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MEDICO-LEGAL SOCIETY OF NSW INC.

SCIENTIFIC MEETING

WEDNESDAY, 22 MARCH 2017

AT 6.15 P.M.

THE TOPIC:

PUSHING THE LIMITS OF PARENTHOOD: LAW AND PRACTICE AROUND GAMETE DONATION AND SURROGACY

SPEAKERS: PROF MICHAEL CHAPMAN
MS JULIE HAMBLIN

MS KEELEY GRAHAM: Thank you very much Julie.

Our next speaker is Professor Michael Chapman who is an Obstetrician and Gynaecologist. He is a Professor at the School of Women and Children's Health and at St George Public Hospital. He had previously been Head of School at the School of Women and Children's Health for nine years. He has also been a Professor of Obstetrics and Gynaecology at the University of London at Guys Hospital. His wealth of experience has been built on posts that he has held across the world, including the Queen Charlotte Maternity Hospital in London, then seen as one of the leading maternity services in the UK. During that time, he developed and specialised in reproductive endocrinology, publishing papers in the area of androgens in the female and infertility. He has been involved in setting up IVF services in London, Naples, Jeddah and Sydney and has published very widely in this area. Please welcome Professor Chapman.

PROF MICHAEL CHAPMAN: Lawyers, I am your friend. I have been involved in IVF for 34 years. I did my first egg collection in the United Kingdom and what we have given to those of you involved in this area, are complex issues that I am sure you will enjoy solving for us.

As a clinician/scientist/researcher in the area of reproductive medicine and IVF, it has been my generation from a boy through to now and I have so enjoyed this most amazing leading edge of medicine. The story begins with Louise Brown, the world's first test tube baby in Cambridge, although the baby was born in Oldham, a little country town in northern England. She was the first of now in excess of seven million babies born worldwide through IVF. That was 1978 - today is 2017.

The basics of ART are well known. We collect sperm and eggs, put them together, create an embryo in the laboratory and put that embryo back in the uterus. The fact that we can create an embryo in a laboratory then opens up a whole lot of issues other than the natural parents and that is what Julie was talking about. It is where we get into the moral and ethical dilemmas and legal dilemmas that confront us on a daily basis.

In Australia in 1980 we had the third, fourth and fifth test tube babies in the world. One is now a young lady called Candice Reed, who is still an ambassador for the IVF limb, as babies of IVF call themselves. We have now had over 200,000 babies from our technologies – a population bigger

than Hobart. We contribute to four per cent of all births, that is one in 25 births in Australia is through IVF.

About eight years ago when we were debating proposed changes to Medicare rebates with Mr Abbott, we suggested to him that any change in Medicare rebates or restriction on practice would interfere with one baby in every classroom. At that time Peter Costello was telling the nation to have one baby for mum, one for dad and one for the country. So, any restriction on IVF, not that I am biased, was potentially going to limit those numbers.

In Federal Parliament we now have friends who have had children through IVF. Some of them do not admit it. There is the classic example of the devout catholic politician who sat down with me sat down with me at lunch in Canberra when I was discussing the Embryo Research Bill and said, “I have IVF boys and I believe in this because God gave you the power.” So sometimes even the Catholics are on our side. Sadly, when I said to him, “How old are they?” he replied, ”17”. I said, “Have you told them they are IVF babies?” and he said, “Oh no, I don’t want them thinking they’re strange.”

In reality IVF babies are just like every other baby. In fact, they are the most researched babies in the world in terms of their outcomes and normality of their growth. Everyone has been terribly nervous about us interfering with nature, but the results in 99.99 per cent of cases are that they are not different from the general population.

We set up the first regulatory body in the world in the 1980s and it continues to be regarded as the gold standard for the way in which an IVF program is overseen. This is the Reproductive Accreditation Committee and the legislation that each individual State has gone forward with. It is a system that is admired even in America. What we do in terms of the Code of Practice is not at all controversial. We probably have the safest standards and the highest quality of practice anywhere in the world.

Where we get into the issues is as IVF parents who are infertile get spread to the less common but probably more controversial areas. Julie has already spoken about some of these. Thirteen thousand babies were born in Australia in 2015 from treatments undertaken in 2014. The vast majority of babies born were from traditional autologous parenting. That means the mother’s eggs were used and the husband’s sperm was used. Only 529 babies came from donation and they are the ones where potentially the law gets involved.

I believe the law gets too involved for a relatively small number of the total package. Also there is more media coverage of those babies than is justified considering what we are doing in the general run of the mill IVF programs. Five per cent of all cycles is what I was saying at the start and we end up with both eggs and embryos.

Embryos are very uncommon. An embryo recipient normally is somebody who is receiving an embryo from somebody who has been through an IVF cycle and with success has had one, two, three, four children and still has spare embryos. The question is what is she to do with them? It is a real issue because they are in many couple's minds, their children. They do not want them "tossed in the bin". They have the option of using them to help with research activities or they have the opportunity to donate them to other couples. However the latter is relatively uncommon with 421 donations in Australia that year (2014) from in excess of 100,000 embryos created that year. It is relatively uncommon to do because it is such a big step.

That process within the IVF clinics involves intensive monitoring, at least two visits with a counsellor for both the recipient couple and the donor couple and then a joint session with both being present discussing the implications into the future. Do you want this child to know where it came from? We encourage that to occur. How much involvement do the donor parents want? Do they want to be there at their birthdays, or do they want to just know that the child is growing up well? There are a number of issues.

