P U B L I C H E A R I N G

before

ASSEMBLY JUDICIARY COMMITTEE

ASSEMBLY BILLS 3035, 3036, 3037, 3038, 3039, 3040 AND ASSEMBLY JOINT RESOLUTION 76

(Surrogate Parenthood)

May 7, 1987
Room 424
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman Walter M.D. Kern, Jr., Chairman
Assemblyman Gary W. Stuhltrager, Vice Chairman
Assemblyman Thomas J. Shusted
Assemblyman John A. Girgenti
Assemblyman Eugene H. Thompson

ALSO PRESENT:

Barbara S. Hutcheon
Office of Legislative Services
Aide, Assembly Judiciary Committee

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Hearing Recorded and Transcribed by
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Public Information Office
Hearing Unit
State House Annex
CN 068
Trenton, New Jersey 08625

New Jersey State Legislature
ASSEMBLY JUDICIARY COMMITTEE
STATE HOUSE ANNEX, CN-068
TRENTON, NEW JERSEY 08625
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MEMORANDUM

TO: Members of the Assembly Judiciary Committee

FROM: Barbara S. Hutcheon, Aide to the Committee

DATE: April 14, 1987

SUBJECT: COMMITTEE MEETING - MAY 7, 1987

Please address any comments and questions to Barbara S. Hutcheon, Committee Aide.

The Assembly Judiciary Committee will meet on Thursday, May 7, 1987 at 10:00 a.m. in Room 403 in the State House Annex, Trenton, New Jersey.

The Committee will consider the following bills:

A-3035 Kern	Provides for liability for failure to warn of the side effects of fertility drugs.
A-3036 Kern	Provides for rights and liabilities of persons engaging in fertilization procedures.
A-3037 Kern	Regulates certain aspects of artificial insemination procedures.
A-3038 Kern	Provides requirements for surrogate parenthood contracts.
A-3039 Kern	Provides for the possession of frozen embryos in divorce proceedings and rights of inestate succession.
A-3040 Kern	Requires physicians to provide patients with certain information concerning sterilization procedures.
AJR-76 Felice	Creates a commission to study the subject of surrogate parenthood.

ASSEMBLY, No. 3035

STATE OF NEW JERSEY

INTRODUCED SEPTEMBER 11, 1986

By Assemblyman KERN

AN ACT concerning the responsibility of a physician to inform patients about the possible side effects from the use of fertility drugs.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. As used in this act "fertility drugs" means any medication administered to enhance the child-bearing capabilities of its recipient, including gonadotropin.

2. Prior to the administration of a fertility drug to a patient, a physician shall:

a. Warn the patient of the possible overstimulation of the ovaries or of potential drop in blood pressure as a result of taking a fertility drug;

b. Warn the patient of any other possible side effect, including, but not limited to, multiple births; and

c. Warn the patient about any possibility that the medication or treatment may result in an inability to reproduce.

3. The failure to comply with the provisions of section 2 of this act shall give rise to a cause of action for compensatory and punitive damages.

4. This act shall take effect immediately.

STATEMENT

This bill sets forth the responsibility of a physician to warn his patients of the possible side effects involved in taking fertility drugs. The failure to provide these warnings shall give rise to a cause of action for compensatory and punitive damages.

TORT LIABILITY AND MALPRACTICE

Provides for liability for failure to warn of the side effects of fertility drugs.

ASSEMBLY, No. 3036

STATE OF NEW JERSEY

INTRODUCED SEPTEMBER 11, 1986

By Assemblyman KERN

AN ACT concerning in vitro and in vivo fertilization.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. As used in this act:

a. "Female donor" means a woman who gives or sells her ova for use in an in vitro or in vivo fertilization procedure.

b. "Frozen embryo" means the frozen conceptus of an in vitro or in vivo fertilization.

c. "In vitro fertilization" means the process by which an egg is surgically removed from a woman and fertilized in a petri dish.

d. "In vivo fertilization" means the fertilization of an egg within a female's body with the intention that the embryo will be removed and transferred to the body of another female.

e. "Male donor" means a man who gives or sells his semen to a practitioner for use in an artificial insemination procedure.

f. "Prospective parents" means the person or persons who intend to raise the offspring of an in vitro or in vivo fertilization, and who entered in a contract pursuant to section 5 of this act.

g. "Surrogate or surrogate mother" means a woman at least 18 years of age who consents to be artifically inseminated with the semen of the infertile woman's husband or with the semen of a male donor and to carry the child to full term and then to voluntarily relinquish her parental rights to that child in favor of the prospective parents.

2. In vitro and in vivo fertilization procedures shall be performed by a licensed physician. The freezing semen, ova or embryos shall be performed under the supervision of a licensed physician.

3. All persons participating in an in vitro or in vivo fertilization procedure, except persons who have donated their genetic material for that purpose, must execute a contract prior to performing the procedure, which provides what action is to be taken if one or both

of the prospective parents dies or otherwise become unable to assume their responsibilities toward the embryo.

4. a. Prior to performing the fertilization procedure, the physician shall, in plain language, explain to the parties the steps that will be undertaken and the risks involved.

b. Failure to comply with the provisions of subsection a. of this section shall render the physician liable for compensatory damages, up to a maximum of $250,000.00.

5. The prospective parents of the embryo or frozen embryo shall have all rights to the embryo.

6. A female donor shall, in writing, relinquish all rights to the offspring of an in vitro or in vivo fertilization prior to providing her genetic material.

7. In the event a physician fails to retrieve an embryo from a female donor after a successful in vivo fertilization procedure, the female shall be entitled to terminate the pregnancy at the expense of the prospective parents, unless the parties agree otherwise. The parties may agree to continue the pregancy by executing a surrogate parenthood contract.

8. It shall be a crime of the third degree to sell embryos or frozen embryos.

9. This act shall take effect immediately.

STATEMENT

This bill sets forth the rights and liabilities of persons who wish to participate in alternative means of reproduction. It provides definitions for in vitro and in vivo fertilization procedures which must be performed under the supervision of a licensed physician. All persons who wish to participate in an in vitro or in vivo fertilization process must execute a written contract which will provide the action to be taken in the event of the death or incapacity of the prospective parents. The physician must explain the nature of the procedure and the risks involved, or be liable for compensatory damages up to $250,000.00. If the physician fails to retrieve an embryo from a female donor, she will be entitled to an abortion at the prospective parent's expense or to act as a surrogate mother and bear the child. It shall be a crime of the third degree to sell an embryo or frozen embryo.

DOMESTIC RELATIONS

Provides for rights and liabilities of persons engaging in fertilization procedures.

ASSEMBLY, No. 3037

STATE OF NEW JERSEY

INTRODUCED SEPTEMBER 11, 1986

By Assemblyman KERN

AN ACT concerning the regulation of artificial insemination procedures and repealing section 7 of P. L. 1983, c. 17.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. As used in this act:

a. "Artificial insemination" means the introduction of semen into a woman's vagina, cervical canal or uterus through the use of instruments or other artificial means with the intent of causing pregnancy.

b. "Department" means the Department of Health.

c. "Donor" or "male donor" means a man who gives or sells his semen to a practitioner for use in an artificial insemination procedure.

d. "Health care facility" means those facilities described in section 2 of P. L. 1971, c. 136 (C. 26:2H-2).

e. "Practitioner" means a physician or a licensed health care provider who works under the direct supervision of a physician.

2. This act shall apply only to artificial insemination procedures performed by a practitioner in a health care facility.

3. The Department of Health shall maintain records of all semen donors. The records held by the department shall be kept confidential and shall be exempted from the requirements of P. L. 1963, c. 73 (C. 47:1A-1 et seq.). The records shall be disclosed by the department only to a practitioner who requires the information to perform an artificial insemination procedure according to the provisions of this act.

4.a. A practitioner performing an artificial insemination procedure shall obtain the proposed male donor's records from the department. If records do not exist for the proposed donor or if the records do not contain information concerning the proposed donor's genetic history, the practitioner shall screen the proposed donor for hereditary disorders as defined in Section 3 of P. L. 1981, c. 502 (C. 26:5B–3) and obtain a genetic history from him. The practitioner shall also test a proposed donor for sexually transmitted disease within one week before his semen is donated.

b. A practitioner shall not use a proposed donor's semen for an artificial insemination procedure if the donor has a sexually transmitted disease at the time the semen is donated or if the proposed donor has a known genetic disease or defect.

5. A practitioner shall not:

a. Use a donor's semen for more than 20 different artificially inseminated pregnancies; and

b. Use semen from more than one donor in any one menstrual cycle of a woman undergoing an artificial insemination procedure.

6. Upon the successful conception of a woman through an artificial insemination procedure, the practitioner who performed the procedure shall send to the department the records of the donor whose semen was used in the procedure.

7. A person who willfully violates this act or any rule or regulation promulgated pursuant to it, is subject to a penalty of $200.00 for the first offense and $500.00 for each subsequent offense. The penalty shall be collected and enforced by summary proceedings under "the penalty enforcement law," N. J. S. 2A:58–1 et seq.

8. The donor of the semen used for an artificial insemination procedure shall be treated in law as if he were not the natural father of a child conceived by the procedure unless:

a. The donor is the husband of the woman who has conceived the child;

b. The donor adopts the child with the mother's consent; or

c. The donor and the mother agree in writing that the donor shall be the father.

9. If artificial insemination is to be performed on a married woman with semen donated by a man who is not her husband, the married woman and her husband shall sign a consent form. The practitioner shall certify their signatures and the date of the insemination, and file the consent form with the department, where it shall be kept confidential and in a sealed file. A married woman's failure to obtain her husband's consent for an artificial insemination with semen donated by a man other than her husband is deemed to be adultery, for the purposes of N. J. S. 2A:34–2.

10. The status of a child conceived through artificial insemination shall be determined by New Jersey law if the child is born to a mother domiciled in this State.

11. This act shall not be construed as a change or modification of the rights or status of a child born before this act is enacted.

12. The Commissioner of the Department of Health shall promulgate those rules and regulations pursuant to the "Administrative Procedure Act," P. L. 1968, c. 410 (C. 52:14B–1 et seq.) necessary to effectuate the purposes of this act.

13. Section 7 of P. L. 1983, c. 17 (C. 9:17–44) is repealed.

14. This act shall take effect on the 120th day after enactment.

STATEMENT

This bill regulates certain aspects of artificial insemination procedures. To remedy the lack of record keeping in this area, this bill requires physicians and other health care practitioners performing this procedure to screen the proposed semen donors for sexually transmitted and hereditary disorders. Information gathered by these physicians and health care practitioners is to be given to the Department of Health where it will be confidentially maintained.

Under the provisions of this bill, a married woman's failure to obtain her husband's consent for an artificial insemination with semen donated by a man other than her husband is deemed to be adultery and therefore a cause for divorce under N. J. S. 2A:34–2.

This bill also addresses the question of paternity in regard to a child conceeived through artificial insemination. A donor shall be treated as if he were not the natural father unless he is married to the woman who has conceived the child, the mother consents to his adopting the child, or the mother and he agree in writing that he shall be the father.

This bill repeals section 7 of P. L. 1983, c. 17 (C. 9:17–44) because the provisions of that section are incorporated into this bill.

HEALTH—GENERAL

Regulates certain aspects of artificial insemination procedures.

ASSEMBLY, No. 3038

STATE OF NEW JERSEY

INTRODUCED SEPTEMBER 11, 1986

By Assemblyman KERN

AN ACT concerning surrogate motherhood and supplementing Title 9 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. It is the intent of the Legislature to facilitate the ability of infertile married couples to become parents through the employment of the services of a surrogate mother. The Legislature finds and declares that surrogate parenthood contracts are in accord with the public policy of this State.

2. As used in this act:

a. "Artificial insemination" means the placement of semen into a woman's reproductive tract for purposes of conception.

b. "Genetic material" means ova and sperm.

c. "Health care facility" means those facilities described in section 2 of P. L. 1971, c. 136 (C. 26:2H-2).

d. "Husband" means the male partner of a married couple.

e. "In vitro fertilization" means the process by which an egg is surgically removed from a woman and fertilized in a petri dish with sperm.

f. "Male donor" means a male who gives or sells his sperm to a practitioner for the purpose of artificial insemination.

g. "Married couple" means the persons who have executed a contract pursuant to section 6 of this act and who intend to adopt the child born to the surrogate mother.

h. "Practitioner" means a physician or a licensed health care provider who works under the direct supervision of a physician.

i. "Surrogate" or "surrogate mother" means a woman at least 18 years of age who executes a contract pursuant to section 6 of this act and who intends to relinquish all parental rights to the child she bears.

3. This act shall apply only to surrogate motherhood procedures performed by a practitioner in a health care facility.

4. The Department of Health shall maintain records of all surrogate mothers. The records held by the department shall be kept confidential and shall be exempted from the requirements of P. L. 1963, c. 73 (C. 47:1A-1 et seq.). Medical information may only be disclosed to a physician or licensed health care provider, if that information is necessary to care for the child produced by a surrogate motherhood procedure.

5. A practitioner performing a surrogate motherhood procedure shall obtain the surrogate mother's records from the Department of Health. If the records do not exist for the proposed surrogate or if the records do not contain information concerning the proposed surrogate's genetic history, the practitioner shall screen the proposed surrogate for genetic diseases or defects as provided in P. L. 1981, c. 502 (C. 26:5B-1 et seq.) and shall obtain a genetic history from her or her personal medical records. The practitioner shall also test a proposed surrogate for sexually transmitted diseases prior to performing the artificial insemination or in vitro fertilization.

6. Prior to performing the artificial insemination or in vitro fertilization, a contract shall be executed by the surrogate, the married couple, and the practitioner supervising the procedure. The contract shall include, but is not limited to, the following clauses:

a. The terms of payment or compensation, if any, to the surrogate, including time and manner of payment;

b. The medical treatment, if any, to be provided to the surrogate, after the birth of the child;

c. A statement providing that the surrogate will relinquish the child for adoption and that the married couple will adopt the child, regardless of the child's condition;

d. A statement providing that the surrogate will refrain from sexual intercourse while she is trying to conceive for the married couple; and

e. A specific medical examination schedule to be followed by the surrogate.

7. A contract entered into pursuant to section 6 of this act shall be voidable up to the point of conception.

8. Whenever the child that is gestated within the surrogate is not genetically related to the surrogate or to the married couple, the married couple shall have the first right of adoption, provided that a contract pursuant to section 6 of this act has been entered into by the surrogate and the married couple.

9. If the surrogate is undergoing artificial insemination by donor rather than by the husband, the donor shall have no legal rights to the child.

10. Artificial insemination of a surrogate shall be performed in a proper health care facility and shall be governed by State health laws governing artificial insemination.

11. The surrogate shall contact the doctor performing the artificial insemination, if there are any major changes in her health which are of a genetic nature, after the birth of the child. This duty to disclose shall be continuing and the failure on the part of the surrogate to do so shall render her liable in compensatory and punitive damages.

12. The practitioner supervising the artificial insemination and the pregnancy of the surrogate shall forward a copy of the parties' medical records and a copy of the contract entered into pursuant to section 6 of this act to the Department of Health.

13. Notwithstanding the provisions of P. L. 1983, c. 17 (C. 9:17-38 et seq.) or any other provisions of law to the contrary, the husband shall be the natural father, with all the rights, duties and obligations of that relationship, of the child born to a woman who agrees to act as a surrogate mother when the child was conceived during the period of time during which it was possible for her to have conceived as a result of the artificial insemination made under a surrogate parenthood contract. The name of the husband and the surrogate shall be entered on the birth certificate for the child as the child's parents.

14. Material assistance provided by a agent, finder or intermediary for or between a married couple and a surrogate mother for the purpose of forming a surrogate parenthood arrangement and executing a surrogate parenthood contract shall not constitute a violation of section 3 of P. L. 1977, c. 367 (C. 9:3-39) or any other conflicting provisions of law.

15. In the event of a dispute as to the custody of a child conceived under a surrogate parenthood contract the provisions of the contract as to the custody of the child shall prevail, unless a court finds that extraordinary circumstances require otherwise.

16. Upon a breach of a surrogate parenthood contract, a court

may grant any legal and equitable relief it deems appropriate, including specific performance.

17. A person who violates any provision of this act is guilty of a disorderly persons offense.

18. This act shall take effect immediately.

STATEMENT

This bill provides for the regulation of surrogate parenthood arrangements and surrogate parenthood contracts. It is the intent of the Legislature to facilitate the ability of infertile married couples to become parents through the use of surrogate mothers.

This bill sets forth the requirements of a surrogate parenthood contract which must be executed prior to performing artificial insemination or in vitro fertilization on the surrogate mother. The proposed surrogate shall be tested for genetic diseases or defects as well as sexually transmitted diseases.

The bill provides for the acknowledgment of paternity by the husband and the relinquishment of parental rights by the surrogate. Payments made to a surrogate or to an agent, finder or intermediary do not violate existing laws which prohibit payment in connection with the adoption of a child.

In the event of a custody dispute the provisions of the surrogate parenthood contract would prevail and in the event of a breach of the contract, a court is authorized to grant any legal and equitable relief, including specific performance.

DOMESTIC RELATIONS

Provides requirements for surrogate parenthood contracts.

ASSEMBLY, No. 3039

STATE OF NEW JERSEY

INTRODUCED SEPTEMBER 11, 1986

By Assemblyman KERN

AN ACT concerning in vitro fertilization amending N. J. S. 2A:34–23 and N. J. S. 3B:5–8 and supplementing Title 2A of the New Jersey Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. N. J. S. 2A:34–23 is amended to read as follows:

2A:34–23. Pending any matrimonial action brought in this State or elsewhere, or after judgment of divorce or maintenance, whether obtained in this State or elsewhere, the court may make such order as to the alimony or maintenance of the parties, and also as to the care, custody, education and maintenance of the children, or any of them, as the circumstances of the parties and the nature of the case shall render fit, reasonable and just, and require reasonable security for the due observance of such orders. *Unless the parties have entered into a written agreement to the contrary, the female party shall have the right of possession of a frozen embryo conceived through in vitro fertilization.* Upon neglect or refusal to give such reasonable security, as shall be required, or upon default in complying with any such order, the court may award and issue process for the immediate sequestration of the personal estate, and the rents and profits of the real estate of the party so charged, and appoint a receiver thereof, and cause such personal estate and the rents and profits of such real estate, or so much thereof as shall be necessary, to be applied toward such alimony and maintenance as to the said court shall from time to time seem reasonable and just; or the performance of the said

Matter printed in italics *thus* is new matter.

orders may be enforced by other ways according to the practice of the court. Orders so made may be revised and altered by the court from time to time as circumstances may require.

In all actions brought for divorce, divorce from bed and board, or nullity the court may award alimony to either party, and in so doing shall consider the actual need and ability to pay of the parties and the duration of the marriage. In all actions for divorce other than those where judgment is granted solely on the ground of separation the court may consider also the proofs made in establishing such ground in determining an amount of alimony or maintenance that is fit, reasonable and just. In all actions for divorce or divorce from bed and board where judgment is granted on the ground of institutionalization for mental illness the court may consider the possible burden upon the taxpayers of the State as well as the ability of the plaintiff to pay in determining an amount of maintenance to be awarded.

In all actions where a judgment of divorce or divorce from bed and board is entered the court may make such award or awards to the parties, in addition to alimony and maintenance, to effectuate an equitable distribution of the property, both real and personal, which was legally and beneficially acquired by them or either of them during the marriage. However, all such property, real, personal or otherwise, legally or beneficially acquired during the marriage by either party by way of gift, devise, or intestate succession shall not be subject to equitable distribution, except that inter-spousal gifts shall be subject to equitable distribution.

2. N. J. S. 3B:5-8 is amended to read as follows:

3B:5-8. After born heirs. Relatives of the decedent conceived before his death but born *within 300 days* thereafter inherit as if they had been born in the lifetime of the decedent.

3. (New section) In the event of the death of either party involved in a divorce proceeding, the surviving party shall be entitled to custody of a frozen embryo. The noncustodial party shall not be ordered to pay child support in the event the frozen embryo is gestated without that party's written consent. A frozen embryo shall not be transferred to a third person without the written consent of both parties. The husband shall be entitled to exercise sole control and authority over any of his semen stored in a sperm bank.

4. This act shall take effect immediately.

STATEMENT

Current law has not dealt with the issue of the status of frozen embryos conceived through in vitro fertilization. This bill gives the female party in a divorce proceeding possession of any frozen embryos unless the parties have provided otherwise in a written agreement. It also provides that in the event of the death of either party, custody shall go to the survivor. Gestation of a frozen embryo, without the written consent of the other party shall not render that party liable for child support. It also amends the intestacy statute to require that a decedent's relatives conceived before his death, must be born within 300 days after the death in order to share in the estate. Present law has no time requirement.

CHILDREN

Provides for possession of frozen embryos in divorce proceedings and rights of intestate succession thereof.

ASSEMBLY, No. 3040

STATE OF NEW JERSEY

INTRODUCED SEPTEMBER 11, 1986

By Assemblyman KERN

AN ACT concerning surgical sexual sterilization and supplementing Title 45 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Before a physician performs a vasectomy, tubal sterilization or other surgical sexual sterilization procedure requested by a patient, the physician shall obtain written consent from the patient or the patient's authorized representative on a form which states that the patient has been informed as to:

a. The possibility that the sterilization procedure may fail to result in permanent sterility; and

b. The availability of procedures to store the patient's reproductive cells for future use.

This section shall not be construed to require a physician to obtain this written consent if the sterilization procedure is performed under an emergency situation that imminently threatens the life of the patient.

2. A physician who fails to comply with this act is liable for action by the State Board of Medical Examiners pursuant to article 1 of chapter 9 of Title 45 of the Revised Statutes.

3. This act shall take effect on the 90th day after enactment.

STATEMENT

This bill requires a physician who is requested to perform a vasectomy, tubal sterilization or other surgical sexual sterilization procedure to inform the patient of the potential for the operation to fail to result in sterility. This bill also requires the physician to inform the patient about procedures for storage of reproductive cells for future use. The physician is not required to comply with these consent requirements if the operation is performed under emergency circumstances.

HEALTH—GENERAL

Requires physicians to provide patients with certain information concerning sterilization procedures.

ASSEMBLY JOINT RESOLUTION No. 76

STATE OF NEW JERSEY

INTRODUCED SEPTEMBER 11, 1986

By Assemblyman FELICE, Assemblywoman RANDALL, Assemblymen Littell, DiGaetano and Assemblywoman Donovan

A JOINT RESOLUTION creating a commission to study the subject of surrogate parenthood.

WHEREAS, Presently pending before the court of New Jersey are several cases involving surrogate parenthood agreements or contracts between an infertile couple and a surrogate mother; and

WHEREAS, These cases present novel issues of law as to the rights and obligations of each of these parties, as well as issues as to the rights of the unborn child; and

WHEREAS, Judicial resolution of these difficult questions on a case-by-case basis does not preclude the need for legislative action in this area; now, therefore,

BE IT RESOLVED *by the Senate and General Assembly of the State of New Jersey:*

1. There is established a commission to be known as the Surrogate Parenthood Study Commission. The commission shall consist of 11 members, two to be appointed from the membership of the Senate by the President thereof, who shall not be of the same political party; two to be appointed from the membership of the General Assembly by the Speaker thereof, who shall not be of the same political party; the Chief Justice of the Supreme Court or his designee; two members from the Family Law and two members from the Women's Rights Sections of the New Jersey State Bar Association; and two public members qualified by their experience in the area of domestic relations, one appointed by the President of the Senate and one appointed by the Speaker of the General Assembly. Vacancies in the commission shall be filled in the manner provided for the original appointments. Mem-

bers of the commission shall serve without compensation, but shall be reimbursed for their expenses actually incurred in the performance of their duties.

2. The commission shall organize as soon as possible after the appointment of its members and shall select a chairman from among its members and a secretary who need not be a member of the commission.

3. It shall be the duty of the commission to study the subject of surrogate parenthood and the public policy implications raised by the issues presented. The commission shall consider whether surrogate parenthood contracts are in accord with the public policy of this State. It also shall consider whether sufficient guidance is provided to the courts in making determinations related to surrogate parenthood controversies and whether legislative action is necessary.

4. The commission shall be entitled to call to its assistance and avail itself of the services of the employees of any State, county or municipal department, board, bureau, commission or agency which may be available to it for its purpose and to employ stenographic and clerical assistants and incur traveling and other miscellaneous expenses necessary to perform its duties within the limits of funds appropriated or otherwise made available to it.

5. The commission may meet and hold hearings at any place or places it designates during the session or recesses of the Legislature and shall report its findings and recommendations to the Governor and the Legislature no later than one year following its organization. Recommendations may include suggested legislation.

6. This joint resolution shall take effect immediately and shall expire upon the submission by the commission of its report pursuant to section 5.

STATEMENT

This bill creates the Surrogate Parenthood Study Commission. The commission shall consist of 11 members who shall study the need for legislative action in this area during the year following organization.

The commission shall consider the public policy implications raised by the difficult issues presented in surrogate mother cases.

