

Consultation on Aspects of Assisted Reproductive Technology

Summary of Submissions:

Part One – Surrogacy Arrangements involving Providers of
Fertility Services

Part Two – Donation of Eggs or Sperm between Certain Family
Members

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Introduction

On 6 July 2007 the Advisory Committee on Assisted Reproductive Technology (ACART) released a discussion document, *Advice on Aspects of Assisted Reproductive Technology: A consultation paper on policy issues*.

It included draft guidelines on surrogacy arrangements involving providers of fertility services, donation of gametes between certain family members, embryo donation, and pre-implantation genetic diagnosis (PGD), as well as proposed parameters for advice on related issues, including use of donated eggs and donated sperm, embryo splitting, import and export of donated gametes and embryos, and informed consent.

The discussion document was mailed to 272 individuals and groups that had previously registered interest with ACART, including government agencies, regional Te Puni Kōkiri offices, researchers, academics, providers of fertility services, fertility consumer groups, ethics committees, bioethics organisations and religious groups, and was emailed to other government agencies and organisations.

The consultation process was advertised in all major metropolitan newspapers on Wednesday 15 August and Saturday 18 August, and in the *Sunday Star-Times* on 26 August. A press release was sent out to 60 news outlets, including all radio and television stations.

ACART held consultation meetings with provider staff and representatives from Fertility NZ throughout August 2007.

A hui was held on 13 August and a public oral submissions hearing was held on 5 September, both in Wellington.

Submissions closed on 7 September 2007. ACART received 48 submissions, including four oral submissions.

This document summarises the submissions received on the draft guidelines for surrogacy arrangements involving providers of fertility services and donation of gametes between certain family members. A summary of submissions on embryo donation, PGD, and related issues will be made available at a later date.

Assisted Reproductive Procedures

The discussion document asked submitters to indicate if they agreed that the following procedures should remain assisted reproductive procedures¹ (ARPs), that is, subject to guidelines developed by ACART and ethical review by ECART:

- surrogacy arrangements involving providers of fertility services
- embryo donation
- donation of gametes between certain family members
- certain uses of PGD.

The majority of submitters agreed that all four procedures should remain ARPs.

Several submitters disagreed in principle with assisted reproductive technology (ART), though some of these, noting that ART is well established in New Zealand, agreed with having a process for ethical review of procedures.

Reasons for supporting ethical review included:

- ethical, emotional, and psycho-social issues
- the need to protect the interests of children born as a result of the procedures
- the relative newness of the procedures
- the ramifications for families, which are unknown and potentially significant
- the lack of evidence of long-term psycho-social and medical safety of the procedures.

Several submitters noted that part of their rationale for support was that ACART would monitor the application and health outcomes of assisted reproductive procedures and revisit whether the procedures would continue to require ECART review.

Feedback from providers was divided between support for the procedures to remain ARPs and a desire for a different kind of framework. Some providers wanted more autonomy and for ECART to function in an advisory capacity for clinics to approach for advice and guidance at any stage of the process. Providers envisaged being able to refer cases for established procedures to ECART where there were specific ethical concerns or a perception of enhanced risk.

¹ An assisted reproductive procedure is defined by the Human Assisted Reproductive Technology (HART) Act 2004 as a procedure performed for the purpose of assisting human reproduction that involves the creation of an in vitro human embryo; or the storage, manipulation, or use of an in vitro human gamete or an in vitro human embryo; or the use of cells derived from an in vitro human embryo; or the implantation into a human being of human gametes or human embryos; but does not include an established procedure pursuant to section 6 of the HART Act.

Part One – Surrogacy Arrangements involving Providers of Fertility Services

The majority of written submissions considered that surrogacy should remain an ARP.

Those who disagreed generally considered that the process of applying to ECART is “an additional hurdle” which is not warranted given that most applications are approved.

Categories of surrogacy

Some providers supported the division of surrogacy into two categories.

- “Straightforward” or “safe” surrogacy, which would be an established procedure approved at the provider level without ethical review.
- Surrogacy where there are “unusual issues” or “risk”, which would remain an ARP subject to ethical review by ECART.

