

Caroline Chisholm Centre for Health Ethics

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From the Director

We welcome Margaret Casey to the Centre as our administrative assistant during Sylvia's maternity leave. As the first issue of Volume 2 of our **Bulletin** goes to press Australia once again has sadly made world headlines on the issue of euthanasia. This time media attention focussed on the world's first legal case of euthanasia when Dr Nitschke assisted Bob Dent to commit suicide with the help of computer technology in Darwin on 28 September.

Kevin Andrews MP has introduced a private member's Bill in the Federal Parliament to prohibit intentional killing. Territory and State rights fade into insignificance when it is a matter of overriding an immoral law that legalises assisted suicide and the deliberate painless killing of the terminally ill upon request. The Commonwealth should use its constitutional powers to protect the intrinsic value of human life being undermined for all Australians. The conscientious wishes of a tiny percentage of the dying do not justify legalising voluntary euthanasia.

It is one thing to choose to take one's own life to eliminate pain and suffering. It is quite another matter to go beyond the private exercise of autonomy to involve a third party by asking a doctor for a lethal injection. While choice is a great value, freedom is always subject to moral obligations. The criminal law restricts freedom to protect important values in the community. Furthermore the sick, elderly and terminally ill have a right to expect they will be treated by doctors who do not practise euthanasia.

The euthanasia debate is now highly political. Supporters of voluntary euthanasia complain the law inhibits their right to practise euthanasia. In point of fact voluntary euthanasia is practised on the quiet without any charges being laid since nobody involved in these cases has a legal duty to report them to the police. Rather than legalise euthanasia it is better to tolerate this untidy situation where reports may be made to the police in a case of suspected family conspiracy or foul play in the practice of mercy killing. We wish Kevin Andrews every success with his Bill in Canberra.

We are holding a **Conference on Treatment Decisions at the End of Life** at St Vincent's Hospital on 15 November 1996. See insert registration form for details

Our Centre has made a submission to the Australian Health Ethics Committee on the "Draft guidelines on assisted repro-

St Vincent's Private Hospital - "a healing haven for the sick"

ductive technology". This has prompted a couple of articles on this topic in this Bulletin.

After receiving a request from a school which needed multiple copies of our Bulletin for its staff, we have decided to introduce discount rates for extra copies. See the back page for details. †

Norman Ford SDB

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Unravelling Casemix and the Networks

This article discusses casemix and the development of the hospital networks in Victoria.

It has been said that a just and equitable health care system is also an efficient one. This manner of thinking seems to have paved the way for health economists to devise ways in which to improve the productivity of the system, so that more and more outcomes (however they are defined) can be achieved, and less and less input into the system is necessary. In Australia and in particular in Victoria, this has meant the introduction of such methods as casemix and the Australian DRG (diagnostic related group), the development of the hospital networks and the building up of the General Practice Divisions. Future streamlining of the system seems evident if the proposed models of general, acute, and coordinated care are adopted as methods of organising the health care system.

Casemix

Much has been written about the dreaded 'casemix'. Economists love it, clinicians are exceedingly sceptical and the consumer in the health system has great difficulty in understanding it. Casemix is really just an economic, organisational tool which obviously has room for improvement, needs updating regularly and must be recognised for the technical limitations that are inherent in its structure.

What is Casemix?

Casemix describes the particular patient mix of a hospital. It describes what goes on in a hospital -- it tells you what that hospital does. Another way of describing casemix is that it is an information tool which involves classification of patient episodes in a user friendly way so that decisions regarding future 'needs' can be made. It enables specific comparison to be made between the same services, same procedures or same treatments for people with the same diagnoses at different hospi-

tals. Casemix provides a tool for assessing hospital performance. It is a clinical information system that assists in the management of clinical services by clinical managers. Casemix can be used just for the information it supplies or it can be used as a method to allocate funding.

Casemix, as it is primarily used in the state of Victoria, is a method of partially funding public hospitals. In Victoria, casemix funding was implemented on the 1st July 1993. It is an example of output based funding as resources are allocated to hospitals according to what they actually produce and this is independent of need. In Victoria this is predetermined by the health department using technical, mathematical formulae. It uses information about the patient's hospital admission such as

"It uses the diagnosis and the procedure done"

their diagnosis, the procedure that was done, the presence of any coexisting or complicating factors (such as age or other diseases) and these are coded via the language of the DRG. As defined by the Health Information Association of Australia...."the DRG system is a classification system which categorises episodes of care into clinically meaningful groups with similar resource consumption". (*Coding and DRGs*, p. 2) Any measurement of the change in health status of the patient treated (the personal outcome for them) under the casemix system appears to be understated or in many cases absent. An 'outcome' in casemix rhetoric means that a patient has been admitted with a diagnosis, a procedure may have been performed, and then the patient has been discharged thereby adding to a hospital's throughput.