DOMESTIC RELATIONS

Creates a commission to study the subject of surrogate parenthood.

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ASSEMBLYMAN WALTER M.D. KERN, JR. (Chairman): This is a public hearing with respect to the following pieces of legislation: A-3035, which provides for liability for failure to warn of the side effects of fertility drugs; A-3036, which provides for the rights and liabilities of persons engaging in fertilization processes; A-3037, which regulates certain aspects of artificial insemination procedures; A-3038, which provides requirements for surrogate parenthood contracts; A-3039, which provides for the possession of frozen embryos in divorce proceedings and rights of intestate succession; A-3040, which requires physicians to provide patients with certain information concerning sterilization procedures; and AJR-76, which creates a commission to study the subject of surrogate parenthood.

This legislation has come about as a result of the new medical technologies that have developed. It is not as a result of any litigation that has recently finished with respect to the trial. The legislation, in fact, preceded the litigation. It is trying to address a situation where technology has jumped ahead of law.

I would first of all like to hear from Gary N. Skoloff, Esq.

G A R Y N. S K O L O F F, E S Q.: Good morning, Mr. Chairman, members of the Committee. My name is Gary Skoloff. I was one of the trial lawyers representing the Sterns in the Baby M case recently completed, and now on appeal to the Supreme Court. As a result of my participation in that case, I have studied the issue of surrogate parenting and all of its ramifications.

I was sent Assembly Bill 3038, introduced by Assemblyman Kern, and asked to come here today to testify on the subject. I am here to testify in favor of this Assembly bill, which I think is drawn extremely well, very carefully, and covers everything that has to be done for the moment. I

would urge, as strongly as I can, that the Assembly and the Senate pass legislation forthwith.

The bottom line is that one out of seven married couples in the United States of America are infertile. They cannot have their own children. The only other alternative as a way of having a family is by adoption. I say to you that all of the studies indicate that that is no longer a viable method. There simply are not children available for adoption, based primarily on the fact that abortion is legalized, and further that many single women who have a child now decide to keep that child, and raise that child. It is socially acceptable. Adoption as a viable alternative is no longer in existence.

Therefore, these one out of seven couples who just suffer incredible pain -- they get married and they seek to put together the American dream of a good marriage, a home, and a family -- fail on the third score. They are not able to have a child. As a result, surrogate parenting is the only viable option they have. When you take into account the fact that it has two very valid aspects to it that adoption doesn't, it makes it even more meaningful.

One, the blood and genes of one of the two parents are in the baby, and secondly, with all of our concerns about physical problems, all of our concerns about illness which exist today, such as AIDS, because of the requirements for the physical examination, you know that the woman carrying the baby -- the odds are very strong -- is a healthy woman, and is therefore carrying a healthy baby. So, for those two reasons alone, surrogate parenting makes that much more sense. In terms of ever declaring it illegal or invalid, it would be as absurd as prohibition. It can never be stopped in this country. The urge of any family -- of any husband and wife -- to have a child is so great, that the only thing you can do is accept the fact, whether you really like it or not, that

surrogate parenting is here, will be here to stay, and that the best that can be done is to set up the kind of legislation that Assemblyman Kern put forth in his Assembly Bill 3038, which will simply legalize it and set forth procedures for it.

This bill carries out the intention of what it would be all about. It is, in some respects, similar to any other bill I have seen pending anywhere in the country, a lot of which have been sent to me. No state has enacted any legislation yet. The time has come, and the quicker the better, because my greatest fear is that what is going to happen is, unless you have legislation in effect right away, unless you have that law set down right away, you are going to face two different kinds of problems. One, you are going to have more Baby M cases, which would be an embarrassment to the legal system and to the Legislatures throughout our country. In spite of the fact that we knew about this for many, many years, not one Legislature in this nation has enacted legislation. Secondly, you are going to have couples who want to have that child start making all kinds of side deals, if they cannot go through it legally, as we know from what happened with adoption in prior years, which will only result in all kinds of chaos, further kinds of legal problems, and a lot of pain and suffering for too many people. Assembly Bill 3038 will clear all of that up.

I also had occasion to look at Assembly Joint Resolution 76, which is a commission to study the subject of surrogate parenthood. While I think that is a great idea and I am always a believer in another commission to do another study, to be perfectly frank, we don't need it. I am totally in favor of some kind of a study commission that will, a year after legislation has been enacted, review what has been happening, and see if there are any supplements or amendments that should occur to make the legislation work even better and clear everything up. But, if we are talking about killing another

year to go through that on which all of the literature has been written everywhere in this country, or all that was produced in the Baby M trial, or all that is already available for every member of the Assembly and the Senate, you are going to see, when we go through a hearing, 200 people take the stand and say that which 200 people have said and written about in literature amassed throughout the country and the world.

So, I say have the commission, but utilize it not in lieu of an immediate act. Now, New Jersey was the State that led the country on the issue. New Jersey litigated the first case. New Jersey has a trial opinion of 131 pages, and our Supreme Court is going to hear it in September. There is no reason why New Jersey should not be the first State to enact legislation. In the same sense that many of the states are reading the Baby M opinion and making their decisions accordingly, let the other states read the first statute enacted in the United States, and follow the Kern bill as closely as they are willing to.

I think that is the information I can give you, except for any questions, which I would be very pleased to answer.

ASSEMBLYMAN KERN: Thank you very much, Mr. Skoloff. We very much appreciate your coming here today. There have been comments in the press from some advocates that this would be a wonderful procedure for those who are not married, those who are homosexuals, and that we could have, in the future, "children with parents of the same sex." This legislation doesn't propose that; in fact, it prohibits that. Could you comment on that?

MR. SKOLOFF: Yes. I, myself, have mixed emotions on those two issues, whether or not a single woman should be allowed to have a child through a surrogate mother under this kind of legislation, or homosexuals. I think that is the kind of an issue that the study commission over the years down the road can look at and make its decisions accordingly and make

recommendations. For the moment, that is a highly controversial issue, with heavy arguments on both sides. For the moment, having the clean bill enacted, which means a married couple who are infertile, because there is also going to be the issue raised one day, suppose there is a married woman who could have a child, but because of her career, or she is a model, or something like that-- There is actually no infertility problem whatsoever, but she does not wish to carry a child. One in 50,000 couples would be my guess. But, whatever it is, this or something else, let the study commission play with those kinds of one-tenth of 1% problems down the road. For the moment, A-3038, as it stands, ought to just be enacted.

ASSEMBLYMAN KERN: Thank you. Does any other member of the Committee have any questions? Vice Chairman Stuhltrager?

ASSEMBLYMAN STUHLTRAGER: Mr. Skoloff, you characterize this procedure as something that with or without legislation couples desiring children are going to look at, much like the same argument used with abortion, or with the legalization of drugs, for that matter. If we can't stop it, we may as well move in that direction.

Just so I understand, are you saying that simply because it is inevitable we have to move forward, or do you have feelings that it is also a positive procedure in and of itself?

MR. SKOLOFF: It is very much a positive procedure in and of itself. These infertile couples-- Unless you know a couple who are married and want children and cannot have them, you cannot grasp how much pain there is, how much suffering. It encompasses their every day. They look around them at their friends who have the house and the family and they're working hard and moving up on whatever ladder they're moving on. These people who cannot have a child become engrossed by it. It detracts from their everyday living. They want to have a child

for all of the good reasons, because it is such a wonderful thing to be a family with children. It is a positive thing. It is something that can be accomplished through the use of this kind of legislation, and it is superior to adoption, because the blood and genes of the father will be in the baby, and we know that the mother carrying the baby is going to be healthy.

It is something that should be enacted. It should be done in the best interest of society.

ASSEMBLYMAN STUHLTRAGER: How do we answer the question, or the charge that it is the haves exploiting the have nots?

MR. SKOLOFF: Oh, I don't accept that at all. It is the have and the have nots, not in terms of economics -- which is what you mean, sir -- but in terms of a couple who cannot have a child and a woman who is willing to give the gift of life to that couple. That is the haves and the have nots. It is not a question of economics. The $10,000 and $20,000 numbers that come into play-- Almost any couple can work it out, the same way that almost any couple can eventually buy some kind of a house or rent some kind of a decent place. It can be done. It is not an economic question. It is the social question of the woman who is infertile and cannot carry a child, and that there is someone else who is willing to offer to do it for her. Why shouldn't that be allowed to be done? It is a good social purpose -- a good social purpose.

ASSEMBLYMAN STUHLTRAGER: I have no further questions. Thank you, Mr. Skoloff.

ASSEMBLYMAN KERN: Assemblyman Thompson?

ASSEMBLYMAN THOMPSON: Counselor, I would like to ask you a couple of questions. I notice that under Assembly Bill 3038 there is no psychological screening of the surrogate mother prior to entering the contract. I think that since the judge so narrowly decided that case based on jurisdiction,

contracts, and another legal term without going into the equitable issues, and you were an attorney in that case, wouldn't you think there should be some prior screening with reference to the psychological demeanor of the surrogate mother?

MR. SKOLOFF: Mr. Thompson, if what you say is correct, then I misread page 2, line 16 e.: "A specific medical examination schedule to be followed by the surrogate." I thought that meant both physical and mental -- psychological counseling -- that sort of situation.

ASSEMBLYMAN THOMPSON: Yeah.

MR. SKOLOFF: If it only means the physical examination, then I agree with you, sir, that instead of "specific medical examination," it should say "specific medical and mental examination," as well as counseling throughout that period of time, which all of the infertility centers throughout the country have -- physical prescreening, and then counseling during the period of the carrying of the baby. I had thought that e., lines 16 and 17, was simply the vague specifics encompassing that kind of a situation.

ASSEMBLYMAN THOMPSON: In essence, this is a very crucial issue, because of the woman's prerogative to change her mind.

MR. SKOLOFF: Before she becomes pregnant.

ASSEMBLYMAN THOMPSON: Well, I don't know, maybe we are rushing a judgment. I have a model statute that was published in the Georgetown University Law School, called "Development and Concept of the Modern Family," and they seem to point out, with reference to the psychological screening-- It isn't just a few sentences saying that you have tests and things like that. They give you some direction, so you are talking about contract law, where she has complied with it, in reference to these terms having been done if you are going to resolve the situation on a contract.

I am asking you, don't you think we should have some stronger language in this legislation, so that we don't come up with another lawsuit because it wasn't done, and you are back in court again?

MR. SKOLOFF: I have no objection to what you said. It makes perfect sense to me to simply put in some more details in terms of minimum hours, minimum amounts of physical examination, minimum amounts of mental examination and psychological examination, and counseling throughout. All of that is totally acceptable to me as an alternate to lines 16 and 17. I really thought this was part of it, sir.

ASSEMBLYMAN KERN: That is also acceptable to the sponsor.

ASSEMBLYMAN THOMPSON: Thank you. I would like to read into the record, if it is permissible, what the model example is. It says: "The certificate of a person who is a licensed psychologist or a licensed psychiatrist, but not a person described in section 3 of the subsection of this act." What it does, in total, is give a breakdown with reference to the person as far as qualifications are concerned, and they determine how the examination will go to make a determination that she is in the right state of mind.

Let me say this, because I have some mixed emotions about this type of legislation. When God created man and woman, He said, "You two are going to have to get along." Man said, "Well, we'll get along, because I am the first to speak." The woman smiled at God, and she said, "Yes, we'll get along, because I will have the last word."

Now, under the New Jersey law of adoption -- this is present law -- the natural mother has 30 days of what is called "post-delivery" to decide whether or not she wants to go through with the adoption. Now, under this law it seems that once the contract is signed, there is no period of law like redemption. It's over. I think that goes against nature, and against women in general.

I will give you an example: A friend of mine, when I grew up in high school-- A girl had a child out of wedlock. She happened to be Irish; he was black. The Catholic Church took the kid and put the kid in a convent, or somewhere. Her mother went up and grabbed the kid. Out of instinct -- 17 years passed -- that woman came from the suburbs with her family and her husband, knocked on the door on Twelfth Street, and told Mrs. So and So, "I want my daughter." Mrs. So and So said, "I raised her for 17 years. You can't have her without a fight, but I will let her make that decision." That's instinct, and I don't see where you can cut something off with a contract, just like that.

MR. SKOLOFF: May I reply?

ASSEMBLYMAN THOMPSON: Yes, sir.

MR. SKOLOFF: Your discussion has to do with adoption. Adoption is the delivery of the child by the mother to a stranger. That is the whole distinction to me between adoption and surrogate parenting. I completely accept the fact that in adoption there should be a cooling off period, a period of time before the natural mother delivers the child -- her child -- to a stranger. There can also be economic coercion involved in that kind of a situation, or all kinds of heavy duty mental problems of a woman carrying a child and deciding to deliver that child to a stranger. I distinguish it totally from surrogate parenting, because, first, the child is being delivered to its natural, biological father, not to a stranger. So, as far as I am concerned, adoption and surrogate parenting are night and day.

In the second case, there is no economic coercion, no kinds of heavy duty mental problems on the part of a woman who, not being pregnant, volunteers to go to an infertility agency and say, "I wish to become a surrogate mother." Then, based on her application, or her voluntarily agreeing to do it, she becomes artificially inseminated by the man, who knows that the

agreement is, "This will be my baby, to be brought up by me, and adopted by my wife." That is the clear understanding of everyone, and the baby is going to the natural, biological father. So, I distinguish between adoption and surrogate parenting, sir, and I say it is a totally different world.

ASSEMBLYMAN THOMPSON: Just one response.

ASSEMBLYMAN KERN: Go right ahead.

ASSEMBLYMAN THOMPSON: The surrogate is the genetic mother.

MR. SKOLOFF: She is the natural mother. By the way, sir, let me just talk about that for a moment. The term "surrogate mother" creates a real problem. You may recollect that at the trial, one of the mental health experts, Dr. Saul (phonetic spelling), took the stand and testified -- and everybody gasped when he said it -- "She is really not a surrogate mother. She is really a surrogate uterus." Now, that can be a little offensive at the beginning, to hear that kind of a term, but I ask you to really think about using the term surrogate mother, which is an improper term, very emotional, leading, perhaps, to an erroneous conclusion. When that woman agreed to carry that baby as a gift of life to another couple, she never intended to be a mother. A mother is one who nurtures and takes care of a child after birth. There was no intention on her part, at the time that this agreement was entered into -- everybody understanding it -- that she would ever be a mother. She would carry the child for another couple and deliver it immediately. So, I even have a problem with the term surrogate mother as perhaps misleading.

ASSEMBLYMAN KERN: Anyone else? Assemblyman Shusted?

ASSEMBLYMAN SHUSTED: Mr. Skoloff--

MR. SKOLOFF: Yes, sir?

ASSEMBLYMAN SHUSTED: --this bill makes reference to contracts. Do you have any opinion on how you could limit the cost? For instance, is there a dollar value? Do we put a ceiling on the stud fee, if you will?

MR. SKOLOFF: Well, I don't like using that term, sir, but I will say this: I would think that it would be appropriate at some time. I would think that perhaps that would be what the commission, after a year or two in operation, would come up with. I would like to see one uniform number throughout the State of New Jersey, so that it would never be a kind of negotiation. Whether the number be $10,000, or a higher or lower number, would be something that would be set, I think, in legislation at some time, and not negotiated through infertility centers.

ASSEMBLYMAN SHUSTED: Then how do we tackle the question of discrimination under those circumstances -- if you set a number? I am talking about economic discrimination.

MR. SKOLOFF: Yes. There is always some kind of economic discrimination. If you say the only way to obviate economic discrimination is not to allow a married couple to have a child, then I say that is worse discrimination. Then you are saying because people are out there, both working very hard trying to do what they want to do, and all for social good-- Because they are making money they can afford to do it and another couple cannot, so nobody can do it. That is reverse economic discrimination.

As to what the number is, I would think that if Assemblyman Kern's bill does not have a number now, a year from now a number will be set, and somewhere down the line it will go up or down, depending on a lot of decisions.

ASSEMBLYMAN SHUSTED: But you do feel that there should be some uniformity?

MR. SKOLOFF: Yes, sir. I would like to see that.

ASSEMBLYMAN KERN: Any other questions? (no response) What about the issue with respect to convenience contracts, where you have a couple who find it inconvenient to conceive and carry a child -- to have one of their own -- and go shopping, so to speak? Do you think there ought to be a

prioritization with respect to procedures to be utilized, in an attempt to utilize the natural abilities of the prospective mother at the present time?

MR. SKOLOFF: A real tough question. Once again, it is one of those one-tenth of 1% situations, because hardly ever will you find a woman who can have a child but is not willing to do it. There will be some along the way. I read all of the arguments on both sides, which go from: "If that is their decision, that even though she is not infertile, she doesn't want to carry her own child," and there is a woman who says, "I understand that you are not infertile, but I am willing to do it for you," then who are we, as lawmakers, to say, "You people can't do it if you want to do it"? All the way to the other side of the coin of, "Now you are reaching a line that perhaps is offensive to public policy."

So, I certainly would agree that at the moment it only be married couples who have infertility problems in their broadest definition. And then let the commission look at it over the years and make a decision as to whether or not it should be expanded.

ASSEMBLYMAN KERN: Do you think that a contract should only be enforceable if -- and only if -- it serves the "best interests of the child," as in the decision in the Baby M case?

MR. SKOLOFF: Oh, no, absolutely not. The whole reason for this legislation is because nowhere in this country, let alone New Jersey, will we go through another Baby M trial, for two reasons. In other words, what I am saying is, let the contract be enforceable or, as you have in your bill, except for that very extraordinary situation -- she finds out he just got convicted when she is in her seventh month, of rape, or some heinous crime -- that sort of extraordinary situation. It cannot be a best interest kind of hearing; otherwise, you will go through one year of litigation in so many of these surrogate parenting cases, and no couple will then do it. You will then have destroyed surrogate parenting as a concept, because once

they even think they are going to face one year of litigation-- It is so expensive; it is so costly in terms of emotion, that it would destroy the whole concept. It has to be a black and white agreement. She understands it, she carries that child, then upon birth, it is delivered -- period. No best interest, other than if you want to have a one-hour hearing just to make sure that the sperm donor, and his wife who is going to adopt, are not cuckoo clocks. If you want to just take some extreme situation like that, but never the real Bessinger (phonetic spelling) hearing in the standard custody case, with all the mental health experts and all the lawyers and the heavy duty drain on the administration of justice unnecessarily.

ASSEMBLYMAN KERN: What about the issue of whether or not the surrogate mother has the right to an abortion?

MR. SKOLOFF: She has that right. She has to have that right.

ASSEMBLYMAN KERN: That cannot be prohibited?

MR. SKOLOFF: No, sir. As stated in Judge Sorkow's written opinion, that cannot be prohibited. If she wants to breach the contract prior to becoming pregnant, she has that right also.

ASSEMBLYMAN KERN: Any other questions?

ASSEMBLYMAN THOMPSON: Yes. Is it in the first trimester, or the third? Is it limited to the first trimester, as far as abortion?

MR. SKOLOFF: I think it goes a little past the first trimester, Mr. Thompson, but I really don't have down pat at exactly what moment that is illegal.

ASSEMBLYMAN KERN: Anyone else? (no response) Gary, I want to thank you very much for coming today and sharing your views with us. I know we are all very appreciative of your taking your time to explore this very important issue. Thank you.

MR. SKOLOFF: Thank you, sir.

ASSEMBLYMAN KERN: I would now like to call Robert Arenstein, Esq.

R O B E R T D. A R E N S T E I N, E S Q.: Good morning, Mr. Chairman and members of the Committee. I appreciate the opportunity to appear before you today to express my views regarding the issues of surrogate parenting and alternate reproduction. I presently chair the Surrogate Parenting Committee of the New York State Bar Association Family Law Section and the American Academy of Matrimonial Lawyers. I am also a member of the New Jersey Bar and a resident of the State of New Jersey. I was also one of the former attorneys representing Mary Beth Whitehead in the Baby M case. We have been studying this area in our Committees in New York, and have made recommendations which are in the process of being disseminated to our Executive Committees. By the way, I have provided a copy of our Committee's recommendations to your Committee, not to be disseminated, but for your Committee's use in your deliberations.

ASSEMBLYMAN KERN: Thank you very much.

MR. ARENSTEIN: I stress that the opinions and recommendations I will make today are those of my personal experience, and do not represent the conclusions of my Committees. These recommendations will be made at a later date.

I have had the opportunity to review Assembly Bills 3035, 3036, 3037, 3038, 3039, 3040, and AJR-76, and as part of my testimony I plan to comment on these bills and expand my views to cover the entire issue of surrogate parenting in the State of New Jersey.

There are many ways in which childless couples can seek to have children. The most prevalent way in our country is that of adoption. Our State, and all of our sister states, have devised laws to protect all parties in the adoption area. There are many people who would say that there are not enough

children in the adoption process to aid and help childless couples obtain children. In fact, they argue that it takes a very long time for a couple to adopt a child, and that many people, as a result of age, religion, sexual preference, and otherwise, have been denied the right to adopt. There may be reasons why these roadblocks have been placed in the adoption process, and I believe that a closer examination of the adoption process in our State may be in order.

To look at the issue of surrogate parenting and the present bills which are before you, raises many questions and problems in my mind. I do not believe that surrogate parenting is a concept which is viable in today's society. I have said on prior occasions that I consider it to be a form of reproductive prostitution, and that it contravenes the prohibitions against buying and selling babies. Further, many nations in the world have found that surrogate parenting should be outlawed, and have taken steps to outlaw the practice before it becomes widespread.

Britain, as a result of the Warnock Commission Report, has banned commercial surrogacy, and the issue has provoked vigorous national debate. Nevertheless, four countries -- West Germany, Norway, Sweden, and the Netherlands -- are considering surrogacy bans and, as we speak right now, the Western European Justice Ministers are meeting in Brussels at a conference on artificial reproduction to ban commercial surrogacy.

In Sweden and Franch, surrogacy is prohibited under adoption regulations, but a Swedish government-appointed inquiry has proposed legislation banning surrogacy as "a doubtful bargaining with children." Israel has banned surrogate parenting as well. The Vatican has strongly condemned surrogacy in a pronouncement in March of this year. The reports of the Waller and Demack Commissions in Australia, and the Warnock Commission in England, all reached the same conclusion with respect to surrogate motherhood arrangements in

any form. They recommend that it be made illegal to: a) advertise to recruit surrogate mothers; b) exchange money as a result of the contract; and c) that surrogate contracts should be treated as null and void and unenforceable as contrary to public policy.

The basic premise in the legislative intent of Assembly Bill 3038 is to facilitate the ability of infertile married couples to become parents through the use of surrogate mothers. The State may not prohibit the practice of surrogate parenting or enact regulations that would have the effect of prohibiting the practice. The right to bear and beget a child is a protected right, but not necessarily the right to contract. The thrust of the European arguments, I believe, is that commercial surrogacy through infertility centers, which are springing up throughout the country, can and should be banned. The altruistic act of somebody who is involved in surrogacy may be for different motivation, but it is clear to me that the infertility centers across the country are profit-making ventures, evidenced by the large number of non-refundable fees which are charged by these clinics.

In addition to protecting the interests of the child born of the surrogate arrangement, the State also has a duty to protect the other children who would be irreparably damaged by the enforcement of surrogate parenting agreements. Physicians who artificially inseminate surrogate mothers usually prefer that the mothers already have one or two healthy children of their own. This is to help assure the likelihood of a normal, healthy newborn. The psychological implication of watching a mother's pregnancy terminate with the giving away or, worse yet, the selling of an offspring, can be disastrous. The siblings of the surrogate child will wonder if they are soon to suffer the same fate, being taken away from their mother for some incomprehensible reason. No one has considered the unbearable guilt reaction that this child will face when later

in life he learns that his sister was carried and sold for funds that were put aside for his education or welfare.

The bills which this Committee is presently considering have many flaws, in my opinion. To begin with, the parties are still left to make a contract, which would include financial compensation both to the surrogate mother involved and to the infertility center or baby brokers which broker the arrangement. After a careful examination of these bills, I do find lacking strict regulations regarding the baby brokers to prevent the commercial exploitation of both the infertile couples and the surrogate mothers who are involved in the process. When the parties are satisfied, the process is fine. However, when one of the parties has a problem -- be it the mother, the father, or either spouse -- the only people to profit from that problem are the brokers. Our State has strict regulations on hospitals and medical care, yet when it comes to the selling or the purchasing of a child, we do not propose to supervise the brokers involved in the process. I find that to be surprising. Certainly the bill includes a provision for independent medical care -- for professionals to be involved in the process -- but the policing of the people involved in profiting from the sale needs to be addressed in A-3038.

Additionally, I find various constitutional problems with A-3038 itself. There is no definition of infertility, and limiting the bill to infertile couples might raise a discrimination problem of constitutional proportions. Can you legitimately discriminate if you allow surrogate parenting only to the infertile? Is being sterile, voluntary or involuntary, infertility? Will you let a person who voluntarily became sterile use the process? Furthermore, the term "child--" Does that include a stillborn or a miscarried embryo, or would it apply only to that of a fully born fetus? This may create a substantial problem for the woman who is engaged in the

reproductive process but does not fully deliver a product; namely a human being. Many of the arrangements which have been used heretofore by the infertility centers diminish payment as a result of a defective product which is produced by the surrogate mother. This bill does not address that issue, and leaves it to the parties.

