogate shall have an ongoing relationship. She wrote it at age 7 and I am told now it was Alice's first opinion piece. Maggie resisted editing it. It was dreadful for her. She wrote: "I've got a dog whose name is Henry. He's the bestest dog around."

She does not like her cousins. "I'm lucky that I'm an only child because there's no-one to bug me except my mum and dad. I'm glad that I'm alive and I'm lucky to be alive. My family is the best family ever. My mum and dad are the best." Then she lists her family members. "Grandpa had a good life but died last year." This is someone who at age seven was able to articulate who she was. Why did she do that? It was because she had been told of the circumstances surrounding her birth from the time she was able to understand in a way that did not attach shame to it. That is what should happen, because there is no shame attached to it. But it is important that people understand this in their preparation and are encouraged. That is why I was hoping for a law that at least permitted it, not encouraged it—we do not need that—so that it would be very easy to speak to children born in this way. They would understand that this was an unusual way because of whatever reason.

CHAIR: I would very much like to thank you for the work you have put in today. It has been very useful to us, as is your submission. I am sure the answers to the questions on notice that the secretary will be contacting you about will be very useful to us. Is there anything else you wanted to say?

Ms DILL: Thank you very much. Mr Clarke, I was not trying to be evasive. Having had so many judgements made about me going through IVF I have learned a few lessons. When things seem a bit strange I ask myself to what extent I would impose things on others. I appreciate your questions because they help inform my thinking. It is important to get a range of views because it allows you to explore. The questions Mr Donnelly raised are very important questions because if the law is not consistent it is prejudicial one way or another. Thank you very much for the opportunity. I appreciate your openness.

(The witness withdrew)

RAYMOND CAMPBELL, Director, Queensland Bioethics Centre, before the Committee via teleconference, sworn and examined:

CHAIR: Good afternoon, Mr Campbell. It is very good of you to spare the time today.

Mr CAMPBELL: Good afternoon. I am happy to be with you.

CHAIR: The Committee has a policy in relation to adverse mention and would prefer that witnesses avoid mention of other individuals unless it is absolutely essential to address the terms of reference.

Mr CAMPBELL: Understood.

CHAIR: What is your occupation?

Mr CAMPBELL: I am an ethicist.

CHAIR: In what capacity are you appearing before the Committee? Are you appearing as an individual or as a representative of an organisation?

Mr CAMPBELL: I am Director of the Queensland Bioethics Centre so I appear as a representative of the Queensland Bioethics Centre.

CHAIR: Are you conversant with the terms of reference for this inquiry?

Mr CAMPBELL: Yes, I am.

CHAIR: If you should consider at any stage that certain evidence you wish to give or documents you may wish to tender should be heard or seen only by the Committee, please indicate that fact and the Committee will consider your request. If we give you some questions on notice that you prefer to have time to get back to us with an answer, if we could have those by 3 April we would be grateful.

Mr CAMPBELL: Okay, that is very good.

CHAIR: The secretariat will be contacting you with whatever the questions are and organising that.

Mr CAMPBELL: That is fine.

CHAIR: Would you like to start by making a statement?

Mr CAMPBELL: Yes, I would, a very brief one just to recap and note something that was not in my submission. As noted in the submission, I believe that there are many ethical problems related to surrogacy—problems which cannot be overcome by Government legislation. I believe one of the key questions is whether surrogacy itself can be said to be in the best interests of the child—an expression which we have heard a lot, I am sure. I think it is all very good to talk about how we protect the best interests of the child after surrogacy has occurred, but it appears to me that the central question for the inquiry is whether surrogacy is a good thing for a child and, depending on that answer, whether the Government should involve itself in regulating surrogacy in any way.

I presume that the inquiry has already been given references to various so-called empirical evidence from various sides of the discussion. I think it would be apparent to the Committee that this question cannot be resolved by a simple appeal to empirical evidence. However, if one were to rely simply on the empirical evidence we have to date, I think you would have to say there is certainly no scientific consensus that harm would not ensue to the child and possibly others as a result of surrogacy. Therefore I believe we should follow what is called a precautionary principle and seek to prevent the harm.

However, as my submission points out, it is just a matter of empirical evidence. Surrogacy touches upon the understanding of the nature of marriage, the nature of parenting, and the responsibility we have to respect others as equal and dignity to ourselves. So whatever the decision the Government makes on this issue, it will impact upon society's understanding of marriage and upon the parenting and on the place of the child in

our society. It is a very onerous task that you have as a Committee to advise the New South Wales Government. I thank you for the opportunity to be with you and assist in any way that I can.