Casemix funding in Victoria according to the Metropolitan Hospitals

Planning Board has "facilitated a move towards a contractual purchaser/provider system" with the health department "purchasing services from public hospitals on behalf of the community". (*Phase 1 Report*, p. 72)

The Positives of Casemix

Basically, casemix is a method of payment and management of public hospitals, and despite many early hiccups it has to be better than the historic method of funding that had been used in the past to finance the state's public hospitals. Historic methods of funding hospitals preserved the inequitable distribution of resources and, in an indirect way supported inefficient clinical and work practices. Casemix enables comparison and at least attempts to make pathways of care less variable and therefore less operator dependent. Hopefully, casemix will assist in the collating of relevant information about which treatments are effective. This will decrease the use of medical regimes whose efficacy is doubtful and it may decrease the duplication of research. Constant revision is necessary though, to keep in touch with developing medical practice.

Casemix as an organisational tool means that restructuring is a much easier procedure because the information about what each hospital does is readily available. In the case of Victoria, this information has contributed to the way in which the Metropolitan Hospital Networks have been organised.

The Negatives of Casemix

The thinking in current health care structure seems to be geared towards assessing outcomes, yet Victoria's version of casemix uses a diagnosis and a procedure rather than real patient outcomes. The efficiency of

hospitals seems to be judged on throughput which is highlighted by the preoccupation with waiting lists which appears regularly in the press. The lack of any baseline standard of quality taken before the introduction of casemix into Victoria's public hospitals has also contributed to problems in evaluating its impact on the health of Victorians and on health care delivery. For casemix to be more than just a method of increasing throughput, and to actually be a technique for improving the population's health by improving efficiency, a way must be found to accurately measure and analyse the quality of the treatment given. Otherwise the average cost per DRG will keep falling without a corresponding improvement in health outcomes.

At the practical level casemix (as it has been introduced in Victoria) fa-

“Much of the health care needed by the chronically ill is difficult to quantify”

vours the surgical procedure and the uncomplicated hospital admission leaving the chronically ill (those with ongoing illness which cannot be cured and only the symptoms palliated), the mentally ill, the aged and the disabled with less than optimal care. It has been argued that this oversight could be remedied by perfecting the formula i.e. the DRG weighting. Part of the problem is that much of the health care needed by the chronically ill, such as nursing care, is difficult to quantify and hard to measure and therefore doesn't get included in the funding formula. Another problem with casemix is that because it only covers the acute admission it does not incorporate the entire episode of care. This criticism is particularly relevant when chronic ill health conditions are becoming increasingly prevalent and acute hospital admissions are only part of the costs of the health care involved.

One method which has been used to assess casemix has been patient satisfaction surveys about which there

has been much sceptical comment. This scepticism may be well founded when one looks at the ways in which these surveys are used. A pie graph with different shadings from 'very satisfied' to 'not satisfied at all' with no description of method or an explanation of the cohorts used or the response rate, does not inspire confidence in the reliability and validity of this technique to assess consumer satisfaction with the Victorian hospital system under casemix.

It could be argued that casemix does little to address the problems of allocative efficiency. By this I mean whether casemix is any help in redirecting services to achieve the greatest health gain from resources invested. There are people who would argue that before deciding which services should be funded and to what level, we need to achieve technical efficiency and casemix is one method that can be used to accomplish this.

The Hospital Networks

The development of hospital networks to serve the 'needs' of metropolitan Melbourne is another strategy that has been devised to improve the productivity of the state's health system. Early in 1995 the Metropolitan Planning Board was given the task of working out a strategy so that the state's health care services (and in particular the public hospitals) would be able to meet the health care challenges of the Melbourne community in the 21st century. The principle underlying this strategy was one of geographic equity which interprets an area's need for health resources as being related to the size of the population to be served. The population is adjusted for a number of factors which affect the relative need for health care services. These may include age, relative ill-health, incidence of particular diseases and the use of private hospital facilities. In the case of Melbourne it was recognised that there was a concentration of hospitals in the inner city while the population was growing more on the

outer fringes. Reductions in the duration of hospital stays, a rise in the number of day and outpatient procedures, the increasing prevalence of chronic disease, an ageing population, and a growth in emphasis on patient (or consumer) based care meant that within the current setup there was inequitable access to services and that each institution was pursuing its own vision rather than an integrated, coordinated one.

Using the principle of geographic equity a system of provider net-

“Their adoption has not been without its problems”

works has been developed. Each network "is a collection of health care suppliers under common governance, possessing a wide range of health care facilities and attuned to meeting an individual patient's needs with the appropriate medical response". (Phase 1 Report, p. iii) Within each network a variety of services are to be offered including acute and chronic hospital admission, aged, rehabilitative, psychiatric, palliative and home-based care. Within a network corporate resources and infrastructure are to be shared and this will hopefully avoid duplication of services. The Metropolitan Hospitals Planning Board did recognise, though, that there are some superspecialty services which cannot be offered in each health care network (such as services for haemophilia or cystic fibrosis) and that these would have to remain centralised for economic and practical reasons.

The objective rationale behind the development of the hospital networks would seem to be sound and entirely reasonable. Yet their adoption has not been without its problems -- there have been debates about the appropriateness of physical sites, personnel problems when smaller providers have come under the governance of larger bodies and the long histories of many institutions cannot simply be disregarded in the pursuit of efficiency. There are also separate dilemmas for insti-

tutions with a certain ethos and mission statement that may not be consistent with the equity of access which the network is trying to fulfil - e.g. Catholic hospitals and the provision of abortions.