Prior to a recent meeting of the Surrogate Parenting Committee of the New York State Bar Family Law Section, I received a letter from one of my Co-chairs, Bruno Colapietro, a distinguished matrimonial lawyer in Binghamton, New York. I would like to read you his comments regarding surrogate parenting, as I find them to be relevant and important to this forum:

"Confirming our telephone conversation, I am waiting to confirm my views in opposition to the Dunne-Goodhue bill." That is one of the bills in New York. "I feel that contracts for surrogate parenting are both illegal and immoral. We know that we cannot go to a woman and buy her baby and place it for adoption, no matter how worthy the adoptive parents are, no matter how willing the natural mother is. The distinction between this and a surrogate parenting contract eludes me.

"One of my strong feelings on this is that people with money will be dealing with people who need money. I do not think you will find parents who are less affluent dealing with a wealthy mother in order to procure a child. It is unnatural for a mother to surrender her child. My experience has been that when she does give up her child, it is done out of an act of love or necessity -- a feeling that what she is doing is in the best interest of the child because no viable alternative exists. If you put it on a commercial level, you are placing the natural mother in a position where she must learn to condition herself to the point where she does not give a damn about the child, only the money. This is unnatural, and I do not want to think that somewhere down the road we have a

generation of mothers who bore children they did not care anything about. I also feel you end up with cases like Baby M, where it is a tragedy for all concerned."

In addition, the A-3038 bill, which allows a court to terminate the rights of a mother at the birth of the child, leads to grave constitutional implications, in my opinion. To begin with, there are no statutes in the country at the present time which allow a pre-birth termination of maternal rights to be enforced after the birth of a child, without an after-birth ratification of the birth mother. The standard used in most states for termination of parental rights is a clear and unequivocal standard, and the right to family integrity has been held to be a fundamental liberty and subject to a higher standard necessary by the court because of the conclusion that the right to family integrity is a fundamental right.

The U.S. Supreme Court, while never expressly declaring the right to be a parent to be an absolute and fundamental right, has nonetheless implied that the right to family integrity is indeed fundamental, and the court has generally found such a right on the basis of one of two tests: a liberty test and a privacy test. The courts have found that the right to associate with one's immediate family is a fundamental liberty protected by the state and Federal Constitutions. Because the court finds a fundamental right is involved, the strict scrutiny standard must be the standard of review. The strict scrutiny standard requires a compelling state interest to be served by legislation in any proposed statute, and there must be no less onerous alternative available to achieve the statutory objective. Termination statutes across the country are generally used only where there is abandonment, abuse, and neglect. In effect, the legislation we address today would allow a termination of parental rights at the time of birth, without giving the mother a right to change her mind after birth. Informed consent clearly means

more than simple knowledge of the terms and conditions of the agreement, and may not be intelligently given by a birth mother until after the birth of a child. That is why the adoption statutes in this country have required informed consent after the birth of a child.

There is no statute in this country which allows a pre-birth termination to be upheld without a ratification after the birth of a child. There must be a right for the birth mother to make an informed consent after the birth of the child. I would suggest that that issue be addressed.

I futher alluded to the commercialism of surrogacy in this country, and I believe if you limit the payment to the medical expenses and maternity expenses of the mother, that you will have more than middle and lower class women volunteering themselves for surrogacy. Have any of you ever seen a wealthy surrogate mother? I have never seen one. I am sure there are some whose altruistic beliefs in helping an infertile couple will certainly be in the forefront if they are so much in favor of this concept.

I found an interesting letter in The Star-Ledger a couple of weeks ago. It asked four interesting questions, and I just thought I would throw them out to you:

"Should the surrogate agencies" -- if there are any -- "be allowed to discriminate on the basis of race when choosing a surrogate mother, thus depriving minority women of this economic opportunity?

"Should the surrogate mothers be paid the minimum wage for their services?

"Should people who receive surrogate babies be required to pay the State sales tax when paying for the service?

"Should a surrogate mother be entitled to collect unemployment after the baby is born since her employment terminates with the birth of the baby?"

I believe these questions raise other questions which this panel may want to address to other witnesses in your search for a fair-minded bill.

The abuse which occurs in the commercialism of surrogate parenting is evident throughout the country. Various lawsuits against infertility centers have errupted as a result of the profit and money one can make in this field. One woman was induced to become a surrogate after five miscarriages and nine pregnancies, and after having her cervix partially removed. The surrogate in that case went into shock after an improper artificial insemination and delivered a premature baby who died shortly after birth. When she tried to collect her fee, it was refused to her. Finally, this woman, who was initially refused her compensation, received a partial compensation seven months after the baby died.

As you can see, I am strongly against surrogate parenting, at least in a commercial setting. In vitro fertilization would be a better place to develop this concept than the present form of surrogate mothering. However, if after all the discussions both pro and con, this body and the Legislature still feel that surrogate parenting should be permitted, I have come up with some specific proposals I would like to recommend for adoption into your legislation. I would suggest that any bill consider the following elements:

1) A period of time after the child is born for the biological mother to change her mind with regard to the agreement;

2) Psychological counseling of the intended surrogate for a reasonable period of time prior to insemination;

3) Screening of the intended couple similar to the adoption statutes prior to insemination;

4) No payment to the surrogate for selling or purchasing of children, only expenses incurred and medical expenses;

5) Licensing, screening, and regulating of any clinics which are involved in surrogate parenting, including the centers which are to test and inseminate the biological mother; one of your bills does address that; and,

6) The adoption of ethical guidelines formulated by the American Fertility Society, wherein fertile women would not be able to use the surrogacy process as a substitute for pregnancy. I would say that you might have constitutional problems with that, but I am still in favor of that.

ASSEMBLYMAN KERN: Well, maybe we would be able to do something by way of severability on that.

MR. ARENSTEIN: The bill before you does not contain many of these proposals. There is no period of time after the child is born for the mother to change her mind, and I believe that pre-birth or at-birth termination is a termination without informed consent. I use the words "informed consent" to mean a full understanding of the personal psychological consequences at the time of surrender of the child. One of the basic requirements of the validity of a surrender has consistently been that it cannot be given any effect if it occurred prior to the birth of the child.

With regard to psychological counseling of the intended surrogate, I think we have addressed that with the questions you had to Gary.

There is no requirement for screening of the intended couples in this bill. Look at the possibilities. In a recent case involving a couple from Rochester, New York, in which an infertility center was involved, a transsexual couple sought to use the surrogacy process to have a baby for themselves. Since they could not have a child on their own, and since they could not pass muster in an adoption agency, they used the surrogate process to get around the safeguard which society has placed in the screening process to have a child under the adoption statutes. Whether or not the court will allow such a couple to

have a surrogate child may be a constitutional question. However, people who do not pass muster or cannot have a child on that basis should not be able to use the surrogacy procedures to buy a child. What if a child molester decides he wants to buy a child?

Furthermore, I believe that payments to the surrogates over and above the normal expenses should not be allowed. There are no wealthy surrogates. If you look at women who present themselves to be surrogates today, you will find that the majority of them are the middle or lower class women. What has occurred in this area is the economic oppression of the poor by the wealthy or upper middle class. In essence, we are talking about buying and selling babies. The opponents of surrogate parenting argue that this is not baby buying or baby selling, but payment for a service. Again, I address to you the issues of stillborn and miscarried babies. Is that not a service for which full compensation is entitled to be paid? A careful look at the contracts will show you that that is not the case.

With regard to the screening of clinics and laboratories involved in this surrogacy process, I find that the bill does address that area and provides for health care, but you must police the clinics and laboratories, or you will have reoccurrences of the many problems in this area. You do not provide -- in A-3038 -- for the screening of the sperm donor for sexually transmitted disease. You do provide for it in A-3037, but I think it is necessary in A-3038 as well.

In addition, the bill does not prohibit the baby brokers from making this a commercial venture. If you pay a reasonable compensation to somebody for his or her service, rather than one of these $10,000 non-refundable fees to these baby brokers, you will be doing a service to society. Commercialism and exploitation by these people have caused them to become very wealthy. One can multiply the 150 births of the

Infertility Center of New York by $10,000 and see that $1.5 million has been amassed in the brokering of babies. An additional 135 babies are on the way in that Center right now, becoming another $1.35 million. Should this be allowed in New Jersey? I think not.

To briefly address the other bills you have before you, I would state that I have been following most of the bills proposed in New York. We now have four. One of them is very similar to AJR-76. Senator Marchi introduced a bill to create a commission to study and make recommendations regarding surrogate parenting. This topic is so encompassing that a study of the area is necessary. The Ethics Committee of the American Fertility Society, in their September, 1986 report -- which I see you have a copy of -- states: "The Committee has serious ethical reservations about surrogacy that cannot be fully resolved until appropriate data are available for assessment of the risks and possible benefits of this alternative." A full study of the issue, without political pressure, would be in the best interests of all concerned.

Assembly Bill 3036, which requires insemination by a licensed physician, is in conformance with the trend in this country, and I favor that.

Assembly Bill 3037, which requires the Department of Health to keep records of semen donors, is also a step in the right direction. As of now, it would be possible for two different women to be artificially inseminated by the same semen donor, and the children produced by those women might unknowingly marry, even though they have the same common father. I think A-3037 with record keeping would be a step in the right direction to prevent that, because many of the clinics still don't have records on the semen donors.

I have already commented on A-3038, but A-3039 is mind-boggling. We are now legislating property rights to frozen embryos. If this isn't the beginning of Aldous Huxley's

"Brave New World," I don't know what is. The new after-birth provision is interesting. I am not sure why custody of the frozen embryo should go to the female in the first instance, but I guess that is the way it was drafted.

I thank you for your time, and am ready to answer any questions you might have.

ASSEMBLYMAN KERN: Are you familiar with the litigation that developed in Australia with respect to the frozen embryos when the--

MR. ARENSTEIN: I am.

ASSEMBLYMAN KERN: Any questions? Assemblyman Thompson?

ASSEMBLYMAN THOMPSON: Counselor, do you agree with the previous speaker, who stated that the contract should be enforced whether or not the outcome would serve the best interest of the child?

MR. ARENSTEIN: I believe that the court should always look into the best interest of the child. I think that is the focal point, and even in the Baby M decision the focal point was the best interest of the child, in the judge's opinion. I think in any situation which involves a child, the child's interest is paramount in this State.

ASSEMBLYMAN THOMPSON: Another question: What about the issue I raised previously with reference to psychological screening? Do you think that both parties should be screened psychologically?

MR. ARENSTEIN: I do. I think the surrogate mother should be screened for a period of time prior to insemination to make sure that we don't have a situation like Baby M, because in that case she was screened and the screening people said she wasn't capable of surrendering. As far as the adoptive couples -- as I said in my statement -- I think you should screen them as in the adoption process.

ASSEMBLYMAN THOMPSON: Thank you.

ASSEMBLYMAN KERN: Any other questions? (no response) Thank you very much.

MR. ARENSTEIN: Thank you.

ASSEMBLYMAN KERN: Dr. David Brodzinsky?

D R. D A V I D B R O D Z I N S K Y: Good morning, Mr. Chairman and Committee members. My name is Dr. David Brodzinsky. I am Associate Professor of Developmental and Clinical Psychology, and Vice Chair for Graduate Studies in Psychology at Rutgers in New Brunswick. I was also one of the mental health experts in the Baby M case, working for the guardian ad litem.

I come before you today not only as a concerned citizen, but as a mental health professional with considerable research, teaching, and clinical experience in areas related to infertility, adoption, and alternative reproductive technologies. My comments, however, will not address directly the proposed legislation offered by Assemblyman Kern -- although some of it will, I suppose -- but rather will focus on a variety of mental health issues that need to be considered before informed decisions can be made regarding such legislation.

As you have already heard, there has been a dramatic rise in infertility in the past few decades. Currently, approximately 15% of married couples can expect to face this personal and medical crisis. As you have already heard, in the past, the primary alternatives open to these individuals were adoption or remaining childless. But today, of course, we have other options which we are talking about -- artificial insemination, in vitro fertilization, embryo transplant, surrogate childbearing, among others. Although most of these options have been welcomed by infertile couples and the medical community, they certainly have opened up a Pandora's box of bioethical concerns. In my brief time, I would like to add my own thoughts and concerns to those expressed by others who have come before me.

My primary concern, simply put, is that we have little, if any, knowledge of the emotional and psychological parameters involved in reproductive technologies. How will these reproductive options impact on the married couple; on the children conceived through them; and on the family system as a whole? What is the psychological impact on the surrogate mother and her family of surrendering a child she has carried to term? Can a woman who has agreed to be a surrogate mother be expected to fully understand the emotional impact of surrendering a child prior to its birth? Should individuals conceived through surrogate childbearing or artificial insemination by donor have the right to full disclosure of information concerning their biological origins once they reach the age of majority? These are but some of the questions that come to mind related to the short-term and long-term impact of reproductive technologies on those individuals who use them or are a product of them. In addition, other questions pertaining to the evaluation of potential embryo and semen donors and surrogate mothers need to be addressed. What safeguards can be built into the system to ensure that the motivation underlying donors and surrogate childbearers, and those infertile couples who work with them, are healthy and in the interests of all concerned, expecially the interests of the child who is the product of these technologies? At the present time, we simply do not have the answers to these pressing questions.

Let me go into more detail about some of these issues. First, it is important to emphasize that the development of reproductive technologies has occurred in response to the needs of infertile adults. In contrast, little attention has been given to the rights and needs of those children conceived by these technologies. There is a parallel to this state of affairs in the history of the adoption movement. Historically, the primary emphasis of adoption agencies was to "supply" children to adults who otherwise could

not have children of their own. The needs of the child and the adults who relinquished them for adoption, although not totally ignored, were certainly given less consideration. This philosophy, however, changed dramatically in the 1950s and early 1960s when agencies began to shift their focus from the needs of infertile couples to the needs of homeless children. Moreover, it took until the late 1970s and early 1980s for the rights and welfare of biological parents -- by that I mean those who surrender children for adoption -- to be given serious consideration. Unfortunately, these types of changes have not occurred as yet in the area of reproductive technologies.

Let us consider the issue of the right of the child to know the truth about his or her origin. From research in the area of adoption, it is clear that withholding this type of information poses grave risks for the parent-child relationship and the child's developing sense of self. Children who find out about their adoption accidently, and in less than supportive ways, typically feel betrayed by their adoptive parents. Their sense of trust in their parents and their view of themselves are often seriously undermined. Such findings have resulted in nearly universal support by the professional community for counseling adoptive parents about the necessity and benefits of open and honest communication with their children regarding adoption. I would argue that children conceived through the new reproductive technologies have a similar right to know about their origins. Parents who choose to utilize one of these reproductive options need to be counseled about the pros and cons of withholding information versus disclosing information to the child regarding his or her origins. Moreover, parents need to understand that for some of these children there may come a day when they will desire to make contact with their other biological parent -- a decision that an increasing number of adult adoptees are making.

Now, admittedly, these recommendations will not be easily accepted by many infertile couples. Research suggests that most couples who conceive through donor insemination, for example, intend to withhold from their child the truth about his or her origins. Moreover, this attitude is often reinforced by the medical community. Unfortunately, this decision, in my opinion, is short-sighted and denies not only the rights of the child, but the burden that is involved in maintaining the deception is a burden that can weigh very heavily on the couple's relationship, as well as the parent-child relationship. In support of my arguments, I refer the Committee to the enclosed report -- which will be distributed, if you haven't gotten it already -- on "Children Conceived by Artificial Insemination." This is a summary report by a Swedish commission, which I consulted with, dealing with the development of guidelines for proposed legislation regulating the practice of artificial insemination in their country. I think many of the points raised in the report are pertinent to the issues being raised here today, not only regarding artificial insemination by donor, but other reproductive technologies as well, especially surrogate childbearing.

A second issue I wish to address is whether a woman who agrees to act as a surrogate childbearer for another couple can truly give informed consent to relinquish the child prior to conception and/or the child's birth. Can a woman fully understand how she will feel about a child before it is born? Is it reasonable to expect that a woman's decision to relinquish a child made prior to the child's conception will be unaffected by the experience of pregnancy? And, if the experience of pregnancy leads to a change of mind, can we expect to hold the woman to a contract that forces her to surrender the child even though she no longer wishes to? In reality, we have little direct information that bears on this

issue. At best, we know that women who surrender children for adoption generally experience profound grief over the loss of their offspring -- grief that often lasts for years, if not a lifetime.

But, of course, there is a difference between surrogate mothers and women who relinquish children for adoption. Surrogate mothers generally have greater control over the process in which they are involved. They have entered into the surrogate process voluntarily and have participated in a planned pregnancy. From the very beginning of the process, they are working with the infertile couple toward the goal of surrendering the child to these individuals. Perhaps the degree of control is one reason why many surrogate mothers report little or no ongoing grief regarding the relinquishment. And yet, ladies and gentlemen, hormonal changes accompanying pregnancy affect women quite differently. Moreover, the motivation of women to become surrogate childbearers is also likely to be quite varied. Consequently, there are likely to be more Baby M cases in the future. It is likely that these cases will involve women who in good conscience entered into a surrogate childbearing contract, only to find that once the baby was born they could not surrender the child.

What are we to do in these cases? I would argue that the ability of women to give informed consent for relinquishment prior to conception and/or birth of a child is impossible, at least from a psychobiological perspective. I will not argue the legal aspects of it, though. Thus, it is imperative that legislation regulating surrogate childbearing allow for this possibility. I would urge that legislation dealing with this reproductive option include a provision that allows a surrogate mother to change her mind within a specified period of time following the birth of the child. Furthermore, the surrogate contract itself must be written with this

possibility in mind and provide a set of guidelines, agreed upon ahead of time by all parties, determining custody and visitation issues in the event that the surrogate mother does change her mind. Should either party wish to challenge the guidelines regarding custody and visitation set forth in the contract, they would then have the option of the courts. Hopefully, it wouldn't get there too often.

Finally, I would like to make a few comments regarding the role of mental health professionals in the area of reproductive technologies. As noted previously, our knowledge of the impact of these technologies on those who choose to use them and those who are products of them is quite limited. As a researcher and clinician, I would call upon my mental health colleagues to begin to focus their attention on this pressing social issue. It is only with greater knowledge that people, and society in general, will be able to make informed decisions regarding these issues. But, we cannot wait for the outcome of the research to act. Advances in medical science will always progress more quickly than our understanding of the impact of those advances on society. Mental health professionals need to be brought into the arena of reproductive technologies as evaluators and therapists even more so than they have been. The skills of psychologists and psychiatrists, in particular, are well-suited for screening individuals for inclusion in the reproductive technology programs. I would emphasize screening both the surrogate mother and the couple who wish the child. These professionals are also well-equipped to provide therapeutic counseling to these individuals throughout the process regarding the issue of the reproduction process.

In short, ladies and gentlemen, I would argue that integration of mental health professionals into the heart of reproductive technology programs is of fundamental importance for the well-being of those individuals whose very lives are being touched by these new medical advances.

Thank you.

ASSEMBLYMAN KERN: Any questions from the Committee? Yes, Assemblyman Thompson?

ASSEMBLYMAN THOMPSON: Thank you, Mr. Chairman. Doctor, I would like to ask you a few questions. One is in reference to this whole issue of artificial insemination, with reference to what happened in history with the German experience during the '30s dealing with the attempt to develop a master race, when women were surrogates in Germany, not with this type of insemination, but with direct sex. Also, on the question of cloning, are we on the edge with this type of legislation?

DR. BRODZINSKY: Well, I am not an expert in the area of cloning. That is not my area. I don't know how close they are. I certainly have concerns about that and its impact on society.

ASSEMBLYMAN THOMPSON: Is there a bond between the child and his or her genetic mother which develops over the period of pregnancy, which cannot possibly be present at the time of the signing of the contract?

DR. BRODZINSKY: Well, let me answer that this way: The development of the bond of the mother toward the child probably begins during the pregnancy, but from everything we know, the bond of the child toward its parent, or its care-giver, is something that grows over time. We don't find any evidence, for example, in research we have done on mother/infant attachment in adoptive mothers' versus biological mothers' child relationships-- We do not find any difference in attachment, even though, of course, the adopted children have been separated from their biological mothers. You usually find attachments beginning to form over the first few months, and you begin to see pretty good evidence of attachment to specific individuals around six months of age.

ASSEMBLYMAN THOMPSON: Thank you.

ASSEMBLYMAN KERN: Any other questions? (no response) Doctor, your research disputes this automatic bonding that some people are putting forward?

DR. BRODZINSKY: Yes. I think in point of fact what they are talking about is less that there is an irrevocable bond, than that a child comes into the world preprogramed with certain behavioral and emotional signals which facilitate bonding. I don't think any reputable scientist would argue against that. But whether or not there is an irrevocable bond that is formed between parent and child mutually -- I emphasize mutually -- at birth-- I don't think there is any evidence to support that. Certainly, all of our experience in the area of adoption suggests that it is not there.

ASSEMBLYMAN KERN: Thank you. Anyone else? (no response) Doctor, I want to thank you very much for coming today and sharing your expertise and research with us.

DR. BRODZINSKY: Thank you.

ASSEMBLYMAN KERN: Nadine Taub, Esq.?

N A D I N E T A U B, E S Q.: Good morning. It is a pleasure and an honor to appear before your Committee today. I am Nadine Taub. I am a Professor of Law at Rutgers Law School in Newark. I am the Director of the Women's Rights Litigation Clinic, which has been involved in a great many reproductive freedom litigation issues in this State, and nationally. For the past two years, I have been the Director of a Rutgers University Project on Reproductive Laws for the 1990s.

I commend this Committee for anticipating and identifying the very difficult problems facing all of our jurisdictions today. I think the issues posed by the new modes of reproduction are difficult ones, and perhaps this Committee is almost too far ahead of the general public response to these issues by coming up with specific legislation at this point.

The issues you are dealing with are controversial. I think they merit study and research, and I would counsel

caution and more study before taking any precipitous action. I take this position for three reasons: First, I think that the number of the substantive positions reflected in proposals are not fully worked out. We have already heard so far this morning strong and different positions on the surrogacy issue. I will be talking a little bit more about that, and trying to give some other examples from the legislation.

Second, I think it is extremely difficult to draft a package like this. There are numerous technical problems in the drafting which have yet to be worked out. You have an ambitious set of statutes, and sometimes you refer to something in one statute that may be picked up or defined in another statute, but you really need to work out a lot of the details.

Finally, I think that on the surrogacy issue -- but it may impact on a number of these other issues also -- it is probably a mistake to act before the Supreme Court rules in the Baby M case. I will talk a little bit more about that. The argument is in September. My guess is that the court is going to move fast to decide, and I think it would be well to take into account their decision.

So, let me return then to my first reason, that is to say, some of the substantive problems within your proposals. I will not dwell on the issues about surrogacy. You have already heard strong views -- strong opposing views -- on those issues. There is a basic question: Does the State of New Jersey really want to facilitate these types of arrangements, both in terms of the immediate parties involved and in terms of the commercialization of these agreements? I suggest that you can break down the issue -- and you have not yet -- into a question about whether the immediate parties should be encouraged, and whether commercialization should be encouraged.

I would second the concerns that have been raised about the potential for exploitation. It seems to me that Mr. Skoloff's position this morning was too facile, that there are

the haves, but the have nots have children. Who has money to get involved in this? Who needs that money? I think that is very crucial. I am sure you heard the concerned voice that as these procedures get more sophisticated and egg implantation or embryo implantation become more common, there is a real potential for racial exploitation, and the development of a breeder class that is analogous to the wet-nurse class.

So, I think that is an issue that bears study. I think you need to look carefully at how likely these procedures are to come about. I think the issue of the commodification of human life does bear more study and discussion, not only by this Committee, but by people at large. I think the question of whether we are looking only at something that married couples should be entitled to, merits more consideration. We have expanded our notion of who is eligible to adopt. We are very much aware of the households that people are living in now. "Ozzie and Harriet" is a TV image. It in no way corresponds to current reality. I don't think we would say that we would condemn the homes that many, if not a majority, of our citizens are in now. If you make this available only to married couples, it seems to me that you are implicitly condemning others as inadequate childrearers.

I think we need to ask and study, what are we doing to protect and prevent infertility? I would urge this Committee, and any study that is set up, to look at how infertility is created. Why are we only focusing on the high-tech expensive and emotionally expensive solutions, like in vitro fertilization, like these kinds of contractual arrangements? What are we doing to prevent the "pain of infertility"? What are we doing to enhance the ways that people can relate to children even if they don't acquire one of their own, even if they don't possess one? What are the ways that we are recognizing the value of other kinds of relationships -- godparents, aunts, uncles? Let's look at what infertility is

about and what society is doing to really help with the problem of infertility, and not try to go through contortions to help people replicate an "Ozzie and Harriet" type of conventional family.