The Hon. JOHN AJAKA: If I can look at it this way, I guess, having regard to your submission and what you have just said, this Committee is faced with three choices. Choice number one is do absolutely nothing and leave the status quo as is in recommendations; choice number two is to in some way recommend that surrogacy be stopped, prevented; choice number three is to regulate and accept the fact that surrogacy is existing as it is. Am I to understand that you are suggesting we just keep the status quo as is, or are you suggesting that we find some way to stop surrogacy from happening?

Mr CAMPBELL: Human nature being what it is, you will not stop surrogacy from happening. Surrogacy has been around for quite some time—longer than I think some people realise. Artificial insemination opened up the possibility for surrogacy and we have good reason to believe it happened in secrecy for some time. So, no, I do not believe you will ever totally prevent surrogacy. Having, though, an eye to the common good of our society, I think Government has a role to try to discourage surrogacy, and there would certain procedures such as the ones I have recommended in my submission, which would serve to have a discouraging function and would certainly have ways of dissuading people, for example, who are involved in assisted reproductive technologies from getting involved in surrogacy.

The Hon. JOHN AJAKA: One of my concerns would be that if we accept that the best interests of the child are paramount, I personally would hate to see surrogacy, if I can use the word, go underground, where there are no checks, no balances and we are in no way assisting in ensuring that the best interests of the child are protected. Whereas with some form of legislation, some form of control, ensuring some checks and balances we can at least ensure or attempt to ensure that the best interests of the child are being looked at.

Mr CAMPBELL: I understand the point you are trying to make but you are addressing the best interests of the child after something has occurred. You are not addressing the question: What can we do to prevent something which is not in the best interests of the child actually occurring in the first place and doing the maximum we can to discourage it? I think the harm that we do to the common good, the common fabric, by passing laws which seem to endorse surrogacy would be such that that is a greater harm to a greater number of children. We would still have other mechanisms in place to seek to protect the welfare of children, where people obstinately go ahead with surrogacy even though it is discouraged by Government and society.

The Hon. JOHN AJAKA: Let us assume we accept to discourage surrogacy but we know it is still going to occur, and we discourage by preventing advertising, by preventing Medicare refunds, any other matter that you might come up with, but the fact is that it does occur, the child is born and then we have all these issues in relation to birth certificates. We have all these issues in relation to intestacies provisions. We have these issues in relation if the child is sick and needs an operation, and the surrogate is not available and the parent the child has been living with for three years. Do we have a responsibility, from an ethical point of view, to at least ensure that the innocent person in all of this equation is the child? Surely we should be bringing in laws and regulations to protect that child.

Mr CAMPBELL: We already do that in various ways when the child is not properly cared for by its parents. So yes, we can put regulations in place such that if someone is not properly caring for the child, and the child should be subject to the processes which ensure that the child's best interests are cared for but not by way of in any way condoning, collaborating with some kind of surrogacy arrangement. There are other ways of doing that.

The Hon. GREG DONNELLY: Can you hear me clearly?

Mr CAMPBELL: Yes, thank you.

The Hon. GREG DONNELLY: I have a small number of questions. First of all, we have had evidence today, primarily today but also on other occasions that we have been hearing evidence, with respect to the position in New South Wales, and I would like to focus on New South Wales if I can for a moment. We have essentially a very bare bones arrangement. There is only a single piece of legislation and within that legislation it effectively prohibits commercial surrogacy, and that surrogacy arrangements are void. In other words, they are unenforceable. However, that is not the full picture because in conjunction with that we have the major service providers of surrogacy services, like Sydney IVF, operating—there appears to be no evidence they are not doing this—in accordance with NHMRC guidelines that deal with surrogacy, what appears to be an industry code that

appears to operate, certainly in this State and also internal company policies or procedures. So to get the full picture about how surrogacy is operating in this State you have to look at that as a totality.

When one, as we have been able to be today, is exposed to the guidelines of the companies, in conjunction with the code, in conjunction with the NHMRC guidelines, there is quite a fabric of conditions which appear to be operating in this State, which are actually sort of de facto placing surrogacy within a framework. So we seem to have almost de facto regulation of it outside the prescription of laws passed by the Parliament. My question to you is: In terms of these guidelines that exist—I am talking about national guidelines, industry codes and individual company guidelines—what is your view about these guidelines? Are they something that provides some comfort to your concerns that you enunciate in your submission, or you have other concerns about these guidelines?