The use of casemix to increase efficiency, and the development of the health care networks to improve equity of access to services have meant some profound changes to the health care system in Victoria. There are many criticisms of what has been done and the way in which it has been done. All the changes appear to have been made in the pursuit of the just and equitable health care system which is also an efficient one. It does make one wonder though, whether once we have

squeezed all the inefficiency out of the system what sort of health care service will survive. Surely we need to look a little deeper and decide what a just and equitable health care system should provide rather than only concentrating on how to provide it.

The next issue of the bulletin will discuss the divisions of general practice and the proposed changes to the health care system.

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Deirdre Fetherstonhaugh

When Does a Foetus First Feel Pain?

When does a human being first have experiences with sensational content? The answers to these questions are more complex than the simple statement, "When there is brain activity."

Why a Foetus Might Experience Pain

The question of when a foetus begins to feel pain is important for several reasons. Foetal surgery is a growing area of interest as are other beneficial but invasive procedures performed on foetuses, including blood sampling and transfusions. Foetal surgery is used to correct defects

"Foetal surgery is used to correct defects"

while the foetus is still developing. At the moment the most common operations performed on foetuses include procedures to rectify malformations of the diaphragm and repair cleft palates. The advantages of foetal surgery are early intervention, reduced scarring as a result of the procedures and also an avoidance of increased complications which may occur if the problem is left untreated until after birth. If in fact the foetus can feel pain then the issue arises as to whether or not the foetus undergo-

ing these procedures requires anaesthesia or analgesia (pain relief). In addition, aborted foetuses also need to be considered, because what is already a tragic event should not be made even worse by inflicting pain on the foetus whose life is about to be taken. This is especially true when considering the surgical method of abortion. On a second trimester foetus this procedure is not only traumatic but quite violent.

Our Experience With Pain

Our current knowledge of pain perception is predominantly gained from reports communicated by the subjects who are experiencing it. Questions like "Can you feel this?", or "Does this hurt?", can be asked of adult subjects who have the capacity to communicate their response and the corresponding physiological changes can be monitored. However, when it comes to the human foetus no such responses can be communicated. To assess if a foetus is experiencing sensation in general,

or discomfort in particular, other methods of inquiry must be used. Investigations such as ascertaining whether the foetus moves away from a stimulus or what physiological changes occur, including changes in hormone levels or nervous system activity, are examples. Since unable to directly question the foetus these alternative techniques need to be used.

Investigating Foetal Pain

Even using these alternative techniques there may be no way of precisely identifying an answer to the question of when a foetus begins to feel. There may actually be a variety of answers which all point to different levels of sensational experience. For example, consciousness - awareness and the ability to appreciate sensation - may not be acquired until the second trimester, but prior to this the foetus is able to exhibit stress responses and aversions to noxious stimuli, so different levels of sensation must be considered.

Research suggests that prior to complete development of the cerebral cortex and its specialised regions the more general structure of the immature cortex may still be capable of registering pain and distress in some form. The specialised regions of the cerebral cortex are involved with motor function, sensory perception and association.

Early Response to Stimuli

Foetal movements are one of the methods used for investigating foetal sensations. The assumption is that a foetus will move away from a stimulus that it can feel or perceive at some level. A foetus of only 5½ weeks gestation will move away from a tactile stimulus of the region surrounding its lips. The cortex has not developed at this stage but the presence of such reflexes demonstrates sensation at some level. At this early stage the foetus moves only its head away from the stimulus. Before long it moves its whole body away until it develops local reflexes which occurs at 8½ weeks gestation. Although these movements are elicited, spontaneous movements of the foetus during this early stage can also be observed. Movements such as breathing, yawning and swallowing have been observed in foetuses from 9½ weeks gestation. Such movements suggest that even at this very early stage the foetus has the capacity to experience and respond to tactile stimuli at a level we cannot completely comprehend.

The Process of Sensory Perception

The process which results in adults having the perception of pain is extremely complex and understanding its chemical, physiological and anatomical components is very complicated. It becomes even more difficult when one attempts to understand the development of the components and of the sensory system as a whole. Although an early foetus responds to tactile stimuli, these responses are not registered by the

foetus consciously because the brain has not yet developed. It is also important to keep in mind that pain as it is experienced by adults may not be the same as for human foetuses. Pain is experienced in adults via a complex system of nerve responses and synaptic connections which register in the specialised pain receptive centres of a mature, functioning cerebral cortex. This results in the adult being aware of a painful sensation. Although the exact process is still contentious this basic pathway is generally accepted. If the same level of pain processing is required for the adult and the foetus, to feel pain then, the gestational age of a foetus with that capacity would perhaps be as late as 30 weeks. This is because of the development of the nervous system and cortex required.

“Activity can be recorded in the brain stem from ten weeks gestation”

The onset of the capacity to experience sensation is usually equated with the beginning of ‘cortical life’. In this capacity cortical life entails both the presence and the functioning of the cortex and its component parts in response to stimulation, in particular in response to somatosensory experience, sensations of the body as opposed to specialised sensations such as sight. Under this criterion a foetus could experience sensations from around 18 weeks gestation. This, however, is only one approach to the question. Other studies of sensation including those involving tactile stimuli and hormonal responses show that perhaps such advanced development as a mature functioning cortex is not required to experience sensations at other levels.