I think we also have to study whether the question of what your relationship is to a person -- a child -- whose progenitor you are, is such a serious question that you should be entitled to change your mind. Legislatures have passed laws that say you can change your mind within a certain period about whether you want to buy a vacuum cleaner. Well, I would submit that this kind of a question is of much greater significance, and may well merit a modificaiton of the "deal is a deal" view of contract law.

Also, it seems to me that we should consider what kinds of mechanisms are important to guarantee informed consent and to equalize our bargaining power in these situations. I am not going to talk at length about screening. I would suggest here, too, that that may sound like a good solution, but it is too facile. I noticed this morning there has been a question raised and litigation over psychological screening for police in New York. It seems to me we all want to make sure we have sound police officers on the street, but the racial bias and the class bias potential in screening is very serious. I think that one of the reasons why we respect family autonomy so much, and are so unwilling to interfere in more conventional ways that people procreate, is that we are afraid of imposing State values about who is an acceptable parent. I think I heard somebody mention the German history today, and I think we need to bear that in mind. This country, too, has had a problem with eugenics. I think how we want to work out those solutions is a difficult question that merits more study.

I wanted to mention the other bills also.

ASSEMBLYMAN KERN: I wish you would.

MS. TAUB: This will not be comprehensive, but I think there is a great risk that today's session will be focused almost too much on the surrogacy question.

ASSEMBLYMAN KERN: That is not the intent. I appreciate your doing that.

MS. TAUB: I am going to try to go fast. I don't pretend that this is complete. For example, on the sterilization bill, I think it is important to give the kind of warnings you are talking about, but I would suggest you take a look at the New York legislation, and also the requirements that have been attached to the Federal Medicaid provisions. They are designed to address the problem of sterilization abuse, which has been a very painful problem in this country. I have already alluded to the problems with eugenics. I am sure the people here are old enough to remember the scandals, the Relph (phonetic spelling) case, the people on welfare who signed consent forms with "Xs." If you look at that legislation, I think you will see provisions like a requirement that specific things be told, but also that you get a chance to think about it; that you cannot be requested to sign an informed consent immediately. Your bill says before -- prior to -- sterilization. The other bills have a 30-day waiting period designed to allow people to get out of the hospital, to talk to their friends, and to consult. There are a lot of other details I would suggest you take a look at.

On the fertility drugs bill -- A-3035 -- I think it is a question about how much you need this bill. How much are you just reenforcing existing potential for tort liability? If you are reenforcing it in this area when you are talking about practitioners, are you undercutting the assumption that the producer will be liable -- that there will be a products liability claim? I think, also, that you want to make sure that you indicate there is a continuing duty to warn, not just a one-shot thing. If more is known, more must be told.

On A-3036, the in vitro fertilization bill, there is a big question you haven't addressed about, what happens to extra embryos or extra eggs? As these in vitro fertilization procedures work, to my understanding, frequently many more eggs are extracted than will result in a particular pregnancy, and that is because you don't know whether that pregnancy is going to work, and you won't have to invade the woman again to get more eggs, given the risk and the bodily integrity concerns. And then you go ahead and frequently try to fertilize more of those eggs than you will need. If you get a successful in vitro fertilization implantation on the frist try, what is going to happen to those extra embryos? And what about the sale of those embryos? You mentioned the sale of eggs and sperm. I think you need to think more about the embryos.

You can see I am just hopping around trying to raise some of the questions. On A-3037, I think there is a societal consensus on the need for record keeping regarding sexually transmitted diseases. I think there needs to be more study, however, on the question of record keeping of the identity of the doner. We are very much aware in the adoption context of adoptees sensing they need to know who their parents are. It is a trickier question on doners, but it seems to me that you have to think about it and address it. I don't think you can just jump over it.

I think the question about genetic diseases and defects -- which I will later mention; I am not sure you have the best terminology there in terms of genetic defects -- but I think that is a tricky question, too, because there you have to decide-- I mean, I have no question in my mind that you should not permit sperm to be used if you are going to transmit a disease that way. However, I think that as we are able to map more and more genetic characteristics, if we allow the practitioner then with that information to choose which sperm the practitioner will make available, then we are giving that

person tremendous power. We are giving that person the power to decide who is going to be born; what characteristics they are going to have. And it may well be that-- For example, if you have a mild case of sickle cell, but you have a lot of other valuable characteristics, you should be born. You will be a contributing person. A lot of times-- Well, it is important to understand the limits to what we can do with genetic screening now. We can tell whether a trait is present, but we can't tell what the quality of life for that person will necessarily be. With things like Tay-Sachs, we may, but that would be a horrible and a short life. But in other situations, we may say there is a potential there, but I have very great doubts about letting practitioners play God in this area. I think that is a question that needs more study and more examination.

There is a basic confusion, I think, in that statute about, are you setting it up to provide information ultimately to the child who is born, who frequently when she or he comes to the age of childbearing wants to know her or his genetic characteristics, or are you doing it to tell the practitioner not to transmit disease, or are you doing it so that the person who is getting the sperm is going to know what she is getting? I think there is confusion in the way the statute is drafted. It is not set up very clearly, and you may want to take a look at that. I think you really need more time to attend to details.

Just one question on A-3039, of the several that could be raised. On frozen embryos, I would second the question about why do we automatically assume that the woman has possession? Maybe you want to resolve it simply; maybe you have a particular view about a woman's role in reproduction; or maybe you didn't think about it enough and you want to take another look.

Let me move then to some examples of drafting problems which again, I think, indicate that you need to spend a little more time on these bills. One simple example is in A-3036. In 1. g., you have a definition of surrogate mother, but that term doesn't even appear in the statute. Also, you talk about the parties may agree to execute surrogate parenting contracts, but it is very hard to tell from the context who the parties are -- what parties you are talking about.

Those are just a couple of examples. I think you need to go through all of these bills very closely, and make sure that your terms are defined and that you are using the terms that you are defining.

On A-3037, you may want to think about including AIDS specifically, given the confusion about how it is transmitted. Does everybody think of it as a sexually transmitted disease? I have a question about why you choose to use the term "natural father." For the natural mother, that is to say the biological mother in a surrogacy case, you call her a surrogate. Maybe you want to talk about biological father and biological mother, but there is a message you're giving that you may not have intended. So I think you will want to go back and read for that kind of thing.

In 4. b., there is a big question about what a genetic disease or defect is. I have bad eyesight. I believe that came from my parents, who also had bad eyesight. Is that a genetic defect?

In A-3038, the surrogacy bill, you use the term that you are going to employ services -- that is in your preamble. Do you want the word "employ"? Do you mean to strengthen the argument -- and maybe you do; and maybe it is an important argument, but you should consider it -- that this is an employment relationship and minimum wage laws apply? I am sure you are aware that that is an issue that is coming up in the Baby M case.

Also, when you talk about employing services, you may strengthen the notion that it is perfectly all right to impose limits on the woman's behavior during pregnancy. I am not sure you want to do that. I think that a woman's autonomy is a very important underlying principle in our system. It has been reflected in the contraception and birth control and abortion cases. It also comes about in the Karen Ann Quinlan case. Do you want to encourage restraints on how a person behaves?

There is again a drafting problem in section 11. You say that if the woman doesn't report major changes in her health -- What is a major change? How is she supposed to know? -- then she is going to be liable for compensatory and punitive damages. To whom? To the child, to the contracting parents? It is a drafting problem. You have to decide what you mean, and tell us.

The question has already been raised about what an infertile couple is. Aside from the underlying policy question, do you want to limit access to infertile couples? You've got to say what you mean -- what is an infertile couple? -- it seems to me.

So, those are some examples of drafting problems. I think you have the staff and the professional assistance to help you. What you really need to do is recognize that you need the time to do a careful job.

Finally, I would suggest that you wait for the Supreme Court to rule in the Baby M case. My basic reason for saying that is that I think the court is going to have to reach some important constitutional questions, that may well affect the legislation that you are going to enact. They are going to look at probably what is the constitutional minimum that has to be shown to terminate parental rights. I think they are going to look at whether Judge Sorkow, once he said the statutes didn't apply, had the inherent power to himself terminate parental rights. So I think the constitutional minimum of

parental rights termination and whether you can waive those rights by contract will be spoken to by the court, and cannot help but inform your decision. I think it is likely that there may be some allusions to whether there is a Thirteenth Amendment problem; financial transactions involving children who are, yes, delivered to one of their biological parents, but who are permitted to be adopted by that biological parent's spouse. Is the sale of a child such that it contravenes the Thirteenth Amendment? I think that is a tricky question myself, but I think the Supreme Court may give you some interesting guidance on that.

I think they are also likely to give you an interpretation of the existing baby-selling statute, which will help you to analyze whether this situation is actually baby selling as it is in the adoption statute. This goes back to my earlier suggestions, but I think you, yourselves, should look closely at the wording of the baby selling statute, because there is really nothing in it, I think, that distinguishes surrender to father and would-be stepmother. That is actually a kind of situation that is contemplated in the adoption statutes. There are provisions about how you go about surrendering in those situations, and I would guess that the baby selling statute does apply to that kind of a situation when you surrender to permit a spouse to adopt. I think that when the Supreme Court addresses that statute, they may give you some suggestions about how you want to go about explaining whether this is or is not baby selling, once you make up your minds, yourselves, whether it is or not.

Finally, I think the Supreme Court will give you guidance on what the rights of the contractual parents are. Is there a constitutional right either to procreate or to form intimate family-like associations which individuals have? That will give you guidance on your question about, do you want to restrict your law, as it is currently formed, to married

couples? I understood Mr. Skoloff to say, "Well, let's start out and let's try it that way," but if the Supreme Court is going to tell you in the fall that individuals -- whether single or married -- have a constitutional right, why enact a law that is unconstitutionally restrictive, that has equal protection and due process problems? It may well be that non-infertile couples also have those rights and, again, I think you would be well-advised to wait to hear the Supreme Court's views on those matters.

So, I really commend you for taking on these very difficult questions. It seems to me that once again New Jersey is in the forefront. I would hope that you will have enough time to listen and actually allow the people of this State to shake down and decide what their views really are on this. It seems to me that Baby M has been a tremendous catalyst for discussion, and I think you do want to reflect the views of the people of this State. I think you should give yourself time to hear them. I also think you should give yourself time to prepare the best-drafted and most well-thought-through legislation you can.

So, I would urge you to go forward with your commission proposal and expand it to go beyond the surrogacy question to include the issues raised by the other proposed legislation. Thank you.

ASSEMBLYMAN KERN: That is why we commenced these hearings. You can't begin to discuss something unless you have a proposal on the table. We are holding hearings so we can hear from the public, both experts and laypeople. We are not only listening to the benefit of somebody's expertise, but opinions from anyone who chooses to voice them. That is what the process is all about.

Are you familiar with the "Harvard Law Review" article on surrogacy of June, 1986?

MS. TAUB: I have to be honest. I have looked at a bunch of different articles, and I am not sure I can keep them straight. Maybe you can help me out a little.

ASSEMBLYMAN KERN: Well, it deals with the Thirteenth Amendment question.

MS. TAUB: I looked at it, but I am not sure I would want to take a test on it. Maybe you can ask me the question you have in your mind about it.

ASSEMBLYMAN KERN: It is the view of the editors of that journal that the Thirteenth Amendment does not prohibit this procedure.

MS. TAUB: I must say, I find it a very difficult question. I was on a panel last night with a woman who feels very strongly that it is -- Dr. Wendy Chafkin (phonetic spelling) -- who is the head of Maternal and Infant Care for the City of New York. I was trying to press her to explain why it was. Her greatest concern was that there is a policy expressed in those provisions that we do not intent to sell human life. For me, the reason why I am not sure the Thirteenth Amendment applies is, I think the Thirteenth Amendment has to do with buying people so that you have total control over the products of their labor. It seems to me that we are talking about acquiring children so that we have control over them in a different sense. But I guess the thing that bothers me is that we are talking about acquiring children; that there is an ownership implication involved. So, it may be that there are very serious policy questions that are related to the Thirteenth Amendment concerns, but the idea of penal servitude or slavery really has to do with exploiting the full product of every aspect of that person's life.

ASSEMBLYMAN KERN: Any questions? Assemblyman Thompson?

ASSEMBLYMAN THOMPSON: With reference to the Thirteenth Amendment question you raised, does compelling a

natural mother to give up custody of a natural child against her will-- Do you think, in your legal opinion, it would violate the Thirteenth Amendment prohibiting involuntary servitude?

MS. TAUB: There is no question that if you were compelling her to go through pregnancy and give birth-- In my mind, it is compelling involuntary servitude. That is, in fact, something that happens whenever you refuse to permit a person to exercise her right to abortion. You are compelling involuntary servitude. I think the part that has to do with terminating her parental rights, handing the child over, to my mind, has more to do with the deprivation of Fourteenth Amendment rights -- substantive rights to have relationships with your children. So, I think they are both involved. I think the compulsion to produce the child to be turned over involves Thirteenth Amendment questions. I think that cutting off your right to have contact with your child involves Fourteenth Amendment questions.

ASSEMBLYMAN THOMPSON: All right. This is a follow-up which may involve the Fourteenth Amendment also. In your legal opinion, is a covenant in which the surrogacy contract requiring the natural mother to surrender custody-- In the Baby M case, unless I read it wrong, it said this was a personal service contract. Do you think it is a personal service contract, or do you think it is a transfer under the uniform commercial code?

MS. TAUB: Well, I think in the Baby M case-- The contract that was involved there could not possibly be one for personal services, because she was not going to get any money for the services she performed if there was a miscarriage prior, I believe, to the fourth month. I can't remember. But there was a point up to which she was going to get no money.

ASSEMBLYMAN THOMPSON: No quantum meruit, in other words, if something went wrong.

MS. TAUB: Right, nothing. And, if there was a stillbirth, I think she got $1000. She was only going to get the money if she fully performed. However, I do think it would be possible to have contracts in another form that could be regarded as service contracts, or almost option contracts. If you had a deal where the woman retains the right to decide -- you were talking this morning about 30 days post-birth, an adoption type model -- someone could enter into a contract essentially to be the first possible parent. Or, they could enter into a contract that would be almost like a stock option, that she retains the right, but if she decides to give up, then they would be the first in line. In those situations, she would not, I think, be getting money for the services directly, and I think you might avoid also the baby selling problem there. But, there is no question in my mind, the way the contract was drafted in the Baby M case, it was not a contract for services; it was a contract for delivery.

ASSEMBLYMAN THOMPSON: Mr. Chairman, I have a couple more questions.

ASSEMBLYMAN KERN: Go right ahead.

ASSEMBLYMAN THOMPSON: One is, well, it is not a question. It is just sort of dealing with conflicts of laws. In the Baby M case, the parties were domiciled in the State of New Jersey. The contract was entered into in the State of New York. It was some type of standard contract at a fertilization center or somewhere in Manhattan. My question is, should New Jersey require -- with reference to valid surrogacy contracts -- that they be New Jersey contracts, rather than under the circumstances of the Baby M case, where, unfortunately, the judge actually enforced the law of another state?

MS TAUB: You are going a little beyond my expertise, in terms of conflicts of law. But, it seems to me that New Jersey could require in its statute that it will not recognize, or it will not enforce, any contract that does not meet the

requisites of New Jersey public policy. In your legislation, you could set out that those requisites are. I am very troubled by the form contracts, because I think they are good evidence that there was not informed consent in arm's length transactions. It seems to me that if there are certain minima that you want in your contracts, you can specify them by statute.

ASSEMBLYMAN THOMPSON: Thank you.

ASSEMBLYMAN KERN: Anyone else? Assemblyman Girgenti?

ASSEMBLYMAN GIRGENTI: Just a follow-up on the question that Assemblyman Thompson just asked. Does that mean that you can go into Pennsylvania and get enforcement?

MS. TAUB: Well, I would be happier if you could get somebody who is more secure about conflicts of law, but my impression is, you might well have a contract in New Jersey that violates New Jersey public policy and is not enforceable, but you could get enforcement in another state if you could establish the prerequisites for jurisdiction in that state, if you had sufficient ties with that state. I think that is an issue that comes up in all contract law. I am sure there are people who can speak to that better than I.

ASSEMBLYMAN GIRGENTI: So, what good is the statute then?

MS. TAUB: Well, I think what the statute would do -- two things. It would make clear what the courts of this State will and will not do, and it would also have a powerful education and symbolic effect in terms of telling the people of this State -- and I think by this time the rest of the country is looking at New Jersey, too -- "This is the kind of behavior we do or do not want to encourage."

I think there would be the concrete effect of saying what this State would enforce. I mean, New Jersey has law about product liability. New Jersey has law about when you can fire an employee at will, that does not exist in other states.

If you have a national corporation, and they are doing business in New Jersey and they need the New Jersey courts, the law will be enforced one way there. If they are in some other state -- I think I just saw that Oregon does not give protections to employees at will -- then what New Jersey said wouldn't go there. But you convey a message to people here, and to people throughout this country, about what you believe should be taking place.

ASSEMBLYMAN GIRGENTI: All right, just another question. I am asking you because you happen to be here right now. Maybe someone else at some point can answer some of these questions, too.

MS. TAUB: I will call my colleague and send him down.

ASSEMBLYMAN GIRGENTI: Suppose the natural mother -- the surrogate -- wins the New Jersey Lottery, you know, after surrendering custody to contracting parents, should the child be cut off from inheritance rights, in your opinion?

MS. TAUB: Well, I think that is a very good question to open up a bigger topic. I really think it is important for the child to have ties, whether it is a financial windfall or an emotional contribution. I personally believe that it is important for those children to know the extent to which they matter to the person who gave birth. I, for example, would like to see, in the Baby M case -- I know you are not legislating the outcome there -- but it seems to me that that visitation, that continued contact, is important, and I would hope that in whatever legislation you arrive at, if you are going to permit and recognize relinquishing custody to a biological father and spouse, or to other parents, you recognize the importance, and permit continued contact, because I really believe that we need to know that we are cared for, and not that we were simply abandoned.

ASSEMBLYMAN GIRGENTI: Should the child be allowed to choose his legal parents upon maturity?

MS. TAUB: I think that by that time the legal parents aren't going to matter that much. It seems to me that it is important to make clear who the legal parents are, who can make decisions ove the child.

ASSEMBLYMAN GIRGENTI: For inheritance purposes?

MS. TAUB: For inheritance purposes. My guess is that it will be simpler to specify who the parents are, and have that be a clean transaction. I haven't thought that much about it, and I don't see great dangers in doing it. My notion would be that it would be simpler the other way. There is always the potential of wills to transmit property.

ASSEMBLYMAN GIRGENTI: But, would it serve the best interests of the child in every case?

MS. TAUB: In the inheritance situation?

ASSEMBLYMAN GIRGENTI: Right.

MS. TAUB: Well, I guess it is a heavy decision, and it kind of encourages the child to look at things in a fairly materialistic way. I would hope that the child would not be put in the position of saying to parents who he truly loved, "I really love you, but, you know, I am going to be better off if I go with these people." I have a slight concern about saying it may be in the best interests of the child to put material considerations before emotional considerations. If you can choose your parents, why shouldn't you be able to choose them on an emotional basis?

ASSEMBLYMAN GIRGENTI: Well, the Baby M decision was decided on materialistic grounds.

MS. TAUB: I think you're right. I am not sure it was the best decision so far.

ASSEMBLYMAN GIRGENTI: One other thing, Walter.

ASSEMBLYMAN KERN: There is no corollary to what was just said in the adoption process. There is a straight cutoff, right?

MS. TAUB: That is true, although there is increasing recognition throughout the country of the notion of open adoption, whereby the parent who has given up the child can continue to have contact, even though there is a legal adoption that takes place. I have a recollection of a New Jersey case -- you may remember it better than I do-- I thought there was a case where a divorced father kept contact with the child even though the stepfather adopted.

ASSEMBLYMAN KERN: Yes, there is a case, but the statute does not provide for that.

MS. TAUB: No, no, but I think there is an opening going on around the country, and at least a little entry into that in our case law.

ASSEMBLYMAN KERN: There is considerable discussion about it, and there is advocacy in this State, too, to do something about it, but there has been no substantive change.

Assemblyman Girgenti?

ASSEMBLYMAN GIRGENTI: Walter, maybe I can ask you this: Do you think that the adopting parents under the surrogacy contract should be compelled to take that child?

ASSEMBLYMAN KERN: I think they ought to be, yes. That is my own personal view, but I think it is going to be up to this Committee to make that policy decision. It is my own position that they should stand like any other parents and take their chances. I don't think-- That is one of the things I do not like about the contract in the Baby M case.

ASSEMBLYMAN THOMPSON: Mr. Chairman, may I ask you one question?

ASSEMBLYMAN KERN: Do you want to swear me in?

ASSEMBLYMAN THOMPSON: I didn't read this case, but someone mentioned the fact that there was a decision in California where you had the same process, but something happened and the man backed up, and the judge said, "You have to pay child support."

ASSEMBLYMAN KERN: Right. There was a California case which allowed visitation in a surrogate situation, but there was a hereditary contact between all three of the individuals involved in the case. It was a family situation. They weren't strangers, so to speak.

Are there any other questions of the witness?

ASSEMBLYMAN GIRGENTI: The only other thing I want to add is, you strongly urge that no legislation should be passed at this point until the Supreme Court makes a decision.

MS. TAUB: Yes, I do.

ASSEMBLYMAN KERN: Thank you. Peter Strohm, Esq.

P E T E R S T R O H M, E S Q.: Thank you, Mr. Chariman. Members of the Committee, my name is Peter Strohm. I am an attorney at law in this State. I am active in health and hospial law and related issues. I was asked by Assemblyman Kern to address you concerning some of this pending legislation. My comments will be brief.

I would like to speak to Assembly Bills 3040 and 3035. I would like to speak against them. These bills deal with informed consent. Informed consent is a problem that courts, lawyers, and doctors have wrestled with, and are wrestling with on a daily basis. For the Legislature to single out two specific medical and surgical procedures, I think, would be wrong. I think there are many surgical and medical procedures which are very important and which involve informed consent, and I just don't think at this stage that the Legislature should single out these two.

I see consent forms cross my desk almost every day. Doctors are not sure what they should tell patients, how much they should tell patients. I am not too sure how much a doctor should tell a patient. These are problems that I think are more properly dealt with between a physician and his patient, as suits the relationship the physician has with his patient.

I would like to speak in favor of Assembly Bill 3037. Specifically, I think it is very important -- and this was mentioned by an earlier speaker -- that there be record keeping of donors, and the identity of donors. We are learning more and more that many of our diseases and much of the composition of our own bodies are hereditary. I think it may very well be important as science evolves that we learn who the father is of a child, and the child knows who his father was.

Finally, I would like to speak in favor of Assembly Joint Resolution 76. As was mentioned by a number of earlier speakers, I think the issue of surrogate parentage is extremely important, but it involves so many related issues that any piece of legislation must consider all of these related issues. I consider myself relatively knowledgeable in the field of health law, and it is only very recently that I read, or studied, anything on surrogate parentage. I recently heard a talk given by Professor Edgar of the Columbia Law School, who raised yet more issues, issues that had never occurred to me, and I am sure never occurred to a lot of people, on surrogate parentage. I think perhaps Professor Edgar should address this Committee.

In any event, I think there are many issues which have to be addressed, and I do not think that at this time, and with the knowledge we have, one piece of legislation could encompass everything.

ASSEMBLYMAN KERN: Thank you. Are there any questions? (no response) Thank you.

MR. STROHM: Thank you.

ASSEMBLYMAN KERN: Alison Ward?

A L I S O N S. W A R D: Good morning. My name is Alison Ward, and I, like perhaps very few people who may give testimony before you, know what it is like to lose a child, because I am a birth mother. I lost my daughter to adoption 20 years ago. For the past six years, since I have been reunited

with her, I have been an adoption activist in both New Jersey and at the national level. For four years, I was the Vice President and on the Board of Concerned United Birthparents, which is a national group for parents who have lost children to adoption. Since last fall, I have been working toward banning commercialized third-party reproduction, which is more commonly referred to as surrogacy. I believe that this process would legally, morally, and ethically redefine what it is to be a mother and what it is to be a father. I almost believe that the very process would change the way the human race is to be continued. I don't think that New Jersey should be the first state in the country to legalize what other governments have banned as a sordid commercial bargain.

I want to speak briefly about Assembly Bill 3038, and explain my opposition to it. My primary objections are: the enforcement of pre-birth relinquishment of parental rights; the commercialization of third-party reproduction; and what seems to be legalization of baby-selling. In addition -- as others have said before me -- it does not define infertility, and only provides for the screening of sexually transmitted diseases for the surrogate, not for the male donor.

Until March 31, when Judge Sorkow handed down his decision in the Baby M case, a pre-birth contract to terminate a mother's parental rights had never been enforced in this country -- never. The inability of a woman to have informed consent prior to her child's birth has been upheld in all 50 states. Proponents of surrogacy argue that since most surrogates have already borne at least one child, they are familiar with the birth process and therefore can make informed consent prior to birth. But, if that is true, why isn't a woman like myself, who has already surrendered one child to adoption-- If I would be considering surrendering a second child, why couldn't they terminate my parental rights pre-birth? I have already done this, why wouldn't I be able to give informed consent?