Mr CAMPBELL: Guidelines, if they are simply guidelines, are as effective as the integrity of the people who swear to abide by them. There we would seem to have a bit of a mixed bag. The reproductive technology industry in Queensland has generally been guided by guidelines. I do not think we have had what you might call much cowboy activity or attempts to move outside those guidelines. In other words, the industry seems to have generally accepted them. If the guidelines are also tied to funding and/or licensing, they are even more effective; there is more incentive for people to abide by the guidelines. So if there is some sort of impact attached to them, there is much more chance of them being effective. Generally, I think guidelines can be a good way to approach matters but, as I said, if they are just guidelines then it depends upon the integrity of the individuals seeking to operate under them.

The Hon. GREG DONNELLY: Moving on to your submission, the issue I want to deal with is this: I have explained to you that in New South Wales we essentially have a light touch regulatory framework, which is the State law—I will put the guidelines to the side for a moment. In your submission—and I am looking at page 10—you articulate the position, and I quote:

> Furthermore, the Government should seek to discourage surrogacy by making it an offence.

You then outlined a few points, which I presume you argue should go into a piece of legislation. Is that your position?

Mr CAMPBELL: Broadly speaking, that is my position. However, there may be other ways in which to accomplish the same end. I am not a lawyer, so I am not conversant with all the different ways in which we might seek to include disincentives. To me that is a broad brushstroke way of saying that these things would be disincentives to legislation. There might be another way of accomplishing the same goals in some of those areas.

The Hon. GREG DONNELLY: What is your knowledge of the surrogacy arrangements in Victoria? Do you have any knowledge of those arrangements?

Mr CAMPBELL: Not a great deal in the sense of what has most recently happened in Victoria. The original legislation in Victoria was fairly carefully crafted and it took into account a wide spectrum of views. But much of what had been common agreement in the original legislation seems to have been thrown out in the last review. However, I have not gone into it in detail; I am sorry.

The Hon. GREG DONNELLY: Just so that we understand the position in Queensland, can you explain to us what is your understanding of the surrogacy position in Queensland?

Mr CAMPBELL: We have just conducted an inquiry. Queensland was the one State in Australia in which altruistic surrogacy, and all forms of surrogacy, were a criminal offence. We just conducted an inquiry into that and the first terms of reference of that inquiry were whether altruistic surrogacy should be decriminalised. To that inquiry I argued in favour of decriminalising surrogacy as it relates to the surrogate mother and to the intending parents. The criminalisation of the surrogate mother or the commissioning parents has never been part of the platform of quite a few of us who are opposed to surrogacy as such.

There is an interesting history of how it came to be a criminal offence in Queensland, which I will not go into now. The present inquiry has delivered its recommendations but the Parliament has not yet reported back. As you know, we are in election mode at the moment. The recommendation of the parliamentary inquiry was certainly to decriminalise altruistic surrogacy. There are then another 25 recommendations that you might have already seen.

The Hon. GREG DONNELLY: This morning Myfanwy Walker, who resides in Melbourne and who represents an organisation called TangledWebs Inc, made a teleconference contribution to the inquiry. The thrust of her testimony was—and you would not have heard it—that TangledWebs is against the practise of surrogacy. Whilst its position is not based on religious grounds, it equates to the position that you advocate in your submission. The interesting thing about her evidence was that she was drawing on her own experience as a child who was born through donor conception. That is the nature of the membership of TangledWebs; individuals have been born through donor conception and ART procedures.

We are now 20 years down the track since donor conception got underway—in other words, donor conception commenced in the 1990s—and the first generation is growing into adulthood; in other words, they are in their late teens or in the first half of their first 20 years. There is some evidence to show, either domestically or internationally, that people who have been born through surrogacy or ART procedures are now articulating their concerns, issues or matters associated with the way in which they have come into this world.

Mr CAMPBELL: We have heard evidence from those such as Myfanwy Walker who are the result of donor insemination, and that goes back much earlier than the 1990s.

The Hon. GREG DONNELLY: That is true, yes.

Mr CAMPBELL: Artificial insemination using donor sperm has been witnessed for a long time. We have heard a bit of evidence from members of a generation who are just starting to find their voice to express something of their experience. TangledWebs is just one website where some of that experience is being articulated. On top of that you have whole networks in which people are trying to find out their biological origins. There is a great quest amongst those who have discovered their origins in that sense.

There is a large body of evidence—I referred to it briefly in my submission—regarding their experience of donor-conceived children. We now have a body of evidence regarding children who were born, for example, as a result of IVF procedures when donor gametes were used because they are still quite young. A whole lot of questions need to be asked about how we go about establishing that. Until someone in this area decides to say something about this issue, it is difficult to conduct research to find out, or to ask those kinds of questions without breaching privacy.