Under this model, the proposed guidelines would become the boundary conditions for “safe” surrogacy, with providers obliged to approach ECART with any concerns. The procedure would be auditable according to the Fertility Services Standard.²

Providers who supported this considered that ECART had now seen many applications (41 as at 30 June 2007), giving a broad base of knowledge and information for providers to draw on, and that the process of applying to ECART is complicated, time-consuming, and perceived to be unnecessary in cases where there are no significant ethical issues. Providers also advised that applying to ECART can impact negatively on the relationship between counsellors and patients. The issue of risk was a defining factor for providers as to whether, in their view, surrogacy applications should be subject to ethical review by ECART.

Other providers considered that surrogacy arrangements involving providers of fertility services should remain ARPs. They considered that the two categories of surrogacy – donor insemination using the surrogate’s own eggs, and surrogacy arrangements using donated eggs – should be separated because there are greater ethical concerns around the former category.

ECART processes

Many submitters commented on the process of making an application to ECART, stating that ethical review was not necessary if most cases were approved.

Users of fertility services supported the concept of an ethics committee, stating that the focus on ethics adds a level of objectivity at an extremely stressful time. However, some consumers identified the following issues around ECART.

- There is a perception that ECART has too much power – if it declines an application, it may be taking away someone’s only chance to have a child.
- The process of seeking and having fertility treatment is disempowering and having to seek approval exacerbates the feeling of lack of control.

² The New Zealand Standard for Fertility Services defines the quality and safety requirements for the provision of fertility services. It will come into force in 2008.

- Most ECART members are not medical people and they have no idea of patient history. There is a perception among some consumers that laypersons do not have the authority to make decisions, and ECART membership should not include them.
- ECART requires people to expose themselves to strangers at a very stressful time, and because of this people might choose traditional surrogacy to preserve their dignity, even though it may not be the best option.
- The waiting time between ECART meetings causes problems for users of fertility services, who have often already spent years pursuing other forms of fertility treatment.

Additional comments from providers

Providers noted that:

- it would be useful if the HART Act allowed a provider to send an application to ECART if there were concerns around a specific case for an established procedure
- monitoring outcomes by ACART should include analysis of existing research and, if possible, the commissioning of New Zealand-based research.

Comments on the proposed guidelines for clinic-assisted surrogacy

Submissions indicated general support for the guidelines and reflected a desire for greater clarity and specificity, which included:

- clarifying what is meant by “independent” (with reference to medical and legal advice, and counselling)
- requiring that one of the recipients have a medical condition
- requiring that one of the intending parents be the child’s genetic parent
- appointing an advocate for the child
- providing for the surrogate to visit the child
- clarifying:
 - what happens if the surrogate decides not to give up the child
 - the parental status of the parties
 - current family law regarding surrogacy
- requiring any intending surrogate to already have children of her own
- considering limiting any surrogate acting for a single individual or couple only, until there is greater knowledge of the psycho-social implications.

Many other submitters requested further detail and clarification around counselling processes, and the legal and custody arrangements around surrogacy.

Health and wellbeing of children

A number of submitters focused on the health and wellbeing of children resulting from surrogacy arrangements involving providers of fertility services, suggesting:

- there should be a requirement for ECART to follow up on cases post-delivery to ensure the emotional and physical safety of all parties
- the future wellbeing of any resulting child should be a primary factor in agreeing to surrogacy.

Despite the support for the guidelines, a strong thread running through many submissions was that surrogacy should be made more available, for example, by allowing intending parents to advertise for surrogates.

Additional comments

Additional comments and concerns relating to surrogacy which do not specifically relate to the guidelines, included the following.