I know firsthand of the changes of heart and mind that can occur at a child's birth. Throughout my pregnancy, I truly believed that adoption was the way to solve the problem of my untimely pregnancy, but near the end of my pregnancy, as my child became more real to me, I began to have mixed feelings. At the minute the nurse told me that I had a healthy, beautiful baby girl, I knew I could never lose her. I tried to keep her, but I lacked the necessary support to do that. Losing my daughter was just as Mary Beth Whitehead described the loss of her Sara; it was like losing one of my arms.

For mothers like Mary Beth Whitehead, the truth may come at the moment of birth, when she realizes that that child looks exactly like her other children. The baby brokers like to call this a product, or an investment, but it is not. These mothers are losing one of their children.

Pre-birth relinquishment of parental rights is not permitted in this country, and I don't think that in September when the Supreme Court hears the appeal they are going to enforce it either. Even Judge Sorkow conceded that the section of the contract which had Mrs. Whitehead prospectively giving up her right to choose an abortion during her pregnancy, and allowed Mr. Stern the right to demand that she have one, was unenforceable. I don't understand how we can argue that a woman cannot give up her right to have an abortion, and not also argue that a surrogate cannot give up her right to change her mind about keeping her child. How can we say that taking away a woman's right to abort is an intolerable restriction of her liberty which would treat her like a non-human incubator, yet find acceptable taking away a mother's right to choose to rear a child she has borne?

Having your child whom you love and desperately want to keep foreably taken from you is, I believe, more horrible than forcing a woman to have an abortion. Taking a child away from its mother in this manner is even worse, because it

creates a situation of lifelong struggle for one or both of them to seek to be reunited. Taking away a mother's choices about relinquishing parental rights after her child is born guarantees trauma and emotional devastation for her. I just don't believe that we should ever enforce pre-birth contracts, because I don't think there can be informed choice.

This bill permits payments to be made not only to the surrogate, but also to baby brokers. Even Noel Keane has said that if money is withheld as an incentive, the supply of potential surrogate mothers would dry up. Much has been said in this situation about the exploitation of less educated and less affluent women in surrogacy. Better educated and compensated women do not have to enter into surrogacy agreements to feel a sense of self-worth and contribute money to their families. I can accept altruism as a motivating factor for going into a contract of surrogacy, or, as Gary Skoloff calls it, "the gift of life to an infertile couple," but when you are only giving the gift of life for the payment of cold, hard cash, I don't accept it any longer.

The baby brokers are not even making babies; they are just making money. The money they get is almost as much, or equal to, the money given to the mother for this service, except that the centers which deal in this get up-front, non-refundable fees, and the only screening they seem to do is of the check the couple gives them.

If surrogacy is ever legalized in New Jersey, I don't believe that any payment should ever be permitted to the mother over and above normal medical expenses associated with her pregnancy. I don't believe that any payment should ever be made to a baby broker.

I believe that this bill would legalize baby selling. Proponents of surrogacy maintain that the mother is receiving payment for her services, not her baby. But, if you look at the contracts, they prove otherwise. Take, for example, the

very infamous, but very standard contract between Mary Beth Whitehead and William Stern. In the event that she miscarried prior to the fifth month of pregnancy, she would get nothing. So much for her services. For a miscarriage later in her pregnancy, or if her child had been born dead, she would have gotten $1000. Only if she had a healthy baby and handed the baby over to the Sterns would she receive more than $1000. So, it becomes very clear. Her services were worth $1000; her baby was worth $9000.

I do not believe that as a matter of public policy we should ever permit the exchange of money for babies. Children are not chattel, and I just don't believe that children should be born to be sold.

This whole process requires that we encourage a new breed of woman, someone who will conceive and surrender her child according to a contract, or a deal, who promises not to form a bond with her child. She is not going to bear any responsibility for the child she brings into this world, and she has the right to abort the baby, but not raise it. As one baby broker said, "We have to find women who believe the advantages of all of this outweigh the psychological trauma of losing a child." For me, the greatest irony of surrogacy is that most of its supporters have never lost a child to adoption, and would never be a surrogate themselves. Even for the men today at this hearing, would you want your mothers or your wives, your daughters or your sisters, to go into this? If one of them came to you and said, "I think this is a great idea," would you second that notion, or would you say, "Wait a minute, I don't think you really understand what you are getting into"?

From studies done on relinquishing mothers in this country and in Australia, we know it sometimes takes up to eight to ten years, or even more, for the coping mechanism of denial to not work any more. In my own case, it took 13 years

before I realized the full impact of what I had done, not just on myself and my family, but also on my daughter. It saddens me to think that these mothers today who are trotting out on the "Phil Donahue Show," among others -- who are contracting away their children through these contracts -- are going to be a new breed of birthparents in the 1990s and beyond. Their grief and pain is going to be even worse than mine, because they voluntarily did this. They sold their children through contracts. I think they are going to have a hard time answering to themselves, their families, and, most importantly, their children, because that is what children who are surrendered for adoption come back and say to us: "Why did you give me away? Why couldn't you keep me?" They say this even to a woman who was 15 years old at the time. They don't understand. It is one thing for men to donate sperm; it is another thing for a woman to do this. I think we hold that value of motherhood very sacred in our society, and I don't think we should change it.

I also think that most people never talk about the impact this has on children; not just the children born of the process, but also the older children of the mother. There is always going to be pain for these children. Even adoptive parents have learned that you cannot love away the pain your children have because of this. No matter how much they are wanted, no matter how much they are loved, you can't love away that pain. I think that people who get children through surrogate contracts are going to have a special set of problems they will have to deal with. Even donor offspring -- children who have found out that they are the result of artificial insemination -- have, over the last several years, come forward, because when they finally find out the truth of their origins, they are angry. They are really angry. Most of them, when they find out, speak of their anguish of not knowing who their father is. They realize how destructive it is to find

out that one of their parents sold them, with no intention of ever loving them or taking responsibility for them. For the children born of surrogacy contracts, I really believe it is going to be worse, because their own mothers did this to them.

In this process, there are always going to be Tuesday and Ryan Whiteheads -- older children of the mother who are half siblings to the child raised by another family. Can we begin to imagine what it does to these children to see their mother carry a child to term, and then give the child, or sell the child to another family? How can we consider the best interests of one child and ignore the best interests of his or her older brothers and sisters?

Other people have talked about the semantics of all of this, and I maintain that women who bear children as a result of surrogacy contracts are not surrogate mothers; they are mothers. They are not alternative reproduction vehicles, Judge Sorkow, and they are not surrogate uteri, Mr. Skoloff; they are mothers. I really believe we should ban commercialized surrogacy and not consider this bill any further. We already have statutes that can cover those things done between people -- between individuals. We already have good adoption, termination of parental rights, and sperm donor statutes in New Jersey which cover all of this.

This Sunday is Mother's Day. It just seems ironic to me, at a time when we give great lip service to the values of motherhood and the sacred bonds between mother and child, that we even consider discussing a process like this, which I really believe would destroy all of that.

Thank you very much. I will be happy to answer any questions you might have.

ASSEMBLYMAN KERN: Thank you. Any questions? Assemblyman Girgenti?

ASSEMBLYMAN GIRGENTI: I have a couple of questions. One is that the Stern/Whitehead contract did not require Stern

to take Baby M. He had to cut off Mrs. Whitehead's right to change her mind. In your opinion, was this a fair and equal contract?

MS. WARD: No. Also, I believe the contract required him to take legal responsibility for the child, but did not require him to take the child into their home. To be fair to the Sterns, they did have responsibility for the child. I think the enforcement of a pre-birth contract, though, is illegal and immoral.

ASSEMBLYMAN GIRGENTI: I think you have given us the answer already, but just to put it on record, is it accurate to say that you disagree that the covenant to surrender custody in the Baby M contract was not a personal service, as the court held?

MS. WARD: We can't talk about all contracts, but if we just look at that specific contract-- If she had a baby, if she went through all of the inseminations, carrying the child for nine months, and all the risk to her health that a delivery entailed, then why, had Sara been born dead, would she get $1000, and $9000 more if she were born alive? Her service was exactly the same. So, I can't talk about other contracts, but that particular contract was very clear that it was not a service she was being paid for; it was a baby.

ASSEMBLYMAN GIRGENTI: So, what was it?

MS. WARD: I think it was a payment for a baby. Part of the payment was for the baby; $1000 was for her services. You know, I don't go along so much with the labor law arguments about all of this and the minimum wage, because I think there are other services that are not necessarily done on that. But I think in that particular contract, because they differentiated-- Other surrogacy centers, though, have drawn up different contracts that kind of circuit that argument.

ASSEMBLYMAN KERN: Anything else? Any other questions? (no response) Thank you very much for coming.

We are going to adjourn at this point. We are going to suspend the public hearing for the moment to do the Senate bill that is on the agenda. We will reconvene the hearing one hour from now.

(RECESS)

AFTER RECESS:

ASSEMBLYMAN KERN: I would like to reconvene the hearing now, and call on Edward Trawinski.

E D W A R D T R A W I N S K I: Good afternoon, Mr. Chairman and members of the Committee. I am Legislative Counsel to Assemblyman and Assistant Majority Leader Felice. I am here to speak on the Assistant Majority Leader's Assembly Joint Resolution 76. He apologizes to the Committee that he could not be present personally.

Having listened to the myriad of witnesses this morning, there is one common theme: The issues are complex and they bear study. There was an editorial in The Star-Ledger in the beginning of April which essentially said that there are times when study commissions are examples of legislative temerity, and there are times when they are appropriate. When the issues are as complex as you have heard this morning, and as you are all generally aware, the time is right to take the time to study the issue properly.

The Assistant Majority Leader is neither opposed to, nor in favor of A-3035 through and including A-3040. What he says is: "Take the time to think about it. Get the best minds in the State that you can to cover the complex issues that are there. Then decide whether legislation is appropriate or not."

So, we submit to you that the issue before the Committee is not whether the Committee should act, but how the Committee should advise the Legislature, and the Assembly specifically, best to act. For reasons that are obvious, as set forth in the Resolution, and based upon the testimony you have heard, we feel the best way for the Committee to advise the Assembly to act is to adopt the Joint Resolution.

That is all I have, Mr. Chairman.

ASSEMBLYMAN KERN: Thank you. Any questions? (no response) Thank you very much for coming, Ed.

Alan Weisbard?

A L A N J. W E I S B A R D: Good afternoon, Mr. Chairman and members of the Committee. My name is Alan Weisbard. I am a resident of Montclair, New Jersey, a member of the faculty of the Benjamin N. Cardozo School of Law in New York City and, as of July 1, I will be assuming the responsibilities as Executive Director of the New Jersey Bioethics Commission, formerly known as the Commission on Legal and Ethical Problems in the Delivery of Health Care. I am appearing today in that latter capacity on behalf of our Commission's Chairman, Daniel F. O'Connell, who is unavoidably out-of-state today. It is an honor to meet with you. I found this morning's testimony fascinating and instructive.

As you know, the Commission was established by an act of this Legislature, quoting from the statute: "To provide a comprehensive and scholarly examination of the impact of advancing technology on health care decisions." We were asked and mandated by the Legislature to help to enable government, professionals, the citizens of the State of New Jersey, and others around the nation, quote again: "To better understand the issues presented, their responsibilities, and the options open to them."

I am appearing this morning in that spirit, to offer the assistance of the Commission and its staff as the

Legislature moves forward in considering the legal, ethical, and social issues posed by advances in technology in the area of surrogate motherhood and other novel or alternative means of human reproduction.

I would like to add my voice to those raised earlier in commending the Chairman and the members of the Committee in putting forward the number of bills before you today, in taking this important step through these hearings and the remainder of the legislative process, in bringing these issues more fully before the public of New Jersey, and in beginning the long road toward careful consideration of these issues and an appropriate legislative response by the Assembly and the State Senate.

The Commission's work, so far, has focused on the area of death and dying and is well under way. We have held a number of public hearings around the State considering such issues as he definition of death, living wills, durable powers of attorney, and other issues related to planning for the end of life. We are hopeful that with my arrival as a full-time Executive Director on July 1, and with several impending additions to the Commission's professional staff, we will be able to complete our first interim report to the Legislature, including a number of recommendations for legislative action relating to death and dying, by this fall.

These additions to the Commission's staff will bring considerable depth and experience in the areas of law and bioethics, including expertise highly relevant to the issues posed by new reproductive technologies. We are ready and eager to put this expertise at your disposal, and to assist you in whatever way you may find helpful.

As is evident from the number of bills now pending before this Committee, and the scope of their coverage, that these new reproductive technologies pose a stunning variety of questions with which our State, our society, and our law have relatively little experience. The issues go to the foundations

of family law, raising questions ranging from abortion to adoption to adultery, to concerns raised by some about slavery, baby selling, and the commodification of human life. These practices raise profound religious and social questions from the dignity and sanctity of sexual expression and procreation to the role and opportunities of women in our society, to indeed the very definition of family and its meaning in contemporary society.

There are also issues regarding the appropriate role of contract law in governing the custody of human beings, particularly given the close linkages of substantial financial payments in connection with the waiver or relinquishment of custodial rights, and the timing of such waivers. There are issues of informed consent. There are other questions of potential tort liability relating to the well-being of the child, the parents, and other participants in the process. There are troubling issues regarding the appropriate role of government action, including both regulatory controls and the use of State power in the enforcement of private agreements. These touch sensitive matters of family life.

Many of these questions also implicate important constitutional dimensions, as courts and legislators continue to struggle to refine the meaning and scope of the right to privacy as it applies to sexual and reproductive behaviors and to new ways of constituting families. And, there are the painful, difficult questions of the implications of these new technologies for the welfare -- both physical and psychological -- of the children conceived by these means, and of other children, potential adoptees, whose potential for being adopted and cared for in a family setting may be profoundly affected by legislation in this area.

With this multiplicity of questions, issues, and perspectives, it is no surprise that different groups have reached different conclusions on how best to proceed. While

the Baby M case is in important respects a first in the American context, several other countries and jurisdictions have had occasion to consider these issues and to respond with legislation. Major examples within the Anglo-American legal tradition include: the United Kingdom, the State of Victoria in Australia, and the Province of Ontario in Canada. You heard this morning about other things pending in continental Europe. Each of these sets of legislation follows a somewhat different pattern and a somewhat different philosophy. Interestingly, in each of the cases I have mentioned, the legislation followed from detailed, comprehensive studies by respected committees or commissions. While in each case the relevant legislative bodies made modifications to the committee proposals -- and I should add that that seems to me quite appropriate; after all, citizens of the State elect legislators, not study commissions -- the process of committee investigation, discussion, and debate appears to have been of considerable benefit in contributing to the quality and thoughtfulness of the legislative process.

Drawing on those experiences, I would like briefly to sketch out some potential avenues of approach that this Committee and the New Jersey Legislature may wish to consider on how to proceed. Let me identify three or four potential legislative approaches to surrogate motherhood that I think will also have application to some of the other new reproductive technologies. I will try to do so without prejudging their respective merits.

At one end of the spectrum, the Legislature might decide simply to prohibit the entire practice of surrogacy, providing criminal penalties for the participants. This would, in some respects, be the simplest approach you could adopt, although on some views of the right of privacy as it now applies to family and procreative matters, and of certain First Amendment concerns, this approach might well implicate the

constitutional rights of the participants and would, of course, have impact on the profound interests of infertile couples who so desperately desire the joys and responsibilities of parenthood.

A second approach might seek to discourage, but not necessarily prohibit the practice of surrogacy. Under such an approach, the Legislature might restrict or prohibit commercial payments beyond necessary medical expenses, declare surrogacy contracts voidable and/or unenforceable in the courts, give statutory status to the common-law presumption that the woman who gestates and gives birth to a child is that child's mother, and direct that the protections afforded to both mothers and children in the adoptive context could be applied to the situation of surrogacy. There might be additional specific provisions restricting or prohibiting the role of commercial intermediaries in surrogacy situations. This general approach would not entirely prohibit the practice of surrogacy, especially that involving relatives or close friends acting on an altruistic basis, but it would serve to limit the practice overall and to place curbs on areas of greatest potential abuse.

A third approach would be for the State to accept the widespread practice of surrogacy as either a desirable or an unavoidable response, I think -- taking off on Mr. Skoloff's observation this morning -- to the problem of infertility, to give formal legal status to the practice, and to structure a comprehensive regulatory regime to govern the practice of surrogacy, providing protections for the adoptive parents-to-be, for the birth mothers, and for the children. Such an approach would, in all probability, require extensive legal provisions governing the terms of surrogacy contracts and the practices to be employed by surrogacy or infertility centers.

A fourth alternative would view surrogacy simply as a desirable social practice among consenting adults and would

While I do not anticipate that such a process is likely to result in any magical resolution acceptable to all -- that, I think, would probably be impossible in a State as diverse and pluralistic, and as interesting as New Jersey -- it could realistically serve to clarify the issues and the values at stake, to provide well-worked-out options for legislative consideration, and to permit the members of the Legislature to perform their responsibilities in as careful, considered, and responsible a fashion as possible. I believe our Commission can be of some assistance in this process. We, as a Commission, are eager to work with you to develop an appropriate format, structure, and timetable for that process, and to turn to this project with necessary expedition. As we have learned, creating and staffing a study commission on issues of this complexity cannot be achieved overnight. We are now in existence and ready to go. We have the statutory authority and mandate to create task forces drawing on participants with expertise in areas of particular relevance to a given topic, which would certainly include new reproductive technologies. Let us know how we can best be of service to you.

I would be happy to respond to questions, or to address some of the other issues raised by the other bills.

ASSEMBLYMAN KERN: Are there any questions from the members of the Committee? (no response) Thank you very much for your presentation, and for offering your Commission's services.

Dr. Ekkehard Kemmann?

D R. E K K E H A R D K E M M A N N: Good afternoon. Thank you for giving me the opportunity to talk to you. My name is Ekkehard Kemmann. I am Associate Professor at the University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School, in New Brunswick. I am the Director of the Division of Reproductive Endocrinology and Infertility; also the Director of the first in vitro program in New Jersey.

I would like to comment on a number of these bills. These primarily address the applicability, as I see it as a physician. Regarding Assembly Bill 3035, about fertility drugs, it is unclear how the definition of "infertility drugs" is meant. The definition, as used in the bill, really defines as an infertility drug any drug intended to increase the ability to reproduce in a woman. Theoretically, that could be a vitamin, if a patient is low in vitamins and the physician thinks she needs more vitamins. It could be thyroid medication if the patient is thought to be hypothyroid, and therefore unable to conceive. So, it is an extremely wide definition.

In practical terms, there are three or four fertility drugs which are clomiphene citrate, human menopausal gonadatropins, perhaps GNRH, which is a gonadatropin releasing factor, and pure FSH. If we talk about infertility drugs, these are the drugs in question.

Now, the implications of what is explained in the bill do not apply to all infertility drugs in general, so it is not correct to talk about overstimulation, except for certain specific drugs. One of the listed implications which I, as a physician, would have to address is a patient with a potential drop in blood pressure. I have never seen it in over thousands of treatments. I don't think it is a realistic risk which the patient should be concerned about.

Multiple births is a very well-known side effect of the specific fertility drugs. Probably every patient today knows about it. We certainly do address this issue very specifically. We not only talk about this, but we have to put it in perspective, because the risk is different for different medications.

One reference is to the fact that infertility drugs can lead to an inability to reproduce. I really would have difficulty discussing this with a patient, because I really don't know what the reference is to. I have really not

experienced that in over several thousand treatments, and I don't think this is a realistic risk. I could, of course, say that pregnancy sometimes ends in cesarean section, where also the uterus has to be removed and then, of course, a patient cannot get pregnant any more.

My feeling is that there are enough regulations, laws, and statutes on the board. If a physician does not properly counsel the patient, the patient today can take appropriate action against that physician. I don't really think the law helps the patient or the physician further.

Regarding Assembly Bill 3036 -- and this applies to a number of other bills, too -- the terminology of donor-- In this and other proposals, the terminology of donor is very wide, and would include a person whose sperm are used in the wife. That is contrary, perhaps, to common medical terminology or usage of donor. If we talk about a donor, it is implied that this is a person outside the marriage. Donor sperm are from men -- from third parties. From this angle, then, using the donor terminology on the couple, or on the woman even herself, if her own oocytes are used-- I think some problems arise, because I don't think there is a contract necessary between husband and wife when their own gametes are needed. It may be very different if other outside parties are involved.

Also in Assembly Bill 3036, one thing I want to point out in section 5 is, "The prospective parents of the embryo or frozen embryo shall have all rights to the embryo." I don't know whether that means the embryo has no rights. I don't want to comment on that further, but it is something that I wanted to point out.

Assembly Bill 3037: That is the act concerning artificial insemination. Artificial insemination has become a very important treatment for couples when male infertility is involved. In probably most of these situations, adoption is the only alternative. There are not many other ways to go.

The definition of artificial insemination, again, does not distinguish between husband's sperm and medical donor outside sperm. So, if you look at it first from a husband's point of view, when a husband's sperm are used, it becomes very intrusive. It is not a help to the couple, and is probably not what may be intended. If I would be a husband in this situation, and my sperm would be used on my wife, what the bill would ask me, first of all, would be for my records to be sent to the Department of Health. As a husband, I would object to that. It would request that I would, apparently prior to each insemination, undergo testing for sexually transmitted disease and, in my specific case, I have myopia, so I have a genetic defect, and I would not be allowed to inseminate my wife.

So, I think you might perhaps consider uncoupling the husband's insemination issue from it, because I am not aware that there is any regulation currently around to regulate it, and I am not sure it is necessary.

Now, if we talk about donor semen from another party, I think that is a very important issue to regulate to create stability. In the interest of time, I will refer to my colleague later, Dr. Bohrer, who handles the program in our institution, and who will discuss that very specifically.

Assembly Bill 3038: We are not doing surrogating. I will not repeat the issues which have already been very well brought to your attention. I just want to let you know that this is not being done at our institution.

ASSEMBLYMAN KERN: What about other institutions?

DR. KEMMANN: I am not aware-- I can't say about certain perhaps private physicians' offices, but I am not aware that any State institution is involved. The only comment I have is, I think it is primarily a contractual issue of human relations. It actually could be done without a physician. It is not a breakthrough in medical technology.

Assembly Bill 3040: It indicates that a physician has to tell patients about the availability of procedures to store the patient's reproductive cells for future use. Now, that is not really available. There are no current methods to store patients'-- female patients' -- oocytes. It would be nice if that were available, but it is not available. Well, they can be stored, but I am not aware that a pregnancy has ever resulted. Let me be more precise about that. Obviously, you can store it, but I am not aware that it has worked subsequently.

Sperm cells, of course, can be stored. I am aware of only one study done several years ago in California, where they looked at how successful that was as a policy. It turned out, if I am correct-- The magnitude was that in about 10% of the males, or less than 10%, down the road a pregnancy was achieved with those frozen sperm. So, it is not a very good method. It perhaps can raise some false hopes or induce the male to undergo a sterilization hoping that pregnancy can be achieved later, when actually the chance of that is very slim. In addition, I am quite sure that there is significant cost involved in the continued storing of this.

I would be glad to answer any questions you might have.

ASSEMBLYMAN KERN: Assemblyman Thompson?

ASSEMBLYMAN THOMPSON: Doctor, what causes blindness in a woman giving birth? To your knowledge, have there been any cases where artificial insemination has caused blindness in childbirth?

DR. KEMMANN: Whether use of a fertility drug has caused blindness?

ASSEMBLYMAN THOMPSON: First of all, to your knowledge, what causes blindness to a woman in childbirth?

DR. KEMMANN: Well, the first thought I would have is when a woman might go into a hypertensive crisis, perhaps due to a preeklampsia complication of late childbirth or labor.

That could perhaps lead to the rupture of a vessel and it could bleed in the eye. So, I would think about that. I don't think blindness occurring at labor in late pregnancy has any connection to the use of fertility drugs per se. An explanation might be diabetes which becomes recognized or more active during pregnancy.

ASSEMBLYMAN THOMPSON: One more question: With reference to artificial insemination, how close-- Let me rephrase that question. With reference to artificial insemination, is that a step toward cloning? How close is that to the concept of cloning?

DR. KEMMANN: With artificial insemination, we distinguish two types. One is using the husband's sperm, and one is using-- If the husband has no sperm, or sperm which are not expected to achieve fertilization, then we use donor's sperm. Artificial insemination was done first in medicine about 100 years ago, by Dr. Sims in New York. It really means that the sperm are placed into the cervix or the vagina or the uterus, and now sometimes into the peritoneal cavity. But then fertilization and pregnancy will occur in the natural way. So, it only refers to the fact that intercourse does not take place, and that a sperm specimen is applied, usually into the cervix, to allow the migration, or the growing of the sperm toward the egg to fertilize the egg inside. It is not a high-tech technology. It has been done for decades.