Electrical Activity in the Developing Brain

Brain activity registers as electrical activity and can be monitored. Electrical activity can be recorded in the brain stem (lower brain) from ten weeks gestation. This corresponds to observations of spontaneous and localised movement of the foetus.

The brain stem at this stage is capable of modifying spinal reflexes, in order to avoid a stimulus, but without development of the cerebral cortex the foetus is unlikely to experience sensations. However, this possibility cannot be positively excluded. Electrical activity can be monitored throughout foetal development and at 18 to 20 weeks gestation the nervous system appears to be complete. At this stage a foetus is likely to have some somatosensory experience and this may well be the beginning of foetal sentience. Although the nervous system is complete and functioning, electrical potentials generated from nervous system messages arriving in the brain in response to stimulation have not been recorded prior to 25 weeks gestation. Since the first signs of a complete nervous system are evident at 18 weeks gestation, the capacity to appreciate sensation develops between then and 25 weeks. We should err on the side of caution and take 18 weeks gestation as the point beyond which a foetus has the capacity to be aware of their sensory experiences.

Hormonal Stress Responses

One study which attempts to determine responses to the perception of pain during foetal development monitored physiological changes rather than observing the foetus or looking at nervous system functioning. The concentration of stress hormones in foetuses aged between 20 and 34 weeks gestation who had undergone an invasive (potentially painful) procedure were monitored. The study monitored the concentration of stress hormones (specifically cortisol and β -endorphin) in foetal plasma when foetal blood sampling or transfusions were performed. These stress hormones are also found in increased concentrations in adult surgical patients but, with adequate analgesia they do not experience pain. If analgesia is not provided then the rise in stress hormone concentration could correspond to distress or even pain in a foetus.

The study compared the concentration of hormones resulting from two different needling procedures. The standard needling procedure involves inserting the needle for blood sampling in the umbilical vein where the cord inserts in the placenta, a presumed painless procedure. The second procedure, performed when the placental cord insertion is obstructed or difficult to connect with, requires needling the umbilical vein within the foetal abdomen. This second technique is suspected of causing stress if not pain in the foetus as it involves puncturing the abdomen. The results of the study suggest that in response to invasive procedures, such as the second needling technique, the foetus does demonstrate a hormonal stress response. The level of response does not differ over the gestational age range of 20 to 34 weeks. The hormonal stress response exhibited in the foetuses undergoing the invasive procedure without appropriate anaesthesia was greater than that found in preterm neonates undergoing surgery with a light anaesthesia. As the mechanisms involved in pain perception at this early stage are not completely understood, it would be hasty to conclude that a hormonal stress response is the equivalent of pain perception. However, it does leave open the possibility that the foetus is feeling pain

and appropriate precautions should be taken, anaesthesia or analgesia, when performing such procedures.

What Should be Done

Although the point at which the foetus begins to experience pain is difficult to locate there is one thing that remains important. That is, the foetus should be protected from pain and distress as much as possible. In order to achieve this aim it is essential that when there is even the chance of a procedure being painful for a foetus the appropriate precautions should be taken. If a newborn baby undergoes surgery it has the appropriate anaesthesia and analgesia. The same should be done in the case of the foetus, to ensure it is not experiencing any discomfort. When abortions are performed on foetuses the possibility that they can experience sensation must be taken into consideration. To kill an innocent human being is morally abhorrent. To kill a foetus in a way that inflicts

“The foetus should be protected from pain”

pain, which could have been prevented, only exacerbates an already gravely immoral act. If a method of abortion is suspected of causing pain then that method in particular should

be avoided. Procedures such as foetal surgery and blood sampling or transfusion are beneficial for the foetus but also carry with them the risk of pain and distress. When such procedures are performed it seems reasonable to expect that the same treatment be given to the foetus as to an adult undergoing similar procedures.

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Tracey Scott

Surrogate Motherhood: Is it Now Legal in Australia?

In 1991, at a joint meeting of Australia’s Health and Social Welfare Ministers, it was decided that a national approach was necessary to ensure surrogacy had no legal standing. Five years later the surrogacy laws are more contradictory than ever. This article looks at the laws in the different states, and their ramifications.

Introduction

The word “surrogate” means deputy or substitute: a surrogate mother is someone who specifically becomes pregnant, gestates, and then gives birth to a child for another person with the express intention of handing the child over to that person after birth. A “full” surrogate is a woman who is implanted with an embryo, usually created from the gametes of the commissioning cou-

ple. In such a case the child is genetically unrelated to the “gestational” or “birth” mother - the surrogate.

In “partial” surrogacy the surrogate mother is genetically the mother of the child: she is inseminated with the sperm of either the “social” father or of a sperm donor, but still agrees to hand custody of the child over to the commissioning parents. In this latter situation the term

“surrogate” is a misnomer. As the biological mother of the child, it is not *she* who is the surrogate mother but the woman to whom she hands the child. However, throughout this article the term surrogate mother will be used according to its widely accepted usage; what makes a woman a surrogate is that she *begins* and *ends* the pregnancy with the express intention of relinquishing the baby to someone else.