- Surrogates should be sufficiently compensated and receive adequate care for the complications and costs that may arise in relation to the surrogacy arrangement. This should include considering:
 - medical costs
 - costs of psychological treatment after surrender of the child
 - unanticipated and ongoing costs arising as a result of the surrogacy.
- There is a huge shortage of donated gametes and embryos in New Zealand and payment for these could provide an incentive.
- A binding legal mechanism that could be entered into prior to surrogacy would be useful.
- The surrogate and the intending parents need to know each other well to deal with the issues that arise. With unknown surrogates, there is more risk that they may not stick to their side of the arrangement or take other action further down the track.
- Parties involved in a surrogacy arrangement should not have to know each other already, as they can get to know each other. However, prospective surrogates may be rejected by providers or ECART because of the lack of a historical relationship, even though this situation occurs in the community all the time.
- Support for intending surrogates needs to be monitored, because there are cases where support has not been sufficient.
- Surrogacy is becoming more common and is now an earlier treatment option than in the past.
- Providers should be able to facilitate meetings with intending surrogates and intending parents. It is inconsistent that the provider can act as broker for egg donation but not for surrogacy.
- Concerns around adoption, including that better co-ordination is required between surrogacy and adoption processes, allowing intending parents to remain in the Child, Youth and Family (CYF) “adoption pool” while undergoing fertility treatment, and that adoption papers should be different for adopting one’s own genetic child.

One submitter noted its support for the recommendation made by the Law Commission in its report *New Issues in Legal Parenthood* (NZLC R 88) that specific mechanisms be enacted for transferring legal parenthood in the case of surrogacy.

Part Two – Donation of Gametes between Certain Family Members

Written submissions indicated strong support for donation of gametes between certain family members remaining an ARP.

Reasons for supporting ongoing ethical review by ECART included that this would:

- limit the potential for inappropriate family arrangements that could harm the child when born
- ensure that parents and donor/s will have thought through all the issues, for example, given proper consideration to the impact that having a biological child might have on future partners
- ensure that there is no evidence of undue pressure or coercion, particularly where donation is intergenerational.

The majority of submitters supported the proposed guidelines. Those opposed considered it ethically and morally wrong to donate gametes within a family, either as analogous to incest or because it was considered offensive to seek gametes from outside the husband/wife relationship.

The main concerns identified by submitters were that the procedure:

- redefines traditional genetic relationships
- creates the potential for identity confusion
- may complicate the process for obtaining informed consent (because the parties to the process will usually be closely related).

Several submitters suggested that using a direct relative (as opposed to an unrelated donor) should be encouraged because it would ensure a genetic link for the child.

Many submitters wanted greater specificity in the guidelines, which includes:

- requiring that one of the recipients have a medical condition
- requiring that one of the intending parents be the child's genetic parent
- clarity on who would be defined as "family"
- appointing an advocate for the child.

Health and wellbeing of children

Some submissions focused on the health and wellbeing of children resulting from donation of gametes between family members, citing the need for:

- follow-up studies of the health outcomes for these children
- counselling sessions covering psycho-social issues in relation to the child's relationship with their donor within their family
- donor offspring to be told of their genetic and biological family origins and actual family relationships.

Some submitters expressed concern that gay people should not be inadvertently discriminated against as a result of wording intended for heterosexuals.

It was suggested that cases with donors under 20 years of age should not require referral to ECART, as people can legally marry and vote at a younger age, and that 18 years of age may be a more appropriate limit for mandatory ethical review.

List of Submitters

Individuals

Brian Gerard Quin
Carolyn Hutton
David Fisk
Eric Blyth
Helen Davies
Hilary Stace
Hugh Moran
Jeanne Snelling
Joan Sullivan
John France
Karen Raaymakers
Lynette and Ian Mason
Maria Jones
Patricia A Hammond
Paul Clarke
Paul Elwell-Sutton
Phillipa Malpas
Robert Ludbrook
Susan Fraser
Dianne Yates MP

An additional four submitters requested that their personal details be kept confidential, and one submitter did not provide any personal details.

Organisations

Abortion Law Reform Association of New Zealand
Auckland Women's Health Council
Bioethics Council
Canterbury DHB
CCS Disability Action
ECART
Families Commission
Federation of Women's Health Councils
Fertility Associates
Fertility NZ Canterbury
Fertility NZ Auckland
Health and Disability Commissioner
Health Law Committee, New Zealand Law Society
Humanist Society of New Zealand Inc
Ministry of Social Development
Right to Life NZ
The Fertility Centre
The Interchurch Bioethics Council
The Nathaniel Centre – the NZ Catholic Bioethics Centre
Voice for Life Wellington
Voice for Life
Women's Health Action Trust