ASSEMBLYMAN THOMPSON: What I really want to ask you is, is human cloning possible?

DR. KEMMANN: Cloning is possible. I am not aware that anybody has done it or shown it. I am not aware of anybody working in that direction in this country. I think it might be possible just theoretically. I think the potential reality is still considerably distant.

ASSEMBLYMAN THOMPSON: It's illegal in this country, though, isn't it?

DR. KEMMANN: I wouldn't know that.

ASSEMBLYMAN THOMPSON: Thank you.

ASSEMBLYMAN KERN: Are there any other questions? (no response) Thank you very much, Doctor.

DR. KEMMANN: Thank you.

ASSEMBLYMAN KERN: I would like to call upon Dr. Michael Bohrer.

D R. M I C H A E L B O H R E R: Good afternoon. I would like to thank you all for the opportunity to come here to speak to you. As the Director of the Donor Insemination Program at the Robert Wood Johnson Medical School and the Robert Wood Johnson University Hospital, I have a considerable amount of contact with both the donors, as well as couples who come in for artificial insemination. So, I would like to give you some of my views on Assembly Bill 3037, which was proposed by Assemblyman Kern.

One of the things that Dr. Kemmann certainly brought up was that there isn't a clear distinction in the bill between husband and stranger -- anonymous donors. So, clearly there are a number of things in the bill which were geared mostly toward anonymous donors, which really do not apply well to the husband donor. Some of those have already been mentioned.

I also wanted to mention not only the fact that he would be required to undergo testing -- extensive testing -- each time he did a sperm donation, but certainly reiterate the point that the general statement, "a known genetic disease or defect" would eliminate someone as being a donor -- would, indeed, inhibit some of our husbands from being donors for their own wives. I don't think it was your intention to wipe out genetic illnesses in our time by this law.

ASSEMBLYMAN KERN: No, not at all. I think it is something we can cure very easily by amendment.

DR. BOHRER: With respect to unknown donors, or anonymous donors, to this date that is the way they have been;

they have been anonymous donors. It does disturb me a little bit -- well, more than a little bit -- that records of all semen donors should then be supplied to the Health Department. What bothers me about this is that these records then can be disclosed to any practitioner. A practitioner is anybody who is capable of doing artificial insemination. Many of our donors are medical students. Many of our donors are physicians. They know other medical practitioners. They, themselves, will be physicians and will have access to files -- their own files, as well as files from other donors; people who they probably weren't aware were donors; people who may not have wanted them to be aware that they were donors as well. So, it is no longer a completely anonymous donor. Suddenly, people within their own community can become aware that they are involved in this process. I think that would inhibit a great many of our donors from volunteering as donors, if they know these records could be obtained by friends or relatives of theirs.

I also wanted to point out that I agree that donors should be screened before being used. We go through an extensive screening process with each one of our donors before permitting them into the program. Fifty percent of the potential donors I see are never allowed to donate a specimen for our patients. That is because I do have very stringent criteria as to previous exposure to illnesses, as well as genetic criteria, by which I protect my patients.

I think that is probably what you are trying to go for here with this idea that no donor who has a known genetic disease or defect should be allowed to donate. But, the vagueness of the term "defect," certainly would mean that even I may not be strict enough for you. To what extent is something a defect? What you think is a defect, and what I think is a defect, may not be the same thing. Is a big nose a defect? I don't know. I don't think so; I have one. Are flat

feet a serious defect? Is that something we need to eliminate a donor for?

Certainly I am screening for serious genetic illnesses -- birth defects, spina bifida. These kinds of individuals are a much increased risk for having offspring who have these afflictions as well. I think they should be eliminated as being donors. I am not only concerned about the couples who are my patients, but, yes, their unborn offspring are my patients as well. They are who I am trying to protect in my screening procedures. So, I really screen fairly significantly.

I also screen for sexually transmitted diseases. The term "sexually transmitted diseases" is kind of vague. It also opens the question, how often is it appropriate to screen for sexually transmitted diseases? Is once a year appropriate? Is once a week appropriate? Is each insemination appropriate? What is the appropriate amount? Well, when looking at sexually transmitted diseases, we look at things such as AIDS, hepatitis, syphilis -- things, again, which can be transmitted through the sperm, or through the sperm specimen.

These diseases take a while before their tests turn positive. In AIDS, an AIDS victim can be exposed to the virus, but it may take up to two months before his blood test turns positive. With hepatitis, there is an equally long incubation period. The same is true with syphilis. It may take a while before the blood tests turn positive after an exposure to syphilis. These people are still contagious, so the questions is: Is once a week a bit too much? I think that once a week is probably quite a bit too much, in that you are not really achieving what we are going after. What we are trying to achieve here is a safe insemination. In this case, once a week is being excessive, and not really achieving our goal; not guaranteeing us that we have a safe insemination, because it is possible that the donor could have been exposed, is incubating the virus, and it is still not showing on his blood test. So,

this becomes excessive at once a week. It becomes very costly at once a week. And the question is: Who is going to pay for all of this? We are already in an age when we are trying to aim for cost containment in medicine. This does just the opposite. It encourages us to do a lot of unnecessary testing that is probably not going to be helpful.

Now, what else about this? It means that our donors will need to come in once a week to be tested as well. Blood tests are one thing, but there are other sexually transmitted diseases. What about gonorrhea? What about chlamydia? If you really want to test for gonorrhea and chlamydia, you have to do urethral cultures. If you were a potential donor, would you come in once a week to have a urethral culture taken? The donors are not reimbursed that much money. They are reimbursed for their trouble. I do my inseminations first thing in the morning, which means that they have to get up early in the morning, produce a fresh specimen, bring it into the hospital, and then go about their regular activities. This all has to occur before eight o'clock in the morning. For all of this, including what they have to pay for parking at the hospital, they get reimbursed $40. No one is going to get rich from that kind of money.

So, you can see that having them come in once a week to get urethral cultures, probably could test a lot of our donors right out of circulation. We do have to be careful about being excessive in our surveillance.

I am also a little bit concerned about records. I mentioned also that not only are the records released, but after successful conception by a woman through an artificial insemination procedure, the donor's records have to go to the Department of Health. There really is not a statement there as to what happens to those records. Are they kept confidential? Are they open to the public so that anybody can request them? Is it just physicians who can request these records, and under

what circumstances should we try to request these records? Are there any limitations as to what is a good reason and what is a bad reason to request these records? Is curiosity as to the name of the donor and what he looks like-- Is that an adequate reason to request these records? Who is going to make that decision as to who gets these records? Suddenly a donor, once he becomes successful, no longer remains anonymous.

Now, the other thing I am concerned about is, if these records remain on file and they become public knowledge, then we have not suddenly opened up to the world the knowledge that these couples have undergone an artificial insemination, regardless of whether it was by donor or by husband. Suddenly we have now taken something which is very personal to this couple, not only their infertility problem, but also the fact that they have now tried to achieve a pregnancy-- Suddenly we open this up for public examination. I do not think that is to the best interests of our couples. I feel it invades not only their privacy, but also, to an extent, it demands that physicians have to give up some of that recognized confidence between the patient and the physician. No longer is this privileged knowledge -- privileged information -- between the physician and the couple; it can be given up easily to public knowledge.

It also now takes away-- Becoming public knowledge takes away the patient's options. Now, people have talked about whether or not to tell the children that they have been conceived through artificial insemination, by donor or not. I don't think that is our decision to make. I think that is up to the couple. If this becomes public knowledge that they had a donor insemination, that takes away their option not to tell that child. These children grow up not knowing about donor insemination. They grow up healthy; they grow up well-adjusted; they grow up very nicely. There isn't any problem with not telling the children, if that is what the

couple is comfortable with. By making it public knowledge, we are suddenly taking that right away from them. We are suddenly dictating to them what they should tell their children. I do not think the government belongs in the sacred relationship of the family, to tell parents how they should raise their children.

I also wanted to bring up that it reiterates a law which is already on file, that the consent form -- basically a consent form -- that documents their consent, as well as that a donor insemination was performed, should be kept confidential and in a sealed file. I am referring to number nine on page two. Now, this is already law in this State. The problem with that, again, is that I am not sure what is meant by "confidential." Does that just mean that that letter is not going to be released to someone who requests to see it? If a request to see the letter is denied, by saying, "I'm sorry, you can't see that letter," that already establishes that the letter exists. That is all that is necessary to establish that, yes, they have had a donor insemination. Again, their silence has been breached by the fact that this letter is even in existence; that this can be received.

Who is allowed to look into this confidential file? Obviously, if we want it on paper and we want it filed away, it is because someone might want to look at it someday. I am not sure who should be allowed to look into this file. There is certainly -- as far as I can see -- no specifications as to who that may be. Should that be their attorney? Should it be just the couples, just their physicians, or the donor himself? Maybe he says he wants to check to see who his inseminations were used for.

Now, also as far as records being maintained in a public place, such as the Department of Health-- That bothers me to some extent. You know, I fear that there are some people who would like to have these records available, in order so

that at some point later in life they would be able to track down a person's donor. I am not sure of the purpose of wanting to track down the donor at a later point. Medically, there really isn't any good reason to try to track down the donor. If the child develops a disease at some point later on, do we want to track down his donor to find out whether or not it runs in his family? We have already screened the donor; we have already asked him that question. That was before he even donated his first specimen. He has already gone through an extensive family screening, as well as a genetic screening. We already know that he doesn't have any illnesses of a genetic basis running in his family. So, we don't need to try to find him for that information.

Are we trying to find him to be an organ donor for this child, who is not his child legally? I don't think so. He has already donated his semen. How much more do we want to ask him to donate? So, I don't know why we need this information. We do keep files on these patients. The main objective of keeping files on the donors is-- Yes, I do think we have to keep track of how many pregnancies each donor has. By doing so, and by limiting the number of pregnancies each donor has, we therefore eliminate the chance that two of his offspring will possibly meet, and possibly get married and have children of their own. I think that by limiting the number of donors, that in and of itself, will limit the possibility of that happening, without having to make their identity known to these offspring. I think that trying to give them that information just makes that a little bit redundant.

That is really all I wanted to comment on at this time.

ASSEMBLYMAN KERN: Assembly Bill 3037 requires that the records kept by the Department of Health be kept confidential. That is in the bill.

DR. BOHRER: Right.

ASSEMBLYMAN KERN: With respect to the criteria that should be utilized in the screening process, I welcome suggestions from you as to what should be screened for, etc. I am sure we can amend the bill to accommodate that.

DR. BOHRER: One of the things I kind of felt in the bill was that it was trying to set up what is good medical practice. I am not sure that is really for us here in the government -- people in the government -- to tell the medical field what is good medical practice. Traditionally, what has been determined to be good medical practice has been based on sound research and past experience, and articles and guidelines that are written. That has already been done. There are already guidelines for the medical community. The government does not have to worry about what good guidelines are, or should they write down and determine what these good guidelines are.

The American Fertility Society has already written these guidelines. I have a copy of them right in front of me. They specifically determine what the minimal criteria are for any donor program.

ASSEMBLYMAN KERN: Do you want to supply those to the Committee?

DR. BOHRER: Sure, I can give you a copy of that.

ASSEMBLYMAN KERN: I would appreciate it if you would do that. Don't you think it is important to keep records, though, with respect to donors, in case the progeny may need a kidney, or something of that nature?

DR. BOHRER: No, I don't think we should have to call upon our donors. How much can we ask of these people? I am not sure it is their place. We have already told them that these are not their children, which is right in the same bill. They are not the children of the donors, regardless of whether the recipients are married or not. Then we are going to go to these people and say, "Now I want you to donate a kidney to this person"?

ASSEMBLYMAN KERN: Well, requiring and requesting are two different things.

DR. BOHRER: Well, it is still a lot to ask. I do keep track of my donors. I keep my own personal records. What bothers me most about it is not that we keep track of the records; it is that I don't want them to be public where another physician could obtain them, and say, "I need a donor for my patient. Well, let me call Dr. Bohrer's donors." I don't want them being contacted by other health care professionals.

ASSEMBLYMAN KERN: We could limit that. We could do that by legislation.

ASSEMBLYMAN THOMPSON: What if there is a genetic deficiency and you don't discover it? Suppose there is a human error, and it comes up through the years and there is no record? Then what?

DR. BOHRER: That is entirely possible. That may indeed happen. The patients are well counseled about that. I sit down with each one of my patients who is about to go through artificial insemination, and I very painstakingly go through artificial insemination with them. It takes me over an hour to do so, so they can understand all of the medical, legal, and emotional ramifications of artificial insemination. One of the things that may happen is, at the time of screening -- at the time we saw the donor -- he may have had nothing in his family history that would be significant. But, just like in your family, later on in life they may all start to get diabetes, which prior to that no one in your family had. I am not sure what information that would give us -- going back and saying to the donor, "By the way, did anyone in your family develop diabetes?" just because this child now has diabetes at age 14. Does that change anything for that child? It just makes us want to try to go back and step into the private life of this person, who donated a specimen, and who was trying to help infertile couples back 14 years ago.

ASSEMBLYMAN THOMPSON: Excuse me, Mr. Chairman.

ASSEMBLYMAN KERN: Go right ahead.

ASSEMBLYMAN THOMPSON: Well, following up on your answer, I am not a physician, by any means, but it would seem that if you had some prior information and some records, you certainly could warn persons who were going to get involved in this artificial insemination that there was a trace-- Maybe the grandmother was a diabetic, or something.

DR. BOHRER: If they have that history, they are eliminated from being a donor. If there is any increased risk above the general population that that person is carrying a gene that may be detrimental to that child, he is not in the donor program; meaning that if he has a grandmother, a grandfather, and a father who all developed diabetes, albeit late in life, there is clearly a pattern forming in that family. Clearly there is something in that family -- not even definitely, that can happen by chance alone -- but still, there is a good chance that that family is carrying a propensity to develop diabetes. That person is eliminated from being a donor. They are already getting screened for that. There is no way of warning the patient that the child may develop diabetes, because no one in the family had diabetes at the time of the initial screening. But, five years down the road, three people ended up getting diabetes, after the insemination had already been done.

All I can do-- I can't guarantee anything. Just like when two people get married, there is no guarantee about what kind of children they are going to have. The only thing I can do is not increase their risks above the general population -- above random chance. Even birth defects-- No matter how hard you screen, everybody has some genetic defects in their genes that amass by the fact that you have a (indiscernible) of normal genes. There is no way of telling if these genes may actually somehow mix with the recipient's genes, and this could

end up with a birth defect, even without any prior history in that donor's family. In fact, if you look at people who have birth defects, and go to their families, many of them don't have any prior history of that in the family.

ASSEMBLYMAN THOMPSON: Are you familiar with Dr. Shockley in California, a controversial -- I guess he is a genetic doctor?

DR. BOHRER: Yes.

ASSEMBLYMAN THOMPSON: Are you familiar with the fact that he runs a private clinic in California dealing with artificial insemination?

DR. BOHRER: Yes. He has a program which has been a Nobel Prize program.

ASSEMBLYMAN THOMPSON: Yeah. He only accepts donors who have a certain high I.Q. -- medically know as Mensa -- and he doesn't accept blacks or Jews. Are you familiar with this?

DR. BOHRER: Yes, I am. I am not saying that with artificial insemination. Of course, with everything that goes on, there is going to be a certain fringe element, and that is where I like to put him. Respectable, normal insemination programs do not follow the precepts of Dr. Shockley. Yes, we do try to find donors-- I am not going to take donors who have below average intelligence. Clearly that is a defect; clearly that is something I need to protect the offspring against. But I am not going out and soliciting only the cream of the crop, and discriminating by race, creed, beliefs, unless there is some reason to think that these would be medically harmful.

There are certain things that are medically harmful. You may have very intelligent people who may be schizophrenic. All right? Schizophrenia is, to some extent, genetically involved. Clearly these people are eliminated from being donors, I don't care how smart they are, or how many other redeeming values they may have. Schizophrenia is-- It is hard to redeem that as a donor. So, I don't think you need to be

afraid that people are going to follow suit with Dr. Shockley. I mean, artificial insemination has been going on since the 1800s, and people haven't really gone the way of Dr. Shockley in 200 years.

ASSEMBLYMAN THOMPSON: There may be a reason. Probably Dr. Shockley doesn't receive any Federal or state funds and, therefore, cannot be sued on those grounds, but I still think his concept is strange.

DR. BOHRER: His concept is strange.

ASSEMBLYMAN THOMPSON: The more we listen to this, although it isn't cloning, it seems to me that we are creeping closer and closer to the "Boys of Brazil" and that whole German concept.

DR. BOHRER: There is a tremendous difference between artificial insemination and cloning. With normal intercourse -- everybody has a mixture of genes -- you give up half of that mixture of genes to your offspring. Okay? The way that mixture is distributed is randomly, which makes for extreme diversity among us all. That is why we all look so different. Even offspring from the same donor, not even considering they are going to end up having different mothers, but even from the same mother-- I am sure we have all seen couples with more than one child, where the children don't look anything like each other. That is because of this random assortment of genes. There are no guarantees. You can take the smartest, most handsome donor you can find, but there are no guarantees as to what that offspring is going to look like, which is very different from cloning.

Cloning is not being done in this country with human beings. But if it could be done -- if it could be possible at some point -- the difference is that you would take the entire genetic make-up from a single individual, place it into an egg, and then get that egg to develop into another individual. Basically, it is like having an identical twin at that point,

and you could make multiple, multiple identical twins, which is basically like a "Brave New World" type of situation, where they make one just like the next, each one being exactly the same genetically, eliminating variation from one to the next.

Artificial insemination by donor is quite different. There is a mix of genes from both the donor and the mother, and there is a random assortment of the donor's genes to each one of the offspring. So, it ensures a variety of genes in the public gene pool, so we are not getting anywhere near the "Brave New World."

ASSEMBLYMAN THOMPSON: I would like to ask you just one more question, through you, Mr. Chairman.

ASSEMBLYMAN KERN: Go right ahead.

ASSEMBLYMAN THOMPSON: With reference to your clinic, are the recipients told the racial and ethnic background of the donor?

DR. BOHRER: Yeah. One of the things is that each one of the donors is matched very specifically to the couples. They are matched on the basis of blood type, hair color, eye color, body build -- which is height and weight -- and even ethnic background, to some extent. So, recipients -- okay? -- can state that they want any type of criteria for their donor at all. If they want their donor to be of a specific ethnic background, then I will only use a donor within that specific ethnic background. So, that information is supplied to the couples.

ASSEMBLYMAN THOMPSON: What about race?

DR. BOHRER: With race, I will only use-- Yes, the race is supplied to the couples. I will use whatever race donor they request, meaning that if I have a black couple, and they request a black donor, then I use a black donor. If I have a white couple who wants a black donor, I will use a black donor. I don't have any problems with that. They have to be comfortable. Most of the time, the only place where that

becomes an issue is if I have a mixed couple, where one is black and one is white. There they will usually request one or the other. Most everyone else requests whatever their own race is.

ASSEMBLYMAN THOMPSON: Do you receive any Federal or State funds for your project?

DR. BOHRER: Being part of the Medical School, I would imagine that there are some funds that go directly to fund our Division. I am sure that most of my salary comes from UMDNJ, so it is a State check. Yes, I guess I do get some funds, but basically the program itself is not controlled by that. It is a fairly self-sufficient program.

ASSEMBLYMAN THOMPSON: No more questions, thank you.

ASSEMBLYMAN KERN: Doctor, I would appreciate it very much, on behalf of the sponsor, if you would supply those criteria and, also, what you categorize as defects. That might be very helpful.

DR. BOHRER: Okay.

ASSEMBLYMAN KERN: Thank you very much.

DR. BOHRER: Thank you very much.

ASSEMBLYMAN KERN: Any other questions? (no response) Thank you, Doctor. Dr. Cecilia Schmidt?

D R. C E C I L I A S C H M I D T: My name is Cecilia Schmidt. I am Assistant Professor at UMDNJ, NJMS, at Newark, sister school of Robert Wood Johnson. I am the Director of Reproductive Endocrinology and Infertility. I am also the Director of the In Vitro Program.

First of all, I would like to comment right now on the bill which Dr. Bohrer just commented on, by saying that that was an excellent presentation of my feelings, and I echo exactly what he said. I have nothing more to add to that.

With respect to Assembly Bill 3035, Dr. Kemmann dealt with the problems inherent in this bill in an appropriate manner. It seems to lack physician input, because these

fertility drugs are, as Dr. Kemmann pointed out, truly a mixed bag, and the specific complications -- potential complications -- that are listed here do not truly exist. If this bill is to get any further, it needs a significant amount of physician input.

ASSEMBLYMAN KERN: Do you think you can give that to us?

DR. SCHMIDT: The bill would certainly not be this long; it would be much longer. It would also take away from the physician the fact that we are going over, with the patient, informed consent, on an individual basis, because even the drug that is being used has to be tailored to the patient, since her complications may be different, depending upon her individual characteristics. For instance, a patient who is being treated with Pergonal, who is known to make huge ovarian cysts on Clomid, will be more likely to make more cysts. So, her complication rate is going to be different from another patient's. It really entails the informed consent on an individual physician basis, but if you want more input, I would be happy to give it.

ASSEMBLYMAN KERN: Good. I would appreciate it if you could do that for us.

DR. SCHMIDT: Okay. With respect to Assembly Bill 3036, we were talking about in vitro and in vivo fertilization at the same time, specifically pointing to the fact that a patient is allowed to give or sell her ova with either of these procedures, but the sale of embryos is specifically prohibited. Well, with in vivo fertilization, this means that the patient is ovulating herself, and is passing her own egg. Her egg then drops into the uterus after being fertilized. So, at that point, the retrieval of that is really an embryo. If she then gives it away, she is, in fact, giving away, or selling, an embryo. So, it is still contradictory. Again, it lacks physician input.

ASSEMBLYMAN KERN: Probably there should be a time limitation.

DR. SCHMIDT: Well, no, there is no such thing as retrieval from an in vivo fertilization that is involved in ova, because an ova only exists in the fallopian tube, and it is retrieved from the uterus, at which time it has been fertilized. Otherwise, if you are taking out an ova-- Nobody has been doing that, because it is not retrievable, and it is past the age of fertilization. So, it would be a useless cell to have.

The other thing is some of the terminology, such as "in vitro fertilization in a petri dish." That does not necessarily occur. Petri dishes may not be used, such culture tubes maybe. As Dr. Kemmann said, there is no way at present to freeze with the thought of retrieving an ova later on.

Assembly Bill 3037: Dr. Bohrer did a nice job of treating that. The only thing I would like to add to his treatment is, many of us have moved to use frozen semen as a way of better protecting against the AIDS virus. What you can do in that case is screen a donor, take possibly 10 or 20 samples, freezing those, and not using any of them until three to four months later, when you have had an opportunity to rescreen the donor, and then take out of quarantine the previous samples. At this point, that gives the patient the best method of avoiding AIDS. It has not quite become the standard of care because of the fact that fertilization with frozen sperm may be at a lower rate than with fresh sperm.

The surrogate mother issue addressed in Assembly Bill 3038 is certainly a complex issue. At this point, we have very little data to go on. The only model that is close to this is the adoptive system. I think there are probably less than 500 babies born of this process at this point, so it is really going to require a lot of input and a lot of study. I would rather leave that bill untouched at this point.

In Assembly Bill 3039, we are again talking about in vitro fertilization, but this time with informed consent. The consents that most of us have with in vitro fertilization are approximately six or seven pages long, dealing with all of the possible complications. The procedure itself is not a single procedure. There are several different ways of getting eggs out. One involves an abdominal approach, which has risks that are different from an ultrasound approach, which would simply mean that you would put a needle through either the abdomen or the vagina, under the guidance of a sinography. So, there are different possible complications.

This seems to be provided for in the individual programs, so if this is going to be acted upon, it is going to have to entail a lot more details than are going on now.

The sterilization bill also suffers the same as saving ova. At this point, it is not possible to save ova, and it would really not be necessary to save ova. If you do a sterilization procedure on a patient, namely if you are able to tie her tube -- to ligate her tube, rather -- the reversal possibility on that is about 80%, if she changes her mind later on. Furthermore, she would still be able to undergo in vitro fertilization, because we would still have access to her eggs in the same manner that we have access to anyone's eggs. To obtain eggs from a patient is not a simple procedure, in the sense that it takes about two weeks to develop those eggs beforehand, so you would be going from a tubal ligation, which can be a simple day procedure in surgery, to one that would take up two weeks of the patient's time. Even more than that, if a patient wants her eggs saved, she is entering into a sterilization procedure which really should be thought of as permanent not with her mind totally settled. She is saying, "I will have the sterilization procedure, but I know those eggs are sitting there, and if I really want to become pregnant I can." That is not a good way to approach a sterilization procedure, because it gives false hopes.

Right now, with embryos, which we are able to freeze, we are able to thaw only between 50% and 70% of them. So there is at least a 20% to 50% chance of not getting embryos back out of the freezer. It is an unrealistic hope at the present time.