The Hon. GREG DONNELLY: Thank you.

Ms SYLVIA HALE: I would like to go back to some of the issues that were raised by Mr John Ajaka. I think you agreed that children who are the result of a surrogate arrangement suffer disabilities such as intestacy provisions, access to timely medical treatment, and the very nature of the birth certificates that are issued to them. Would your position be that those issues should be dealt with positively, even though in dealing with them it might be tantamount to recognition of the legality of surrogacy?

Mr CAMPBELL: My position would be that we should treat it much the same as adoption. Rather than condoning the surrogacy arrangement of the surrogate mother who wants to give up the care of her child, she does so in a process similar to some other mother who, for some other reason, feels that she is unable to support her child, and the child's best interest is then decided by a judicial process, thus ending a surrogacy arrangement.

Ms SYLVIA HALE: Provided there was consent from the surrogate mother to the handing over of the child, and provided that the courts were dissatisfied with the ability of the intending parents to raise that child adequately, would you say that the courts should facilitate an outcome?

Mr CAMPBELL: If the intending parents have a genetic biological connection to the child I think the court should take that into consideration.

Ms SYLVIA HALE: What if they do not have a genetic biological connection?

Mr CAMPBELL: I do not think they have any special standing towards that child if they have no genetic biological connection to it.

Ms SYLVIA HALE: Often people who adopt children have no genetic relationship.

Mr CAMPBELL: They would be in same position as someone applying for adoption.

Ms SYLVIA HALE: You would not stand in the way of that arrangement, provided the prospective adopting parents met the various criteria and the mother was prepared to hand over the child? In that context you would be quite happy to ensure that all the impediments surrounding that child's birth were removed.

Mr CAMPBELL: Part of my conditions would be that they had a genetic connection to the child.

Ms SYLVIA HALE: What if they do not have a genetic connection?

Mr CAMPBELL: Then I would see the child as being put up for adoption and I think they would join the queue.

Ms SYLVIA HALE: In that context, when the birth mother has expressed a strong preference for these parents to look after that child, should her wishes not be taken into consideration?

Mr CAMPBELL: I see where you are going with that. When we talk about open adoption that could be taken into consideration, yes. I would take that on board.

Ms SYLVIA HALE: In your submission you refer to the Prime Minister's apology to a generation of indigenous people. Would you agree that having to make that apology is indicative of how notions of what constitutes the best interests of the child have changed dramatically in a relatively short space of time? We are apologising to children who may have been removed from their families as late as the 1960s or 1970s when it was strongly argued by government authorities that it was in the best interests of the child to remove children from indigenous families and to place them in orphanages, or whatever. Do you believe that society's perceptions of what constitutes a reasonable relationship or family situation in which children grow up is changing so rapidly that we should be adjusting our laws to cope with them or to meet those expectations?

Mr CAMPBELL: Let me make a couple of points to contrast that example. In the case of indigenous children, as you said, we now have a different perspective of what might have been the best interests of the child, without judging either way. However, you are talking about a situation that existed and that people are trying to remedy. They sought a remedy by removing it. A situation existed that people thought had to be remedied where children were already in existence and needed to be supported in some way. The thing to remember regarding surrogacy is that we are talking about intentionally creating a situation—intentionally bringing children into a situation.

We are not talking about remedying a situation that already exists, as we do in adoption; we are talking about intentionally creating a situation, which is significantly different and which also makes our legislation around it significantly different. We know that we have many different kinds of family groupings within society today. As I pointed out in my submission, once again you have to step back from this and ask, "Which ones did we set out intentionally to create"? Someone does not get married with the intention of not having children, getting divorced and remarrying someone with children, but that happens. Generally speaking, someone does not become a single parent with the intention of being a single parent, although that is what appears to be happening today. There is a difference between what happens in our life story and what we intentionally set out to create. In surrogacy we are talking about the intention to create a new situation, which is totally different.

Ms SYLVIA HALE: As you conceded at the outset, surrogacy exists and no doubt it will continue to exist. We need to address the problems that are created just because of its very existence at the moment. It exists when there is a biological relationship between a child and the surrogate mother, and people can go overseas and possibly enter into a commercial or other relationship, or maybe even an altruistic relationship, and a child can result, and that child is then raised by the family, the couple, or the individual who went overseas. Whether we want it or not, these complex situations arise. Surely we are better to try to deal with the reality that exists at the moment rather than try to act as though that reality does not exist.