In the media last year there was reported one particular surrogacy arrangement that went badly astray. During the counselling sessions of which there were four separate ones all clearly documented, the recipient couple pledged, not in writing but pledged, that they would allow contact in the future. The particular patient who received the embryo rang the clinic 14 days after the embryo transfer and said to the clinic nurse, "I've had a period." We assumed, therefore, that the baby was not going to happen because 60 per cent of the time that would be the normal outcome. About 11 months later the donor mother looked on Facebook at this particular woman's name and saw a picture of her holding a baby. The donor mother then went to the media and came to us wanting to know how this could happen. She wanted us to write a legal document that ensured that what was agreed, in fact occurred. However it did not. They have not made contact, despite all the media attention that has then occurred. There are lots of grey areas in this. Whose baby is it? We go out of our way to try to ensure that people know what the consequences

of their actions are but it is almost impossible to avoid deceit.

There were 2,684 recipient cycles, mostly in older women. aged 40 years and over. It is the older age group that are more desperate to make sure that they can have that baby that they always wanted. I spend my life frustrated as 60 per cent of my practice is 40 years of age and above and I know that the outcomes are not going to be that positive. We talk a lot about women having babies earlier. It is actually the men that are the problem. They are the ones who do not want to settle down and have a baby. They want to have the car, a drink at the pub with the boys and a house. That is what stops them. We blame the women, but it is not the women.

I will now consider the issue of surrogacy. Gestational surrogacy, which is what is legal in New South Wales, is carrying a child for another person, for the intended parents and the child will be raised by the intended parents. In that situation, the sperm will come from the intended father in most cases and the oocytes will generally come from the intended mother, but they definitely will not come from the woman carrying the child.

For example, couple where the wife had ovarian cancer and had no eggs because of the chemotherapy that she had received, used a donor egg and his sperm in a third party woman and achieved a child. For these patients, particularly the women who in their reproductive years have had their pelvis cleared because of cancer, surrogacy has made that couple’s life so wonderful, having been through cancer, survived and then being able to have a baby.

Generally, most big clinics, although I am talking about IVF Australia in particular, have a fairly rigorous process by which to get to a surrogacy arrangement. We demand that they demonstrate to us that they have obtained legal advice about the parenting, the parenting orders and the long term future for that child.

We generally also obtain a psychological assessment of the surrogate. That is not suggesting that any woman who wants to carry a baby for another woman must be out of her mind. The reason we do that is the one thing we want to minimise is the risk of a surrogate wanting to keep the baby. There have certainly been cases in the USA where there have been huge fights about whose baby it is. Hence, we go out of our way to prevent, or put barriers to, the possibility that the surrogate would ever want to take the baby home. Making it

genetically not hers is the first step, but secondly, making sure that she is doing it for the right reasons and she understands the consequences of it.

The implication is the counselling that I have discussed is essential. In most situations and most clinics each case ends up with our NHMRC appropriate ethics committee for final decision making. In my group, IVF Australia, every month as part of our general business we discuss surrogacy cases and whether we think it appropriate to put them up to the ethics committee or not. We do turn some back but the majority of these are because of clearly medically defined reasons. We certainly would turn back any social surrogacy. For example: "I don't want to have a baby because I don't want a fat tummy in the future" as some actresses in the United States might do. I am not saying that happens but it probably does.

Surrogacy is not a big deal. It is not a big part of IVF practice. Fifty five couples produced 157 cycles from the donors and 130 ended up with a transfer producing 36 babies to fight in courts around Australia that we know of.

There is a very recent case with which I, as President of Fertility of Australia, became embroiled. There was a media program on the ABC about a particular woman who then published proudly in the *Woman's Day*, I think, that she had gone through a surrogacy arrangement. She had done it on the cheap because the couple could not afford it. She had approached an IVF unit and said that she was infertile. At the time of the sperm production for her IVF she said that she swapped the sperm of the couple she was helping for her husband's, carried the child and delivered it about ten weeks previously. She was proud of the fact that she had beaten the law, beaten all the ethical guidelines and had deceived the clinic. We have had an RTAC inspection of that unit to ensure that it was not them colluding with the patient, which they were not. However I am not sure what will happen when they go to the Family Court, in Queensland.

I would again stress that it is not large numbers that we end up dealing with. Of the 36 I am probably responsible for three of them and the outcomes have been absolutely fantastic. These couples involve women who have had cancer and cannot carry a child.

There is no question that the IVF technology and the doctors and the scientists have pushed the barriers of ethics and law. We will continue to do so, but in so doing we are responding to what patients want. Unfortunately, as doctors,

we try to do our best for our patients and that does lead to ethical and moral dilemmas.

This week's dilemma is that the HFDA, which is the overseeing body in the United Kingdom, has now approved the first three parent family where the mitochondria from one normal person has been injected into the embryo of a woman who carries a mitochondrial disease. Those mitochondria were taken out, the donor's mitochondria have been put in, the husband's sperm has been put in and so there are potentially three genetic parents of that child. These mitochondrial diseases are so horrific because they end up with children dying in the first five years of life. Hence to be able to prevent this is a real step forward scientifically and for that couple. However it does open up a whole can of worms.

Thank you.