I would be happy to answer any questions.

ASSEMBLYMAN KERN: Yes, Assemblyman Thompson?

ASSEMBLYMAN THOMPSON: I have one question, Doctor. What we are attempting to do in the legislation is be consistent. We are not good at it all the time, but sometimes we are. I am quite sure that as a physician you are familiar with the Karen Ann Quinlan case.

DR. SCHMIDT: Yes.

ASSEMBLYMAN THOMPSON: We attempted to come up with some legislation to deal with that. We worked on it, I imagine, for a period of two years, dealing with the living will and the question of, where a person is dying of a terminal illness, that person has a right for this document to be effective. In that process, there was a revocation clause. In that process, it could be the eleventh hour, and if the testate said, "I changed my mind," they couldn't pull the cord.

I use that in trying to go back to some questions that were asked earlier by several members of the panel, and that were also brought up by some of the people who testified. Do you think the medical doctrine of informed consent should be applicable to a woman's decision to become a surrogate? If so, what would constitute an informed consent in that context? And, most important, what if the woman later changes her mind about custody of the child?

DR. SCHMIDT: Well, at UMDNJ at Newark also, we have not done surrogate mothers as a State institution, so I do not have any firsthand experience with this. But, the major point of that consent would seem to be that this patient is going to give away a baby who has been born of her own ova. As far as she is concerned, this baby will be as much a baby to her as

she has experienced before, other than having her husband's sperm. She will go through the same process. If it is a woman who has given birth before, she will at least have an idea of what that is like. If she decides that that is what she wants to do, then that would be fine. But, to make that decision before she is pregnant, when her hormone levels are totally different, and her feelings may be totally different, her attachment to a fetus that she has not experienced before may be different in the pregnant state, and this really can't be answered before she is pregnant.

So, it would seem that the consent could start before she was pregnant, but not be finalized until afterward; again, using adoption as a model, since we have no other model.

ASSEMBLYMAN THOMPSON: Do you think she should have a right to change her mind?

DR. SCHMIDT: I personally think she should have the right to change her mind, again following the adoption process.

ASSEMBLYMAN THOMPSON: Thank you.

ASSEMBLYMAN KERN: Any other questions? (no response) Thank you very much. Kathryn Quick?

K A T H R Y N Q U I C K: Mr. Chairman and members of the Committee: My name is Kathryn Quick. I am not a lawyer; I am not a doctor; I am an infertile woman. Five years ago, with my blessings, my husband boarded a plane to the West Coast with the sole purpose of getting another woman pregnant. On May 30, 1983, our beautiful Gerard was born to our surrogate mother.

Now, Gerard was the end product of many years of dreaming and trying and failing. I have had several operations, one of which was an eight-hour, delicate, microsurgical procedure, only to be told after each one that nothing was changed, I was still infertile. My husband and I spent 18 months in an in vitro fertilization program, where a total of 15 embryos were transferred to my body in four different attempts to become pregnant. They all failed. My

husband and I have been poked and probed and prodded, injected, and studied, with no success.

Surrogacy was our final hope of increasing our family, and we have gotten more than we could ever hope for with our son. I have heard many arguments today about this wonderful concept, and most of them were against it. I cannot agree with any one of them. Surrogate mothers are special women, who give the most precious gift any human can give another human -- the gift of life -- by giving a part of themselves. They are totally unselfish, mature, wholesome, giving, and mainly they know that once they agree to help an infertile couple fulfill their dream, there should be no turning back, and that is for the sake of the child.

They have been accused of baby selling; we have been accused of baby buying. This is not so. Any money agreed upon is not payment for the child, but rather payment for a service that cannot be performed by the infertile woman. Men can sell their sperm; why shouldn't women be able to contract to aid in the conception and care for the developing fetus until the birth? Money is a rational reason to become surrogate mother, but with the surrogate mothers I know, it is not the only reason to become one.

I have heard arguments saying that surrogates are not rich; there are no rich surrogates. My surrogate is upper middle class. She is very well off. She and her husband own two homes, three cars, and property. They did not need our money, but we contracted with them and gave them this money to compensate her for the time she lost from her job while bearing our child. I have heard arguments that said surrogate motherhood is akin to slavery. This woman contracts by choice, not by force. She is well-aware of what she is about to do, and many times has the advice of counsel. Many would have us believe that surrogate mothers are shanghaied, locked away for nine months, and then discarded. Quite the contrary. The

surrogate mothers I know are cared for and cared about, before, after, and during the pregnancy.

Those opposed to surrogate motherhood stand behind maternal bonding. They feel that the child belongs to the mother because the baby is carried within her body for nine months. Should the mother own this child, or can this child have a father who cares for the baby, even though it was not carried below his heart for nine months, but inside his heart for those nine months.

There has been a position taken that surrogacy takes conception out of the sanctity of the marriage contract. Quite the opposite. It is the marriage contract itself that gives the couple the desire to have the child, the stamina to investigate all of the options, and the courage to choose surrogate motherhood and see it through to its final joy.

I have been told to adopt or to get a foster child. Well, adoption is not that easy, and foster children can be taken away. I also felt very strongly that if my husband could have a child of his own bloodline and his own heritage, we must try that option.

But, surrogacy does need strong regulations, so that the concept is not misused. Both the couple and the surrogate mother must be protected. The surrogate mother must know that once she enters the contract there is no turning back. If the laws are strong and the contracts enforced, there will be less women entering surrogate contracts who are uncertain about relinquishing the child. They need counseling; they need evaluation and medical and psychological testing, to make sure they are not taking unnecessary steps.

Let me remind this panel that Mrs. Whitehead was turned down by one surrogate mother program and actively sought out another. I believe that once a woman has been turned down, she should not be allowed to enter another program, just so there will be no more Baby M children.

The couple must feel confident in knowing the child is theirs. After all, this child would not have been conceived if it had not been for the initiation on the part of the infertile couple. But they must also realize that this child is theirs, no matter what the mental or physical condition of this child is at birth. Would Mrs. Whitehead have fought for this child if Melissa were any less than perfect, or would the Sterns have fought for this child if she were any less than perfect? I don't think so.

The surrogate mother must be protected in the event of miscarriage or stillbirth. Our contract provided for four payments to our surrogate mother -- equal parts, one at the beginning of each trimester -- to cover her service through that trimester. If she had miscarried our son, the money she had received would have been kept by her, and the contract terminated. If our son had been a stillborn baby, the full contract would have been paid to her.

We do need the agencies to search and screen and have laws to protect all the people involved. I urge this Committee not to brush this issue away by making this concept illegal. I commend this Committee for having the courage to face the future, with all of its technology. Please do not brand the children of surrogacy as a product of an illegal act, to have their origins hidden away and spoken about in the shadow of whispers. Let's help them to be conceived, and greet them when they are born as the modern generation of brave new children, the product of a very special type of love.

Thank you. Are there any questions?

ASSEMBLYMAN KERN: Thank you very much. Any questions?

ASSEMBLYMAN SHUSTED: I have a question.

ASSEMBLYMAN KERN: Assemblyman Shusted?

ASSEMBLYMAN SHUSTED: If I may be presumptuous, may I ask you how much you paid?

MS. QUICK: Our surrogate mother contract was $17,500. It was a private contract, not through an agency. It was a private contract between the two families.

ASSEMBLYMAN SHUSTED: You mentioned also that you know many surrogate mothers. How many do you know?

MS. QUICK: I am closely related with Dr. Betsy Agen (phonetic spelling), who runs a surrogate mother clinic in New York. She has done a study on about 200 surrogate mothers. She and I worked together with these mothers, doing counseling--

ASSEMBLYMAN SHUSTED: So, you personally know--

MS. QUICK: --and a support group. Yes, I have sent many women to her agency also.

ASSEMBLYMAN SHUSTED: Have any of those women you know had any repercussions after surrendering their children?

MS. QUICK: None that I know of, sir, but I know there are some that do exist. I read about some in the media. I follow these cases closely.

ASSEMBLYMAN SHUSTED: Thank you.

ASSEMBLYMAN KERN: Any other questions? (no response) I think you have given us some very valuable input, and I very much appreciate your coming forward. I know it is not easy, but I think you have done a lot to enlighten us, enabling us to see the other side of the issue. Thank you.

MS. QUICK: Thank you very much.

ASSEMBLYMAN KERN: Mary Strong? (Ms. Strong not present) Mary Strong isn't here?

T. P A T R I C K H I L L: She asked me to stand in for her.

ASSEMBLYMAN KERN: All right. You're Patrick Hill?

MR. HILL: Yes. I want to thank you very much for this opportunity. I am representing the Citizens' Committee on Biomedical Ethics, which is a grass-roots movement set up in New Jersey in 1983, with two specific purposes: One, to provide public forums throughout the State, by means of which the general public could become engaged in a discussion of the

medical ethical issues that confront us, particularly in the latter part of this century, and secondly, to conduct a statewide survey of public opinion on a range of these issues, including things like the use of living wills, the treatment of the terminally ill, the whole issue of the right to refuse treatment, the question of organ transplantation, and the issues related to the cost and the payment of medical care.

It is a coincidence that earlier this morning, the Citizens' Committee conducted a press conference in this building, during which we made public our preliminary findings on these issues. I will merely quote from one of the preliminary observations that I think may be of interest to your Committee: "The general conclusion is that Americans are thought of as pragmatists, not ideologues. This study, even among the partially self-selected group of interested people, bears out this generalization. The common theme throughout the results is that while arguments about issues in biomedical ethics often tend to be dominated by those with strongly held feelings, often representing extreme polar positions, the majority hold much more complex and" -- this is significant -- "centrist views."

One example of this that came through in our survey, which represented the findings of respondents numbering 1251-- There was an overwhelming majority of support, for example, for the concept of living wills, and allowing the inclusion of instruction about heroic measures to keep someone on respirators or artificial means of support, this in the course of -- that is, in the form of a living will, but only half of that same number actually felt that the use of living wills should be allowed to include instructions on such things as withholding artificial food and hydration.

What I think emerges -- and this is the interesting question for policymakers in these issues -- is that generally the question must be where is the middle ground, rather than which polar position is preferred.

One of the other significant things that came through in our study was that the general public clearly wants guidance from the Legislature, in the sense that they certainly feel the need for parameters to be clearly laid out. However, within those parameters, the general public would like to be assured that there is room for individual choice.

One of the other issues that was covered in this particular survey, which I think may indeed be of considerable interest to your deliberations, was an extensive section on the whole question of confidentiality of records. The findings were somewhat complicated, and I would be more than happy to leave those with you.

ASSEMBLYMAN KERN: I would appreciate it if you would do that. That may be very helpful, since that is an issue that has been talked about a lot today. The bills provide for it, and there have been comments as to whether or not the protections are sufficient. I would appreciate it if you would leave that with us.

MR. HILL: I think finally, again speaking on behalf of the Citizens' Committee, which is a nonpartisan group, our feeling is -- and this reflects the consensus that we find around the State, having conducted some 125 community and professional meetings since last April, and will, in fact, be continuing until December -- that the public needs time to assimilate these very complex issues. They need time to reflect on their implications, and they need this time because these issues touch each of us and our, not only fundamental societal values, but also our personal values intimately.

Therefore, we would hope that before any kind of legislation is, in fact, passed, that systematic efforts will be made to engage the public -- this is one of the functions that the Citizens' Committee has taken upon itself -- in such a comprehensive and deliberate discussion.

I would be happy to answer any questions, if there are any.

ASSEMBLYMAN KERN: Any questions?

ASSEMBLYMAN THOMPSON: One question. You mentioned living wills, and I brought up that issue to a previous witness. In a living will situation, which is a contract basically, you have a revocation clause. With reference to the issue we are faced with here now dealing with Mrs. Whitehead, she entered a contract, but in the decision of the Baby M case, she had no right to revoke that contract. In other words, the court said, "A contract is a contract is a contract."

Do you have any suggestions in reference to some type of balance that we could possibly reach here, especially since in a living will you are dealing with someone who is near the end -- someone with a terminal illness -- but who still has the power, at the eleventh hour and 45 minutes, to say, "No, don't pull the cord"? That protection is in the legislation we passed, but in the Baby M case, which was decided by a judge -- and it is on appeal now -- that type of protection is not there. I would like to know if you have any input or some type of suggestion on this.

MR. HILL: I think this is a good example of human beings being put in the horns of a dilemma. Obviously, if you insert a revocation clause, then one of the consequences will be to render the contract unsure from the very beginning. And one of the consequences of that, obviously, may be that there will be fewer and fewer people willing to enter into these contracts. So, one would have to consider if this, in fact, would not be to undermine, first of all, the contractual system used in this particular situation, but the very procedure of, say, surrogate motherhood.

I think, again, that this is a situation where clearly public policies and our ethical positions have been caught off guard. It seems to me that we need to-- This is precisely a good example of where, in fact, the technology and the medical possibilities have, in fact, gone ahead of the public policies

-- the ethical expectations. We are presented, in a sense, with a fait accompli. It seems to me that we have to ask the fundamental question, do we want surrogate motherhood? If we do, then we would have to construct contractual provisions which would secure the viability of those contracts. But, as I said, if, in fact, you introduce a revocation clause, particularly in a situation like this, clearly the danger is that you will undermine the contract from the very beginning. You will render the parties uncertain, and that could have a very serious inhibiting effect on the whole medical process as a result.

What I am saying, I think, is that I do not have a direct and clear answer to your question, Assemblyman.

ASSEMBLYMAN THOMPSON: Thank you.

ASSEMBLYMAN KERN: Any other questions? (no response) Thank you very much, Mr. Hill. If you would leave that material, I would appreciate it, and if you have other material you want to share with us, please give it to the Committee Aide.

MR. HILL: Thank you.

ASSEMBLYMAN KERN: Angela Hanlon?

UNIDENTIFIED SPEAKER FROM AUDIENCE: She had to leave.

ASSEMBLYMAN KERN: Okay. Professor Richard Kruse?

P R O F E S S O R R I C H A R D A. K R U S E: I am Richard Kruse. I am a Professor of Social Sciences at Fairleigh Dickinson University, and Co-Chairman of the New Jersey Citizens Against Surrogate Parenthood. I have provided a three-part statement to the Committee. The first part will be an analysis of Judge Harvey R. Sorkow's opinion in the Baby M case, which is done from the position of my speciality -- decision analysis. The second will be an analysis of the issues of commercial surrogacy agreements; and the third will be a pithy comment on Assembly Bill 3038, which you may attack in any way you want. I thank the Committee for hearing me.

On March 31, 1987, Judge Harvey R. Sorkow issued his 121-page opinion in the Baby M case. Sorkow's decision gave custody of the child to William Stern, stripped the natural mother of all parental and visitation rights, and declared the surrogate contract legal. This sweeping decision was greeted with cries of victory by Noel P. Keane, a Michigan lawyer and head of the Infertility Center of New York, and Harilyn Quill, a spokeswoman for the newly formed 61-member National Association of Surrogate Mothers.

ASSEMBLYMAN KERN: If you are going to read your statement-- I notice it is seven pages. We have it -- all of the Committee members have been given a copy of it -- and we will make the statement a part of the formal record, if you would like. I know you and I have talked about this issue. You gave me some highlights the other day, and perhaps that might be very important to put on the record.

PROFESSOR KRUSE: I have changed a lot of it. If you want me to skip the--

ASSEMBLYMAN KERN: You have changed the statement then?

PROFESSOR KRUSE: Well, I gave you a preliminary statement on Tuesday.

ASSEMBLYMAN KERN: We have your statement today.

PROFESSOR KRUSE: No, I have not changed that statement.

ASSEMBLYMAN KERN: You have not changed that?

PROFESSOR KRUSE: No.

ASSEMBLYMAN KERN: If you want, we will make it part of the record, in the interest of time. I have six more people who are listed to testify. If you want to read the statement, that's fine, but that may mean that we will have to go another day. That's all right, too. But, if you want, we will make the statement part of the record, because this hearing is being recorded and will be transcribed, instead of reading the statement in its entirety.

PROFESSOR KRUSE: Well, I will leave that to the Committee. I really wanted to put into the record the analysis of the opinion, because I--

ASSEMBLYMAN KERN: Why don't you do that?

PROFESSOR KRUSE: I have noted that certain Committee members have asked questions about the logic of Judge Sorkow and his method of arriving at this opinion, and some of the things he approved and disapproved. If you want me to omit that, I will be happy to do it. It is up to you, you know.

ASSEMBLYMAN KERN: Well, we are not in a position to appeal Judge Sorkow's decision. You may be very valid in your analysis. I am not going to argue that one way or another. I think it is more important to hear what you think of the legislation. I know your organization is opposed to surrogate motherhood as a commercial enterprise. Perhaps you can give us some enlightenment on that, which I think is a little bit more on target to what we are about.

PROFESSOR KRUSE: Okay. In number one, the analysis of the opinion, there is a second part. If I start there, I will eliminate most of the things in the interest of time.

ASSEMBLYMAN KERN: We will make the analysis part of the record, but it is not pertinent to our process. It may be pertinent for the appeal. I mean, you may want to file that as an amicus curie.

PROFESSOR KRUSE: Let me then turn to page 4. I will eliminate that much, thank you, and deal with some of our other issues.

Legal scholars, religious, and political leaders and other thinking people differ over whether physical custody of the child should go to the Sterns or the Whiteheads. But there was virtual unanimity condemning Judge Sorkow's decision to declare the contract legal. Prior to the decision, Robert E. Gould, a psychotherapist who specializes in child, adolescent, and family therapy, stated: "Surrogate mothering should be

outlawed. If proliferating middlemen -- lawyers and agents -- were eliminated, this inherently evil practice would virtually grind to a halt."

Following the decision, Larry I. Palmer -- who is a friend of mine -- Professor of Family Law at Cornell University Law School, called the contract "fundamentally flawed." He compared commercial surrogacy to donating bodily organs. "We want people to give kidneys, not sell them." He continues: "The Federal statute that created the computerized listing of donors and patients actually forbids the sale of organs. It has a lot to do with the way we view ourselves as a society. There are no contracts; no money changes hands. I think having children, too, falls outside the scope of a market decision." Professor Palmer's remarks direct us to the central issues of commercial surrogate parenting and public policy.

The question of whether we should allow commercial surrogate contracts is for you, our legislators, to answer. It should not be the province of judge-made law. We elect and depose our representatives over issues of this sort. Legislatures, when considering the legality of surrogate contracts, should consider the experience of other countries, religious authorities, and intelligent independent voices.

Daniel Lazare, writing in The Record on April 8, 1987, pointed out that: "Commercial surrogacy is banned in Sweden and France, while legislation outlawing such practices is expected to be introduced shortly in the Netherlands." It has been introduced, by the way. "A British court ruled, just last month, that a woman who bore twins for a childless couple had a right to change her mind about giving them up. In Strasbourg, France, Frits Hondius, Deputy Director of the 21-nation Council of Europe, told The Christian Science Monitor that the consensus was already strong against surrogate motherhood on a commercial basis."

Great Britain is years ahead of us in this area -- at least 10 years medically ahead. The first successful in vitro fertilization, Louise Joy Brown, took place there in 1978. In 1984, the famous Warnock Committee Report concluded: "We recommend that legislation be introduced to render criminal the creation or the operation in the United Kingdom of agencies whose purposes include the recruitment of women for surrogate pregnancies or making arrangements for individuals or couples who wish to utilize the services of a carrying mother. Such legislation should be wide enough to include both profit- and nonprofit-making organizations. We further recommend that the legislation be sufficiently wide to render criminally liable the actions of professionals and others who knowingly assist in the establishment of a surrogate pregnancy." Subsequently, the Parliament passed overwhelmingly the Surrogacy Arrangements Act of 1985, which forbids, under penalty of fine and imprisonment: 1) advertisements designed to bring together would-be commissioning couples and surrogates; and 2), negotiating or making of surrogacy arrangements on a commercial basis. I have appended to my opinion that piece of legislation from Parliament. The New Jersey Citizens Against Surrogate Parenthood suggests this approach to the New Jersey Legislature.

Disparate voices, such as A. M. Rosenthal, George Will, Roger Rosenblatt, and many others, have called Judge Sorkow's decision poor judgment and bad law. The Roman Catholic Church's "Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation," issued last year, opposes surrogate motherhood. Rabbi Joseph Friedman, speaking for the Board of Directors of Jews for Morality, an Orthodox Jewish group, denounced Judge Sorkow's decision as, "Unethical, an affront to traditional family life, and a violation of the dignity and human rights of the surrogate mother." Rabbi Friedman added: "The main victim of this baby selling is often the baby itself."

Judge Sorkow's decision omitted the ethical, philosophical, or public policy aspects of the problem. This is for people and their legislators to consider. Yet legislatures, impelled by Judge Sorkow's legally indefensible and aberrant judgment, should not rush to hastily pass laws in this area. Existing law, which holds that a woman who bears a child is the legal mother until she knowingly gives up her legal rights, should meanwhile prevail. Legislative bodies should hold paramount the welfare, happiness, and security of the yet unborn. What are we to do when a child born of such an arrangment is unhealthy and unwanted by the receiving couple? Where does that child turn for love, security, and welfare? Surely not to the surrogate, who consciously avoided forming a loving attachment to the baby. When I was in the Bergen County Freeholders Chamber awaiting Judge Sorkow's verdict, one of the surrogates present, when asked what her boyfriend thought, answered: "My boyfriend said it is like watching someone's car for nine months." That kind of uncaring attitude should not prevail. Should the contracting couple be forced to take the unwanted child, as in your legislation? Does the unwanted child become a ward of the State? It is clear that a commercial surrogate contract is not an appropriate way to bring a child into the world.

Upon close examination and with careful deliberation, state legislatures should provide legislation that commercial, for-profit surrogacy contracts are contrary to public policy. Such legislation should not only be based upon existing laws against the selling of babies, but upon the commercial exploitation of both needy women and couples who desperately feel the need for a child. Alexander Morgon Capron, who holds the Topping Chair of Law, Medicine, and Public Policy at the University of Southern California, and is arguably the leading expert in family law in the United Sates, has stated: "The only clarification needed in the law is that for-profit

brokering of surrogate contracts should be seen for the illegal and undesirable activity that it is; illegal because of the baby selling laws, and undesirable because the financial motive will lead to inadequate screening of surrogates. Not only is it unseemly to profit in this way from such a desperately felt human need, but also lining up a group of potential surrogates for inspection by infertile couples resembles nothing so much as the role of a madam displaying her wares in a bordello." He is an expert on this contract.

The real issue lies beyond all legal theories and legislative considerations. It is the commercialization and depreciation of our basic humanity. The decision to have and raise a child is a costly and uneconomic enterprise, which violates the self-centered notions of a narcissistic society. Such a decision should be entered into in the spirit of loving and caring, values which can never be quantified. The urge to love and care for a child is one of the best aspects of what it is to be human. it is our declaration of hope in the future of humankind. The fundamental issue in the Baby M case is, therefore, the nature of our humanity, our essence as human beings. It is into this area that contracts and commercialism should not enter, for when they do we diminish our human status.

I have appended something I call "A Decalogue of Don'ts: Or, What We Find Objectionable in the Kern Bill" -- as it now stands, remember, because we had discussions on this.

1) The bill contains a Machiavellian blend of in vitro fertilization and surrogate parenting in a brazen attempt to give support to the latter. These are separate questions and should be treated separately. I thought you would enjoy that, so I wrote it that way for your delectation.

2) The provision for forced separation of a child from its mother by means of a contract is contrary to existing law and the experience of all civilized societies which always provide a period for the natural mother to change her mind before an adoption.

3) The bill provides for the legalized exploitation of one human being by another, based on the law of supply and demand. There is a demand for white babies, so we must invent a method of supplying the demand. We oppose this commercialization of life.

4) The bill assumes that a human being -- a child -- can be owned and treated like chattel.

5) The bill operates on the assumption that money and social class are paramount in life. We hold that there are such things in life as the good, the beautiful, and the true, which stand beyond these things.

6) The bill approves of the idea that the life of a person -- the mother -- and the mind of a child can be put at risk because of the desire of a childless couple for a child.

7) The bill sends a message to children that they, too, may be sold. It says to them that we hold money dearer than love and devotion. In this sense, it contributes to the unhappiness of children and their disrespect of adults and authority.

8) An approved fee structure, presently about $30,000 in commissions and fees, reduces the procedure to a kind of prolonged prostitution. If you cannot rent a woman's body for 30 minutes, why should you be able to do so for nine months?

9) Forcing the contracting couple to take a child they deem to be physiologically or mentally defective is socially unsound and potentially harmful to the innocent child.

10) Finally, commercial surrogacy, as approved in the bill, fosters the existence of an uncaring, insensitive, and amoral society.

I thank you for your time. I will be happy to answer any questions you may have.

ASSEMBLYMAN KERN: Any questions? (no response) Thank you very much, Professor.

PROFESSOR KRUSE: Thank you.

ASSEMBLYMAN KERN: Jim Samuel?

