Mark Warner
Committee Clerk
Legislation Committee
Via email: lclc@parliament.wa.gov.au.

Dear Mr Warner:

Re: *STANDING COMMITTEE ON LEGISLATION*
Human Reproductive Technology and Surrogacy Legislation Amendment Bill 2019
Questions on Notice

I provide to you my answers to the questions I took on notice, during my appearance before the Standing Committee on Legislation on 20 May 2019.

1. **If it the case that in those two states [Queensland and NSW] it is a requirement before the Family Court determines the parentage order that the court has before it a report from an independent counsellor, my question is: who has the responsibility for getting that independent counsellor's report and putting it before the court?**

Background:

Queensland:
Surrogacy Act 2010 (Qld) ss 25(1)(i) and 32 *(Requirement for 'Guidance Report')*
A surrogacy guidance report, prepared by an independent and qualified counsellor (defined in s 19), must have been given to the court. This report cannot be done by the same counsellor who gave counselling to any of the parties before they entered into the arrangement.

New South Wales:
Surrogacy Act 2010 (NSW) section 17 (*Requirement for 'independent counsellor's report')*
Surrogacy Regulations 2016 (NSW) reg. 7 ('Definition of 'independent counsellor' for purposes of section 17).

Response to Question 1:

The reports require assessment of (among other things) each of the parties' understanding of the transfer of legal parentage, openness about genetic and birth history for the child, contact arrangements, arrangement, whether consent requirements have been met. Thus, all parties would be involved.

There is no prescription under the Act as to who has responsibility for obtaining the report. However, as it is for the purposes of an application for transfer of legal parentage and is required to be placed before the Court (with the Counsellor's affidavit) by the Applicant. As the application is made by the intending parents, they would place it before the Court.

In addition, as reimbursement of costs is permitted in altruistic arrangements – any costs incurred by the altruistic surrogate mother would be reimbursed.

2. Further to that area on the risks to surrogate mothers, the committee has received a submission, which is public submission number 18 and which provides a number of peer-reviewed articles on this issue. Would you be willing to take on notice a review of submission 18 and provide the committee with your comments on it?

Response to Question 2:

Submission 18 presents a limited number of studies that present findings of certain risks (hypertension, multiple pregnancies, pre-eclampsia, premature birth) related to egg donation and/or gestational surrogacy. The submission the posits that providing surrogacy to single or same-sex coupled males will 'increase risks to women and children in Western Australia'.

I make the following comments:

1. In relation to consent:

I provide the committee with an extract from a book I have authored *Law and Ethics in Australia for Health Practitioners* which will be published later this year (Elsevier, 2019) regarding the requirements for consent under Australian law. I provide the extract as it was written with time to consider the requirements for lawful consent, and I believe it is informative to the considerations of the committee, and in regard to Submission 18:

The law seeks to protect the right of patients and clients to choose what is done to their bodies, via legislation and the common law.[1] The legal requirement for a valid consent by the patient prior to any interference applies regardless of whether the patient would benefit from the treatment or be harmed by refusing the procedure. [Lawful] consent thus includes the right to choose what treatment a person will undergo, and the right to refuse treatment a person does not wish to have.

For consent to be valid in a health care setting, the person must

- have the legal capacity to make a decision about the proposed treatment;
- be informed of and understand the broad nature or character of the treatment and its effects;
- give consent that relates specifically to the proposed treatment or intervention; and
- have made the decision voluntarily, without pressure or coercion, misrepresentation, duress, or fraud.

Capacity

Every adult of sound mind is presumed to have 'capacity' or to be legally 'competent' to provide a valid consent or to refuse to consent to treatment, unless there is evidence otherwise.[2] The legal capacity to consent is defined at common law, and in various ways by statutes relevant to specific situations (for example, mental health, guardianship and administration, and blood alcohol legislation; legislation regarding protection of children at risk). Generally, capacity is defined as 'the ability to understand the specific situation, relevant facts or basic information regarding the decision and choices that may be made; evaluate reasonable implications or consequences regarding the

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[1] *Department of Health and Community Services (NT) v JWB (Marion's case)* (1992) 175 CLR 218.