Surrogacy is not a new phenomenon; there are even instances of surrogacy in the Old Testament, with Sarah giving Abraham her maid Hagar saying that "I shall obtain children by her" (Genesis 16:1-4), and Rachel giving Jacob her maid Bilhar saying that "even I may have children through her" (Genesis 30:1-13). In Australia it was reported to the NSW Law Reform Commission that the recorded use of surrogates as

"In 'partial' surrogacy the surrogate mother is genetically the mother of the child: it is not she who is the surrogate mother but the woman to whom she hands the child"

mothers dates back to 1870.

In spite of this however, the surrogacy arrangement has been the cause of great legal, moral and ethical debate. Community opinion is divided. Some see it as a reasonable solution to the problem of infertility. Others see it as another way of exploiting women and commercialising and commodifying children. Because of the diverse range of opinions and the fact that, until recently, surrogacy has not been legally recognised, there is a lack of data concerning surrogacy situations, and it is only celebrated cases, such as that of the Kirkman sisters' IVF surrogacy agreement in Melbourne in 1988, which reach the media and thus the wider public.

National Response Needed

In 1991, with the increasing publicity being given to such situations as the Kirkman sisters, a joint meeting of Australia's Health and Social Welfare Ministers was held. A national approach was necessary, it was decided, to ensure that surrogacy had no legal standing and to rationalise the differing legislation in the states and territories. In reaching their decision the meeting took as its paramount consideration the "protection of women and children from exploitation". Also of rele-

vance to the discussions at that time were an influential report of the

"An influential report of the Family Law Council rejected surrogacy as contrary to the interests and welfare of the child"

Family Law Council (1985) which rejected surrogacy as contrary to the interests and welfare of the child and a New South Wales Law Reform Commission Report (1988) which stated surrogacy "should be discouraged by all practicable legal and social means." A national approach was needed because if even one state legalised surrogacy then people from other states would be "border hopping". It was unanimously agreed that surrogacy agreements should be void and unenforceable; that is, no surrogacy arrangement would be upheld in courts of law. It was also decided that payment of any kind with regard to surrogacy be an offence and that the provision of any technical or professional service to aid a surrogacy agreement should attract a criminal penalty.

Victoria: The First Surrogacy Laws

Victoria was the first state to introduce a statutory response to surrogacy, with amendments in 1988 to its *Infertility (Medical Procedures) Act 1984* ("the Act"). S.30 of the Act distinguishes between commercial surrogacy (for money) and altruistic surrogacy (no payment involved). Any kind of surrogacy agreement that involves payment is subject to criminal sanctions of either a fine or two years imprisonment (s.30(2)(b) & (c)). An altruistic surrogacy agreement, while not criminal, is not recognised by law (s.30(3)). This means that if either the surrogate mother or the commissioning couple change their minds, the agreement cannot be enforced in court.

It is also an offence in Victoria to advertise for a surrogate or to advertise offering surrogacy services (s. 2

(a)). In addition, the stringent requirements of the rest of the Act effectively prevents the use of artificial fertilisation procedures in all surrogacy arrangements since access to treatment is only provided to infertile women or women who are at risk of giving birth to a child with an inherited disorder. Victoria has subsequently enacted new legislation, the *Infertility Treatment Act 1995*, yet to be proclaimed in parliament. However, the gist of the surrogacy provisions in the new legislation is the same as the old, with commercial surrogacy and advertising for surrogacy services still being illegal, and altruistic surrogacy agreements still being void. The only change in law

"An altruistic surrogacy agreement, while not criminal, is not recognised by law. This means that if either the surrogate mother or the commissioning couple change their minds, the agreement cannot be enforced in court"

involves the establishment of the new Infertility Treatment Authority. The Authority has power to grant exemptions to the Act on a case by case basis. Theoretically, it is possible that at some stage in the future an infertile couple may apply to the Authority for an exemption to the above laws, in order to use their own genetic material in IVF surrogacy. Whether the Authority would grant such an exemption is unknown.

Queensland: A Strict Approach

In Queensland the *Surrogate Parenthood Act 1988* ("the Act") is even stricter than Victorian legislation. It is an offence to enter into any kind of surrogacy contract, whether or not for payment (s.3(1)(c)), and the publication of advertisements for surrogacy is prohibited (s.3(1)(a)). In addition, the Act not only proscribes surrogacy in Queensland but also covers persons who are "ordinarily resident in Queensland" regardless of where the offence occurs (s.3(2)).

Surrogacy contracts are void and it is not possible to bring court action in order to enforce a surrogacy contract or to recover money paid in relation to a surrogacy contract (s.4).

Tasmania: Similar to Victoria

In Tasmania the *Surrogacy Contracts Act 1993*, makes it an offence to introduce potential parties to a surrogacy contract (s.4(1)), to induce a person to enter a surrogacy contract (s.4(2)), arrange or negotiate a surrogacy contract (s.4(3)) or to give or receive money in relation to a surrogacy contract (s.4(4)). In addition, s.5 states that a person must not provide any technical or professional services in relation to achieving a pregnancy which to that person's knowledge is the subject of a surrogacy act. The Act also specifies that a surrogacy contract is void and unenforceable wherever the contract is made and whatever law may be the proper law of the contract (s.7)

South Australia: Less Intervention

The South Australian approach in relation to the control of surrogacy was to amend the existing *Family Relationships Act 1975* by means of the *Family Relationships Amendments Act 1988*. This renders surrogacy contracts and procreation contracts (that is, contracts agreeing to arrange a surrogacy contract) illegal and void (s.10g(1)-(2)). It is an offence to publish an advertisement for surrogacy services (s.10h(c)), to gain financially from a procreation contract (s.10h(a)) or to induce others to enter surrogacy contracts (s.10h(b)). However the Act does allow for the recovery of money given in relation to a procreation contract (s.10g(3)). Over all, by restricting criminal penalties to third parties, the South Australian legislation takes a less interventionist approach than that of Victoria, Queensland and Tasmania, by directing offences at third parties and not penalising the immediate parties to a surrogacy contract.