Mr CAMPBELL: We have many things happening in our society that we would probably prefer not happen, even though they are not illegal. I do not see the government stepping in to try to necessarily facilitate it from happening. I do not think that kind of logic really follows. We are turned back to the situation of what we as a society are going to endorse as being an appropriate way of bringing our children into being and having them raised and nourish our society. What do we stand by? What do we hold out? Then when things happen,

such as a parent dies, we have other measures in place to try to assist the child. That is at the heart of the question. Once you start to get down that track, the law has a very educative function. When you institutionalise surrogacy, you are saying something about how we see the formation of family. For government to go down that path is heading in a negative direction for our society and our future children.

The Hon. DAVID CLARKE: Mr Campbell, the thrust of your submission is that government should not become involved in regulating altruistic surrogacy. Assume for a moment, for the sake of argument, that the Government did decide to do so in New South Wales. We have to consider what format that will take. I want to raise this issue with you: surrogacy involving same-sex commissioning couples, especially where there is no genetic link between either member of that couple to the child. If there were going to be surrogacy laws, do you have a view as to what the attitude of the Government should be on that?

Mr CAMPBELL: I think you are experimenting with the lives of children in a very gross, irresponsible way, if I may be quite blunt about it. That would be, to my mind, the extreme end of the outcome of surrogacy. That would be the thing that I would put at the end of the spectrum. There are certain things before that which I would say on the basis of harm minimisation you would begin with. To go right to introducing same-sex parenting, so-called, is an abdication of our responsibility towards our children.

The Hon. DAVID CLARKE: You would say that as the interests of the child are the paramount consideration, before we move into those uncharted waters, which flow against historic precedent, we need to set a very high onus. We do not base it just on the balance of probabilities of whether being raised in a same-sex household is going to be in their interests. We have to put the bar far higher than that, particularly as it is going into uncharted waters. Would that be your general view?

Mr CAMPBELL: Definitely. For example, the first step I would take, as I said, would be harm minimisation. If government were going to legislate surrogacy my first, if you like, fallback position would be that the intending parents would be the genetic parents of the child and the surrogate would be a gestational surrogate. To allow surrogacy at that level keeps the harm, if you like, the possible confusion affecting the child, to a minimum. I still think there are a lot of problems regarding the effects upon the surrogate mother in that case, and I am certainly not speaking in favour of it. But I think you can see where I am getting at. I am saying if you are going to enter into it, enter into that minimal level and leave the others out because the further down the track you go the more risk of harm you are creating for the child.

The Hon. DAVID CLARKE: While it is the case that there are bad fathers and bad mothers, the situation is, all things being equal, it is far more preferable for a child to be raised, where possible, in a family situation that involves both a mother and a father?

Mr CAMPBELL: That is indubitable. Even with the empirical evidence, comparing with other groups, not with same-sex, we know that generally children do best in a stable, married, heterosexual family. There are statements regarding the effects upon the nature of parenting, I think there is a thing such as the nature of parenting. Men and women are different. There is a biological difference, which is obvious to anyone. Unless you are a complete dualist, you understand that our biological differences affect us as persons. So there is a personal difference and, therefore, we parent differently. We parent as male and we parent as female. I believe that the best thing for a child to experience is a male parenting and a female parenting. We could talk about some of the obvious differences regarding parenting in that area. You can put a child on as many male breasts as you like and the child will not be able to suckle to achieve nourishment. It is just a simple biological fact, but it is much more than a biological fact.

CHAIR: The Hon. Amanda Fazio, do you wish to ask questions?

The Hon. AMANDA FAZIO: I do not have any questions.

CHAIR: There are no further questions. Mr Campbell, I thank you very much for the work you have put into your submission and for talking with us this afternoon. In this particularly inquiry, although it is not groundbreaking, it is the first time we have used the teleconferencing system. It has meant that we have been able to speak to more diverse people on this issue. We are very grateful for your participation. Did you wish to say anything before we finish?

Mr CAMPBELL: Just one thing, Madam Chair. Mr Donnelly made reference to religious arguments. Although in my submission I refer to some doctrine of the Catholic Church and the Queensland Bioethics

Centre is an agency of the Catholic Church, my fundamental background is philosophy and the arguments I have put are based upon reason. They are not necessarily founded on special revelations of the Catholic faith. I would like to put on record that I am arguing from a point of view of reason, not simply from an exclusive point of view of faith.

CHAIR: Thank you. You have questions on notice that we did not reach and the Committee may have further questions. We would ask that you respond by 3 April 2009. The Committee secretariat will be in contact with you about this matter.

Mr CAMPBELL: Thank you, Madam Chair.

CHAIR: Thank you very much for your evidence.

(**The witness withdrew**)

(**The Committee adjourned at 5.10 p.m.**)