2. See comments in *Marion's case* at 233 and in *Rogers v Whitaker* at 193. See also the more recent decisions of *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88; [2009] NSWSC 761 and *Brightwater Care Group (Inc) v Rossiter* (2009) 40 WAR 84; [2009] WASC 229 have expressly acknowledged this point in the context of dealing with the refusal of life-sustaining treatment.

decision and choices; use reasoned processes to weigh the risks and benefits; and communicate relatively consistent or stable decisions and/or choices'.[3]

….

Provision of information

When providing information to a patient it is incumbent on the health practitioner to ensure that, prior to obtaining consent, the patient understands the nature and effect of the information that has been given.[4] …The health practitioner should also check the understanding of the patient, for example, by asking the patient to explain in their own words what they have understood.

….

Consent must be voluntary

… consent to treatment must be given voluntarily and freely. This requirement will not be met if consent is coerced, induced by fraud or deceit, induced by the impairment by drugs on the person's faculty of reason, brought about by constraint on a person's freedom of will, or a product of the power relationship between the person who is 'consenting' (the patient) and the health professional. Such factors, when present, mean that a decision no longer truly represents the patient's will and any consent given in such circumstances will not be valid.

2. Consent to undergo assisted reproductive treatments for the purposes of a surrogacy arrangement; consent to act as an altruistic surrogate mother

Noting the submitted research in Submission 18 and the above discussion of consent I further note to the Committee that:

- Medical procedures carry with them some risks.
- Some medical procedures carry specific risks.
- There is some evidence – such as that supplied in Submission 18 – about specific risks associated with assisted reproductive procedures, including some research related to egg donation, multiple births, and surrogacy pregnancies.
- However, a search of the research reveals papers that reflect variable findings; risk factors that apply to anyone undergoing ART (whether for surrogacy or not).
- Some such risks may also be increased in jurisdictions, that for example, do not practice single embryo transfer (such as the United States). Note Australia has a single embryo transfer policy –supported by earlier research that this has better results for women and children. (See Alex Y. Wang, Sandra K. Dill, Mark Bowman and Elizabeth A. Sullivan, *Gestational surrogacy in Australia 2004-2011: treatment, pregnancy and birth outcomes* – paper supplied to Committee with this reply).
- There are also differential results in the research on the health outcomes for children born as a result of ART procedures, and we need to be mindful that procedures once used have advanced. (On outcomes for children born via IVF generally in Australia see a recent study - Jane Halliday, et al. 'Health of adults aged 22 to 35 years conceived by assisted reproductive technology', *Fertility and Sterility*. DOI: 10.1016/j.fertnstert.2019.03.001'

Consent

- A woman who is freely and voluntarily entering into a lawful altruistic surrogacy arrangement who has the capacity to consent, also has the agency to decide whether or not she consents to such risks. That is, in Australia, including Western Australia, provided

[3] Sonia Allan and Meredith Blake, *Australian Health Law* (2018) [6.31]-[6.32].

[4] See for example the case of *Ljubic v Armellin* [2009] ACTSC.

she is an adult with capacity, and she understands the broad nature of treatment, then she can consent to the treatment.

- Once a woman is provided information about the broad nature of the treatment, and informed of the risks based on current research knowledge and findings, then she is free to consent to becoming a gestational surrogate.

3. The assertion in Submission 18 that allowing single men and same-sex couples to access surrogacy increases risk to children.

- I find this assertion logically flawed.
- It conflates the medical risks of treatment with the consideration of who is permitted to enter into a surrogacy arrangement.
- There is no evidence whatsoever of increased risk to a woman who consents to be an altruistic surrogate for example,
    - for her single sister versus for her single brother;
    - for her female friend in a same-sex relationship versus for her male friend in a same-sex relationship
    - for her sister who has female sex organs but who identifies as a male
    - for her brother whose wife cannot carry or bear a child.

That is, no evidence that there is increased risk to women who are altruistic surrogate mothers for single women, married women or men, or defacto heterosexual couples, versus being a surrogate mother for a single male or same-sex male couple.

- I am assuming that the logic applied by the author of Submission 18 is based on concern that if access by single men or same-sex couples is permitted there may be more altruistic arrangements – but this is equally flawed. It is not that such arrangements do not take place, it is that they are currently taking place interstate or overseas. There is no greater risk to women and children if they take place in Western Australia, indeed the findings to my review found that excluding people from or creating barriers to lawful altruistic surrogacy in Western Australia meant some people were led into much risker situations involving commercial arrangements, multiple embryo transfers, and more overseas.

I hope that the above is of assistance.

Kind regards,
Sonia

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