ACT: A New Approach

A major change in the law in Australia was made in the ACT in 1994 with the *Substitute Parent Agreement Act 1994*. This Act distinguishes between "commercial substitute parent agreements" which involve a "payment or reward" and "substitute parent agreements" which are altruistic. Commercial agreements are prohibited, as is "procuring" or advertising for a person to enter into any kind of surrogacy agreement *with a third party*: in

"A private friendly agreement organised by the actual parties to the contract is not permitted"

other words, a private friendly agreement organised by the actual parties to the contract is permitted. This allows for the existence of surrogacy arrangements but precludes US-style third party "Baby brokers".

In addition, while it is illegal to use reproductive technology in the case of a "commercial" surrogacy agreement, it is permitted to use it for altruistic surrogacy. The Director of Children's Services has the power to inform him or herself as to the "correct" particulars to be entered into the ACT Register of Births (s.3 *Substitute Parent Agreement (Consequential Amendments) Act 1994*). Under proposed legislation - the *Artificial Conception (Amendment) Bill*, not yet in force but currently under discussion in the ACT Assembly - the woman who gives birth to the child can nominate who the parents of the child will be, thereby overriding the presumption that the woman who gives birth to the child is the legal mother. Even under this proposed legislation however, the surrogate, or birth mother, will have a 30 day "cooling off" period, during which she is entitled to change her mind. Already, according to newspaper reports, one baby has been born under these relaxed surrogacy laws, with a number of other pregnancies being attempted.

Other States: Relying on

Other Laws

In New South Wales, Western Australia and the Northern Territory the legal status of surrogate motherhood remains uncertain: while there is no specific prohibition on surrogacy, existing laws are unlikely to encourage participants. There are a number of legal problems that arise as a result of surrogacy situations, not the least being the confusing issue of exactly who the parents of the child are deemed to be. Current law in all Australian states - apart from the proposed legislation in the ACT - deems the woman who gives birth to a child to be the legal mother, and her husband, if she has one, to be the legal father. This is regardless of whose sperm or ovum was used: the provisions were originally introduced to clarify the situation of children born as a result of reproductive technology such as IVF, with the use of donor gametes.

Even in those states that have no surrogacy legislation at all, it is unlikely that a court would ever uphold a surrogacy contract as being valid, or enforce the terms of such a contract. On the basis of authorities in the UK it would appear that such contracts would be held to be invalid on the grounds of "public policy". While placement of the child is determined with regard to the "paramount welfare of the child", in the absence of overriding legislation such as that proposed in the ACT, it would be almost impossible to rebut the presumption that the woman who gives birth to the child is the legal mother.

Whose Child is it?

Currently any child born in Australia to a surrogate mother will be regarded as *her* legal child, even after she has handed custody over to the commissioning parents - the proposed legislation in the ACT will change this for that territory only. A commissioning couple need to adopt the child in order to avoid this effect, voluntarily giving a child up for adoption being regarded as a legal and voluntary surrender of all rights

by the birth mother. Although there are no reported decisions in Australian courts about surrogacy, or adoption in surrogacy situations, it is possible that such cases have been dealt with. However, because such proceedings are generally conducted in camera, no record of decisions and reasons are generally published.

It is important to remember, however, that Australian adoption legis-

“Although there are no reported decisions in Australian courts about surrogacy, or adoption in surrogacy situations, it is possible that such cases have been dealt with”

lation is stringent. It is an offence to make, give or receive payment or “reward” in consideration for the adoption of a child. Therefore, even in those states that have no surrogacy legislation, any kind of commercial payment to a surrogate mother, in some cases even the payment of her medical expenses, would constitute an offence if the couple were to apply to adopt the child. It is also an offence to “conduct negotiations to make arrangements” with a view to adopting a child; unlike American law, Australian law frowns upon private adoption negotiations, particularly before the birth of the child in question. This is in line with the United Nations *Declaration of the Rights of the Child (1959)* which provides that

“The United Nations Declaration of the Rights of the Child (1959) provides that ‘the child shall be protected against all forms of neglect, cruelty and exploitation, [and] not be the subject of traffic in any form’.”

“the child shall be protected against all forms of neglect, cruelty and exploitation, [and] not be the subject of traffic in any form.” (My emphasis).

Conclusion

In 1991 it was decided that a national approach to surrogacy was necessary, partly to clarify the law and partly to prevent “border hopping”. Unfortunately, we still do not have a national approach. Indeed, if anything, the law is less clear than it was several years ago. The approach taken by the legislature in Canberra will have ramifications for the whole of Australia. There is little point in the law in Victoria, South Australia or Tasmania refusing to recognise surrogacy or allow IVF surrogacy if couples can simply travel to Canberra for treatment. As reported in Melbourne’s Herald Sun, “the treating doctor...has 14 couples travelling from around the country to try for a surrogacy baby, including five from Victoria.” It remains to be seen what further effect this confusing legal situation will have on surrogacy in Australia, and whether it will be challenged, as the Northern

Territory Euthanasia legislation is currently being challenged in Federal Parliament.

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Catholic Moral Teaching on Infertility Treatment and Reproductive Technology

This article discusses the moral principles that underpin Catholic Teaching on infertility treatment options.

Biblical

The Book of Genesis begins with an optimistic account of the creation of men and women: "God created humankind in his own image, in the image of God he created it; male and female he created them" (Gen 1:27). In God's plan "a man leaves his father and his mother and cleaves to his wife, and they become one flesh ... and God blessed them and said to them 'Be fruitful and multiply'" (Gen 2:24; 1:28). Up to this point in the Bible, God is presented as a loving and provident Creator. Man and woman, taken individually and as a couple, are portrayed in this same divine image.

Child of the Marriage Union

Children are a blessing for a married couple. The natural expression of the mutual love of husband and wife is designed to enable children to be conceived and born of the marriage union, loved and reared as members of the family. Marriage is given a privileged status in every society. Though essentially personal, marriage is also an important social institution for the benefit of the spouses and of their children. Little wonder Christ made marriage one of the sacraments of salvation and grace for the baptised.

The serious responsibility spouses assume for each other in wedlock should extend to their children. The union of spouses' gametes resulting from their conjugal act of love should be followed by commitment on the part of the wife to bear the child, supported by her husband. Only couples who are committed to each other and who are prepared to accept their parental responsibilities should contemplate having children.

The institutional requirements of mar-

riage expressed in common and civil laws are important. Society needs laws to define marriage, child of the marriage union, parental obligations and rights of inheritance. The Church needs laws to determine the requirements for the validity of marriage, to define impediments which may make a marriage invalid, e.g. *impotence*, and to define the *consummation* of a marriage in case an unconsummated marriage needs to be dissolved by the Church.

The requirement for the child to result

"The requirement for the child to result from the conjugal act is important for the good of the child and to protect marriage as an institution"

from the conjugal act is important for the good of the child and to protect marriage as an institution. If it were morally permissible to procreate children without any need for the conjugal act, it could be argued marriage was not morally necessary for procreation. It would leave it open for single women and lesbians to claim a moral right to have children.

Moral Options for Infertility Treatment

Marriage enshrines a moral right to seek to have and rear children conceived and born of the marriage union, but this outcome cannot be guaranteed. Up to 15% of couples are unable to have children of their own. This can be a cause of much suffering. We feel much sympathy for the anguish experienced by an infertile couple. We can readily understand and support a couple's desire to seek assistance to enable them to have a child of their own.

The Church is most anxious that chil-

dren should be conceived and born of the marriage union out of respect for the bodily and spiritual unity of human beings, the dignity of their origin and the unitive and procreative meanings of the conjugal act. It does not suffice for the child to be the genetic offspring of the married couple. The Church requires that the child be conceived as the result of the marital act performed in a truly human way. This implies the Church disapproves any artificial reproductive procedure whereby conception occurs outside the mother's body. Extra corporeal conception tends to treat embryos so formed as products of technology, subject to quality control.

Citing canon law, the Church teaches: "fertilization is licitly sought when it is a result of a 'conjugal act which is *per se* suitable for the generation of children to which marriage is ordered by its nature and by which the spouses become one flesh'. But from the moral point of view procreation is deprived of its proper perfection when it is not desired as the fruit of the conjugal act, that is to say of the specific act of the spouses' union." (*Donum Vitae*, II B 4a).

Hence the Church does not approve

"Fertilization is licitly sought when it is a result of a 'conjugal act which is per se suitable for the generation of children to which marriage is ordered by its nature'."

artificial insemination of the husband's sperm because it separates the unitive and procreative meanings of the conjugal act, even though conception occurs within the mother's body. Likewise the Church disapproves *in vitro* fertilisation (IVF) because the child is not conceived as the result of the conjugal act and so is not the child of the marriage union.

There is no right to have a child as though she or he were a commodity. The more we fail to submit to, and diverge from, the Creator's design for the transmission of human life imprinted in the nature of the human person, the more we tend to view human embryos as impersonal objects and less our equals in dignity and nature with a claim to our care.

Assisted Insemination

Assisted insemination differs from artificial insemination in that assistance is given to enable the conjugal act to occur or to enable it to achieve its natural purpose of conception. Technological assistance may be required to enable semen deposited in the vagina to reach the fallopian tubes where conception normally occurs. Assisted insemination is morally permissible since it does not replace the conjugal act and conception occurs within the mother's body. Sperm retrieved after the conjugal act

“Assisted insemination is morally permissible since it does not replace the conjugal act and conception occurs within the mother's body”

may be placed in a catheter with eggs separated by an air bubble. They may then be injected into the fallopian tube for conception to occur where it normally does. This procedure is called **G.I.F.T.** (*gametes intra fallopian transfer*) and from a moral point of view may be deemed a form of assisted insemination. *G.I.F.T.* has been neither approved nor rejected by Catholic Teaching.

Donor Gametes

Infertility may be caused by defective sperm or eggs on the part of one or both partners. The only treatment option available is to use healthy donor gametes or donor embryos. Based on the above moral principles, the Church is unable to approve of the use of donor gametes or embryos. Clearly, the child conceived by the use of **donor sperm or egg** is not the

child of the marriage union. Gametes should not be used from outside the marriage union. This deprives growing children of the knowledge and love of their genetic parents and family relations (uncles, aunts, cousins) since the donors are usually anonymous. The social and ethical implications of the use of donor gametes are frightening when so many young people are already personally alienated from their parents and families. The Victorian Parliament has tried to redress this situation by denying permanent anonymity to future donors of gametes. A law was recently passed recognising the right of children born of donor gametes to have access to identifying information about their genetic parents after they turn 18 years.

Everybody has a history and relationships, linked to our genetic origins, that are close to each person. It belongs to our personal identity to have this father and mother, brother and sister, cousins, grand-parents, uncles and aunts etc. These relationships are not arbitrarily chosen. They are determined at our very origins. Unlike animals, we can appreciate the importance of such biological relationships as genetic motherhood and fatherhood which causally determine our biological identity.

Breeding methods that are suited to animals fail to befit the dignity of persons. There is a need to know, to love and be loved by, our own genetic parents. Many adopted children yearn to meet their unknown biological parents. It would be normal for young persons to experience some suffering as a result of the deprivation of a loving relationship with their ge-

“Breeding methods that are suited to animals fail to befit the dignity of persons”

netic parents. Many single mothers are only too acutely aware of the harm inflicted on their children by the absence and neglect of their unknown natural fathers. In fact, this is one of the reasons why many women feel the need of having an abortion in

such tragic circumstances.

Adoption is a solution for children deprived of their natural parents by death or some tragedy. It is one thing to adopt infants and children abandoned by one or both of their natural parents, it is quite another thing to deliberately engineer situations that result in children being conceived and born who will be unable to know, love and be loved by one or both of their natural parents. To discount the importance of genetic parents is to underestimate their role in constituting our personal identity. The situation hardly improves when the child eventually meets one or both natural parents, only to be confronted with abysmal apathy or total rejection. This should not surprise since the original reasons for non-involvement only gain momentum as the years pass by. In the upshot, this brings no comfort to young persons seeking a sense of identity by knowing their genetic parents.

It is morally irresponsible for people to anonymously donate sperm or eggs and thereby become natural parents without a care in the world for the wellbeing of their offspring. The same applies to donor embryos. Harm is not meant -- indeed host and foster parents have the best of intentions. Effective harm, however, is done all the same in many cases. Infertile couples should think twice before having children at the cost of using donor sperm, eggs or embryos. Parenthood is something wonderful: its greatness derives from the personal dignity of the child, whose life is yet to unfold for years to come. Parenthood should not be achieved at the expense of the authentic personal dignity and value of the child.

Artificial insemination by donor (AID) is already fairly prevalent in Australia. If its incidence were to increase significantly it would be possible for informed teenagers to question whether their *parents* really were their genetic mother and/or father. This would impact negatively on their personal development and security as it would undermine trust in their parents. There are enough youngsters

from disturbed families who experience hurt and who cause harm to the community without risking destabilising families further.

Surrogacy

A wife who has had a hysterectomy may have good eggs, but she cannot bear a child. The couple may have an embryo formed from the fusion of their own or donor gametes implanted into the womb of a surrogate mother for gestation. After birth the surrogate mother would be expected to hand the child over to the commissioning couple -- be they the genetic or social parents. All this would undermine the importance of natural motherhood which includes the genetic dimension, gestation and the rearing of the child. The true mother is the one who gives birth to the child. The mother's role should not be reduced to gestation alone as though she were just an *incubator*, divorced from on-going maternal relationships with her child.

As a matter of public policy, the law should not undermine fundamental family relationships like motherhood to the detriment of the long-term in-

terests of children and parental responsibilities. The legal sanctioning of surrogacy blurs the child's identity, disrupts the natural links between marriage, conception of the marriage union, gestation, birth and the rearing of the child.

Adults involved in surrogacy arrangements cannot act as though only they are involved. An individualistic con-

“An individualistic concept of autonomy and reproductive freedom overlooks the rights of the child who is easily treated as an impersonal object”

cept of autonomy and reproductive freedom overlooks the rights of the child who is easily treated as an impersonal object. The notion of harm is restricted to exclude psychological hurt. It is not a question of it being better to be than not to be. Accepting this line of argument could lead to justifying the conception of children by adulterous affairs. Adultery is immoral and ought not be committed even if it may give rise to children destined to enjoy eternal happiness in heaven.

Granted that infertility is frequently self-inflicted either intentionally or as a result of ignorance or sexually transmissible diseases, the Government should allocate more funds to research the causes of infertility and to educate the young and the whole community on how to reduce the incidence of infertility. Technology should be at the service of persons, not persons at the service of technology.

These moral reflections on the use of reproductive technology for infertility treatment options will be concluded with considerations on the manipulation of human embryos in the next issue of the Bulletin.

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