J A M E S S A M U E L: Good afternoon. My name is Jim Samuel. The organization I represent is RESOLVE, Inc. RESOLVE is the peer support group for persons and couples with impaired fertility. We are the population most affected by the discussion today. Our national organization is 10,000 members in 47 chapters in 34 states. There are four chapters with New Jersey members. Our population is larger than most people realize. One couple in six, of child-bearing age, has difficulty in conceiving and maintaining a pregnancy. That works out to 10 million Americans who either have a fertility impairment or are part of a couple who have a fertility impairment, and are involuntarily childless.

This number is on the increase for a variety of reasons, but more importantly, resolving impaired fertility is much more difficult than it was, say, 15 years ago, since traditional resolutions are less available. Back then, fertility work-ups were relatively cursory, and couples who could not create children adopted healthy, white newborns easily. But, nowadays, problem pregnancies are terminated; single women often keep their children; and birth control is more widely practiced. Next year, we expect the month-after pill to be available by prescription, and the already tight baby pool will be constricted further. Not all of us -- in fact, very few of us -- fit the profile of persons who adopt hard-to-place kids, which is 40s or older, with kids already. So, many of us adopt internationally or trans-racially. But, there are waiting lists and expense, and these options are not right for everybody. Besides, pushing additional people toward adoption would exacerbate an already overloaded situation, and just lengthen the waiting list for everyone.

I find it no coincidence that surrogate parenting began as a commercial practice in the 1970s -- 1974, I believe -- shortly after the Supreme Court set guidelines for the

legalization of abortion; 1974 was also the year that RESOLVE was incorporated. With uncertain success rates in fertility medical treatment, and an ever-shrinking pool of healthy, white newborns for adoption, things were getting tough for infertiles, and they started seeking other options and support from one another.

The emotions of infertility have been linked to the emotions couples feel when they experience the death of their children. I would think that what I experience is also like the difficult experience that parents of missing children face, daily grief and constant frustration. I don't know if I will ever see my children, just as they don't know if they will ever see their children again.

Assemblymen, we need all the legal and honest options available. Please don't abridge any of them. I applaud Assemblyman Kern for taking an interest in our population. I have a few specific comments. I will keep them short. We have a few pages of them, but I sent this to the Committee back in January, and also back in April.

On Assembly Bill 3036, section--

ASSEMBLYMAN KERN: We will make that part of the record.

MR. SAMUEL: Okay, thank you. May I just stress, for maybe two minutes, the things that stand out most?

ASSEMBLYMAN KERN: All right.

MR. SAMUEL: In A-3037, we echo that donor AID should be separated from AIH. If the husband is the donor, then some of the constrictions really shouldn't really apply. Also, testing donors just within one week of when the donation is to occur is a problem, because you don't really know when the woman is going to ovulate, and you don't know-- Some of the tests take longer than a week to do. So, maybe semiannually would make more sense. There really isn't a problem with communicable diseases in AID at this time.

Also, the recording of donors compromises confidentiality, which will lead to a shortage of donors. AID is widely practiced -- something like 20,000 births in the United States annually. If you constrict AID, you are going to leave a lot of couples without the option that is the best one for them. By forcing the recording of donors, a lot of these donors won't come forward. The man in the street really doesn't know what confidentiality procedures are in place at the Department of Health, and may be reticent about coming forward.

On A-3038, the main objection we have is a minor one. We are not really sure that doctors really need the whole medical history of the surrogate. That might be a compromise to her privacy. We are not really sure that is necessary.

Thank you.

ASSEMBLYMAN KERN: Thank you very much. Any questions? Yes, Assemblyman Thompson?

ASSEMBLYMAN THOMPSON: Just one question. With reference to this whole issue, with the predictions of medical groups throughout the country saying there will be an increase in AIDS and other communicable diseases at this time in the history of this country, don't you think we should have overemphasis with reference to the Assembly Resolution as far as the study commission is concerned dealing with this whole issue, rather than trying to enact legislation in the dark?

MR. SAMUEL: I agree with Dr. Bohrer, who said that every week would be very cumbersome, expensive, not practical, and not workable. It couldn't work. In particular, our organization, RESOLVE-- Our Medical Coordinator notes that there is not a problem of communicable disease in AID -- artificial insemination by donor. Even though it is a problem for the population at large, with AID it doesn't seem to be a problem, maybe because the donors are medical students and they take care of themselves better, or maybe because they are more

carefully screened. I don't know, but it is not a problem with AID.

ASSEMBLYMAN THOMPSON: Thank you.

ASSEMBLYMAN KERN: Any other questions? (no response) Thank you very much. Brian Kelly?

B R I A N J. K E L L Y, E S Q.: Thank you, Mr. Chairman and members of the Committee. I am here on behalf of the New Jersey State Bar Association. I have listened to all of the testimony that has been given today. I think all of you can agree that much of it has been expert; some of it has actually been moving. I have three observations about what has been said.

The first is, it is clear that reasonable minds -- indeed intelligent, expert minds -- can differ on the issue of surrogate parenthood. The problem is clearly a multifaceted one which requires an appropriate response -- a multifaceted, interdisciplinary response. For these reasons, the Bar Association has taken the position that the most appropriate approach to surrogate parenthood is through the Joint Resolution that is proposed. It is the position of the State Bar Association that this ought to be an ongoing, extensive inquiry into the problems surrounding surrogate parenthood.

Thank you.

ASSEMBLYMAN KERN: Thank you. Anything else? (no response) Any questions? (no response) Thank you very much. That helps me out, too. Albert Anouna? I hope I got your name right; I probably didn't.

A L B E R T A N O U N A: I compliment you on your distinctive pronunciation. Thank you for allowing me to speak.

Mine are just a few comments, and inasmuch as I am an owner of a commercial sperm bank within the State of New Jersey, you would be interested to know that there are no -- I am sure you know this -- criteria for establishing a sperm bank. I have been in touch with the New Jersey State

Department of Health for many years, and to no avail. We, however, as a sperm bank, belong-- I, as an individual, belong to the American Association of Tissue Banks, which has a subcommittee referred to as a Reproductive Council. I also belong to the American Fertility Society. I am a bioanalyst laboratory director, which brings to mind that the way we operate the sperm bank in New Jersey follows the rules, regulations, and proficiency testing of laboratory work. Besides being a sperm bank, the other corporation which I own and operate in New Jersey is a medical laboratory. So, we have established standards and guidelines that are very comprehensive and very proficient in making sure that our donor population, or human homologous sperm population, has been tested or kept properly.

In view of those points, one of the items in your Assembly Bill 3036, line 22, referring to "the freezing of semen, ova, or embryos shall be performed under the supervision of a licensed physician--" Keeping what I just said in mind, we do operate under those guidelines, but we have to affirm the health related care facility, and I am considered to be one of them, at least that is my opinion. That should be included in our format.

We do follow one established guideline by the American Association of Tissue Banks and CDC -- the Center of Disease Control -- which is quarantining all human donor samples for at least three months. We are the only sperm bank in the country that does monthly testing -- a series of chemical and biochemical tests -- which I have forwarded to the members of the board, which includes AIDS, drug testing, genetic testing -- which means to look at the chromosomes and the normalcy -- chemistry, sexually transmitted diseases, and others. Our intent as a sperm bank is to make sure that the donor is protected and the recipient is protected. A donor is not accepted if he does not remain in quarantine for three months; if he does not submit himself to a monthly testing.

So, it is very vigorous. You don't just become a donor because you get paid, but because you follow very strict regulations.

The other issue relates to the next bill, which is A-3037. Again, the health care facility does come under our ability to obtain peer supervision under the American Association of Tissue Banks. It is organized so that we are inspected by qualified individuals who are themselves in the business of sperm banking, or who are well-known in that area.

The other issue on that same bill is the use of donor semen for more than 20 different official inseminations. There is no way I know of to obtain the physicians' cooperation to let us know when a pregnancy takes place. It is so anonymous that the only time you get feedback is when accidentally they say, "By the way, we did get a pregnancy." By the same token, I don't think that releasing those records -- the donor records, that is -- to the State Department of Health, and operating as a State Motor Vehicle agency or USDA agency, would help us in any way. We are professionals; we do maintain a set of records. The donors are aware that their records are in our keeping. We do not destroy anything. We are very much aware that we are liable under medical legal practices. Our insurance company is behind us, and so are the attorneys who are helping us.

The testing of the donor is so vigorous that only 20% of the individuals who present themselves as possible donors do become donors at our sperm bank. You really have to have a high sperm count, have a high recovery count, to be able to be a donor. Only the healthiest sperm do maintain to the freezing and thawing process. It is really amazing -- and I welcome any of you to come to our sperm bank to see how we do it, because it is not difficult once you know what you are doing -- to see how well a living cell can be frozen and brought back to life with the right environment. This has been done since 1866, and

documented in some of the august clinical facilities. It has been promulgated since then, but the first birth in the United States occurred in 1953, using frozen sperm.

The other objective the sperm bank has is that we work on a very personal level. Our brochure points out that the individual recipient gets to choose from a list of donors. We answer their questions; we work with them. We let them know what testing has been done. I feel the only way to approach the subject is on a one-on-one basis. We do not run a supermarket of choice, but ours is a very qualified, very detailed medical facility. The donors themselves have to fill out a 13-page information health record for us to be able to evaluate them. That information -- the donor questionnaire or the recipient questionnaire or any of the forms we may use on a day-to-day basis -- can be made available to the Committee.

I would be happy to answer any questions you may have.

ASSEMBLYMAN KERN: Do you charge a fee to the recipient?

MR. ANOUNA: I charge a fee to the physician, who in turn charges it to the recipient. We do not deal with the recipients directly. We get the information -- the statistical analysis and characteristics the recipients would like us to match, or the recipients themselves want to match -- but the fee is charged to the physician, who in turn bills the patient for the delivery, depending on which part of the country we have to ship the sperm to, or which part of the world we have to ship the sperm to, plus the specimen itself. We do not charge the patient or the physician if the number of sperm moving and their motility do not satisfy a level of fertility. That is a motility of greater than 60%, and a number of 40 million sperm, which is considered a very healthy, normal specimen. So, our target is really a healthy pregnancy.

ASSEMBLYMAN KERN: I see. What is the amount charged?

MR. ANOUNA: We charge $75 per vial, and that is one cc of human sperm, that can be either used as is, or as in the medical, now progressive, technology where the sperm is washed and placed in the uterus directly.

ASSEMBLYMAN KERN: Yes, Assemblyman Thompson?

ASSEMBLYMAN THOMPSON: One question: On your 13-page questionnaire, do you ask a question about whether or not there have been any mental disorders in the person's family background?

MR. ANOUNA: Yes. We try to go back four or five generations whenever possible. It is very hard. Donors have to meet with me, or with an individual at my facility, at least four or five times. We get to know them very personally. It does not operate the same as a blood bank. You cannot just walk in, drop your specimen, and never be seen. If someone asks me for a profile of a donor, there are very high moral ethics. They are not just there for the money. They are giving people. There are not too many of them. There is a shortage of donors that is truly unbelievable, as you can see by the numbers that were given to you. Parenting is a very dear and important part of the infrastructure these days.

ASSEMBLYMAN KERN: Could you give us a copy of the criteria you utilize?

MR. ANOUNA: Sure. I will be happy to forward that.

ASSEMBLYMAN KERN: I would appreciate that. Now, suppose a physician were required to report back to you with respect to whether or not a pregnancy occurred?

MR. ANOUNA: At the present time, we are attempting to undertake a statistical analysis, because there are no true statistical analyses as to how many pregnancies have occurred using a sperm bank. We have been in business -- I, on my own, that is -- for the last six years. What we are attempting to do is ask the physicians for the number of vials used on individual patient X, Y, Z, whether there was any course of

treatment or medication, whether there has been a pregnancy, a loss of pregnancy -- what happened to that specimen? Those statistics are being asked of recipients and physicians at the same time. Does it work? We know it does. What is the percentage? Are they healthy pregnancies? As far as we know, they are, because sperm bank freezing is a way of eliminating all unhealthy sperm. Only healthy sperm can take the freezing and thawing process, because of the membrane conditions -- the cell membrane.

ASSEMBLYMAN KERN: Assemblyman Shusted?

ASSEMBLYMAN SHUSTED: I assume you pay the donor. Is that correct?

MR. ANOUNA: Yes, it is.

ASSEMBLYMAN SHUSTED: What kind of a fee do you pay them?

MR. ANOUNA: Again, we are one of the highest paying sperm banks in the country. We pay $75 for a good sample. It has to meet very stringent criteria. It has to be over two cc's. It has to have a count of over 100 million cells per cc. It has to show 90% motility. In other words, if it is not there, I cannot charge someone else for that, and the donor does not get paid, because he just drops off a specimen. It has to be a good, viable sample.

ASSEMBLYMAN SHUSTED: Do you have donors who are repeat donors?

MR. ANOUNA: Oh, yes. Do you mean where pregnancies occur, or--

ASSEMBLYMAN SHUSTED: No, I am talking about the donor -- the sperm donor.

MR. ANOUNA: Oh, the life span of a donor with our facility is anywhere between one year and three years.

ASSEMBLYMAN SHUSTED: What steps do you take to be certain that that sperm is the sperm of the donor and not of someone else?

MR. ANOUNA: Well, first of all, again, we follow very strict laboratory procedures. Everything is dated, numbered, and logged. On our vial, we etch a number that is non-removable, with the donor identification number and the date it was frozen. It is segregated, depending on the date and the type of donor. So, to the best of our ability, it is done the same way we would handle your blood specimen compared to other blood specimens; that is, by name and the proficiency and the expertise of the person doing it. We follow State health regulations.

ASSEMBLYMAN THOMPSON: I think the Assemblyman brought up a good question. One of the problems we had in New Jersey quite some time ago -- which we resolved -- was in reference to methadone programs, where the addicts were coming in and switching the urine. They were out drinking and getting high, and the urine was showing up clear until they had to clamp down and screen them to find out whether or not it was their urine.

MR. ANOUNA: Well, I have to try to trust my donors. There is no way of identifying under the scope whose sperm they are, but you would be surprised, once you have done it many times, there is a particular finger pattern on what a sperm looks like from individual donors. Each one of us, upon ejaculation, may look a little different -- not that I am an expert, by far, or can look into a crystal ball. But, you have to trust people. You have to test them, and they are aware of it. They usually give us the same volume. They do not vary greatly. You know, they have particular patterns.

We do not pay them immediately. They are three months behind in being paid, so it is not-- Their money is banked, as we say. There is no immediate cash on hand. But, they are serious people, and we need them to come over and over again, because the requests of people who have conceived once are that they want the same donor for their next conception. We have that available as well. It is a very high practice to create a family unit.

ASSEMBLYMAN KERN: Over what period of time can you keep frozen sperm?

MR. ANOUNA: It has been promulgated by individuals in the same field, 500 years or more. And, nobody would want to come back. (laughter)

ASSEMBLYMAN KERN: Are there any other questions? (no response) Thank you very much. David Hollander, M.D.

D R. D A V I D H O L L A N D E R: Assemblyman Kern and honored members of the Committee: My name is David Hollander. I am a New Jersey native. I reside in Hillsborough. I am a physician; I am a cancer researcher; I am on the faculty of the University of Medicine and Dentistry of New Jersey in New Brunswick. But I am also a member of Central New Jersey RESOLVE. I am here today not as a physician, but to bear witness as one who is deeply, personally affected by the issues you are judging today.

I am a husband in this situation. For three years, my wife and I have been trying to conceive. For the past two years, we have been under medical care for fertility treatment. We yearn for a child. We dream and fantasize about our child, but we remain frustrated daily.

Let me first address some feelings on a personal level about surrogate parenting. Surrogate parenting -- surrogate mothering, in particular -- is a wonderful gift. It is absurd to portray surrogate mothers as one monolithic class of people who are victimized by a system. They are not all the same. The mention of Mary Beth Whitehead today -- I have lost count of how many times-- She is an aberration, an exception to the rule. I wish we could discuss the dozens, in fact hundreds, of other successful surrogate parenting situations. It is as if we are here to condemn blood transfusions because of one transfusion reaction.

Surrogate parenting -- as I say -- is a wonderful gift from a woman to a couple. It is more than lifesaving; it is

life-giving. It is a sharing of an ability that one person has that she can develop and share with another. In the last three years, my wife and I have personally received, unsolicited, three offers of help from three adult women. They are not poor women -- one an elementary schoolteacher, one a physical therapist, and the other a physician. They have all offered to act as surrogate mothers, if it would help us.

We appreciate the concern of this Committee meeting today. We appreciate the opportunity to speak. We live in a society that is overwhelmed by the fear of conception. Our society strives for the perfect contraceptive for those of whom I am envious, those who are so capable of fertility that they can't control it. Well, I am jealous. It is difficult to find sympathetic, understanding listeners, who are willing to discuss difficult issues regarding infertility.

These legal acts -- these proposals today -- are not perfect as they stand. They must be refined, and they must be established so that practices are regulated. There are clauses, there are conditions, that I feel are medically inaccurate; some that need more medical input. There are also invasions of privacy that I object to, invasions that fertile couples are deemed immune from.

Let me point out when we discuss confidentiality, that it has nothing to do with shame. None of us who are infertile are ashamed of our infertility. Maybe in the first few moments in the first few months of dealing with it, because we have become so used to blaming ourselves for everything, we are shameful. Once we come to understand that it is a medical illness, it is not something that we brought on ourselves, it is something we have been victimized by, the shame is gone. We are not proud of being infertile, but we are not ashamed of it. Confidentiality has to do with both private confidentiality -- the acts of privacy; people have a right to have control over what is known about them -- and there is also

medical confidentiality. It is not a matter of people unwilling to admit to having a child by donor insemination, or by surrogate parenting; it is a private matter. I don't mean to become crude, but for those of us who were conceived in the traditional, natural way, there is no record in the State Department of Health about what sexual intercourse our parents were in, or the date and time we were conceived. That is a private matter, and so should other matters of fertility treatment be private.

These acts are not perfect. I appreciate your efforts. I would have comments about specific items on the different bills, but I agree with the feelings of Dr. Kemmann, Dr. Bohrer, Jim Samuel, and Dr. Schmidt, who have already addressed you, and delivered copies of their statements. There are medical and technical aspects of these bills which I would not expect legislators to automatically understand. I am a scientific writer. I cannot write legislative language, and I can't expect you to intuitively know how to write medical language.

I would appreciate it if future workings on these bills were in conjunction with medical professionals, as well as people on both sides of the issue who can contribute from personal experience.

ASSEMBLYMAN KERN: We'll put you to work.

DR. HOLLANDER: Yes. We ask that you treat us, and this issue, with the same respect and concern shown to fertile people. I would like to point out -- it has already been pointed out -- that there is a great deal of misunderstanding and confusion over some of the items, which clearly cannot be passed as they stand now in these bills. It is very obvious that the issues of infertility in these bills have nothing to do, with all due respect, to cloning or blindness, and it is very irritating to hear discussions about living wills and blindness brought up. It is evidence that there has not been

enough research, and we are not at a point in this hearing where people are knowledgeable enough to decide matters that affect people like me.

That is all the statement I have to make.

ASSEMBLYMAN KERN: Thank you. We are going to put you to work. If you do not have copies of the bills, we will give them to you. If you can work on refining them so that they are much more accurate, as far as medical terminology, etc. is concerned, we would welcome your suggestions. These are a beginning point. They are really working drafts. You have to start somewhere. That is why we are holding hearings, so that we can get the input; we can get the expertise; and we can develop a product that is superior, and not just a mere suggestion.

Are there any questions? (no response) Thank you very much, Doctor. Mary Gans?

M A R Y L. G A N S: It is a privilege to be with you, and I thank you very much for the opportunity to come.

I could not agree more that the trauma of childlessness is one of the most difficult things for any couple to bear. My mother miscarried all of her children. I was born at the seventh month; I weighed three pounds. My brothers and sisters were lost. My mother miscarried -- as I say -- nine times. I had one brother who was born when I was a teen-ager. I spent my sibling life praying that I would have brothers and sisters. I do understand the terrible tragedy of losing children.

Compassion is a prime requirement for mutual interaction in personal and national relations. But, wisdom and experience, and the existence of basic moral concepts must be equally considered. Maudlin sympathy cannot be allowed to obfuscate reason and truth. The inability to conceive and carry a child is, indeed, a grave sadness, but many painful conditions exist in the world. They must be considered and

assisted where possible; they cannot be solved by imposing injustice on innocent others by opening and protecting by law the right of a wealthy few to purchase a child; to place the woman in temporary bondage and contractual obligation; to sell the use of her body, and finally her child; to bind herself, though willingly; to allow her child to be killed by abortion or embryo discarding if that child in any way fails to measure up to its purchasing parents' standards. Even if that paternal parent is the donor of the sperm, his right to take possession of his child, however conceived, is limited by the guaranteed legal rights of that child, a citizen of our country, where no man can be purchased by another. It is a crime in this country for a parent to sell a living child, even to the other biological parent, or any other person, even though that person may be better able to care for the child.

Shall we take children away from less qualified parents? What criteria shall we use to decide? Shall we test for parenting permission, wealth, education, emotionally and religious attitudes? We have long rejected the argument that the condition of the "savage black man" was improved by the kind slave owner who bought him. We would all decry the licensing of parents with reusal for those who did not qualify to master race standards. Yet, the right to procreate is not an unrestricted right. No one can be forced to procreate by partner or government. No one can force an unwilling partner to attempt procreation.

What we are doing in legalizing contracts to sell a bearer's body -- that is, the natural mother -- and the product, the baby, is an outright renewal of slavery. Now, in upholding the founding documents of this great country, perhaps we must consider that we are "one nation under God," and whether that obliges us to consider the inalienable rights of all men who are endowed by their creator -- not by their government -- with their right to life. We might find it

necessary to consider the expert advice of the diverse experts in the fields of religious service, which our country also guarantees. We seek legal and medical advice, but surely this issue cries for religious advice, unless we are to violate our principle of sovereighty under God.

Religiously speaking, morality has always had the consensus that natural parenting was a right, and that family rights preceded government. The assumption that new technology has replaced old morality is rash indeed, and contrary to our own fundamental documents which we have sworn to uphold. When a government attempts to legislate the sale of children to governmentally approved child raisers, to consider methodology for child improvement through juggled parenting, gene control, or embryo management, we are opening the way to the same kind of imbalanced, self-seeking, and, finally, vicious and inhuman practices that we have seen before in Nazi Germany. Let us remember that human life is a gift of God, and the duty of government is to defend and protect each innocent life. The fact that a thing is possible does not necessarily mean that it is wise, or even right to do it.

ASSEMBLYMAN KERN: Any questions? (no response) Thank you very much.

That concludes the formal list of people who submitted an announcement that they wished to testify. We will be receiving a statement from the National Association of Surrogate Mothers, which will be placed into the record. That is being forwarded to us from California.

This particular hearing is concluded. Undoubtedly, there will be future hearings on these very complex issues.

I want to thank everyone for coming to voice their opinions, and those in the audience who came just to listen.

The hearing is adjourned.

(HEARING CONCLUDED)

APPENDIX

A Statement on the Issue of Surrogate Parenting and Assembly Bill No. 3038

To

The New Jersey General Assembly Committee on the Judiciary
Hon. Walter M.D. Kern, Chair.

by

Richard A. Kruse
Professor of Social Science
Fairleigh Dickinson University
Co-Chairman, New Jersey Citizens Against Surrogate Parenthood

This statement is in three parts: The first part will be an analysis of Judge Harvey R. Sorkow's opinion in the Baby M Case, the second an analysis of the issues involved in commercial surrogacy agreements, and third, comment on Assembly Bill 3038. It is my hope that this information will aid the Committee and the General Assembly in their deliberations on the subject.

I

On March 31, 1987 Judge Harvey R. Sorkow issued his 121 page opinion in the Baby M case. Sorkow's decision gave custody of the child to William Stern, stripped the natural mother of all parental and visitation rights, and declared the surrogate contract legal. This sweeping decision was greeted with cries of victory by Noel P. Keane, a Michigan lawyer and head of the Infertility Center of New York, who arranged the Sterns' contract, and by Harilyn Quill, a spokeswoman for the newly formed 61 member National Association of Surrogate Mothers. William Handel, lawyer-Director of the Center for Surrogate Parenting of Beverly Hills, California, proclaimed that "Surrogate parenting is here to stay." This statement is premature. Judge Sorkow's verdict is not legal precedent, even in New Jersey, until it is affirmed by the New Jersey Supreme Court. As Judge Zoran Popovich of the Superior Court of Pennsylvania has pointed out "A verdict and judgment by a trial court is binding on no one except the litigants of the case. It may be "unprecedented" in the historical sense, it is not precedential in the legal sense."

Judge Sorkow's reasoning legalizing the contract is based upon several theories aimed at overturning the common law dictum that a human being is not the proper subject of a contract.

Sorkow asserts that if a man is free to sell his sperm than a woman has a similar right to rent her uterus. The comparison is faulty. Biologically the sperm equivalent is not the womb but the ova. This "uterus rental" deprives the woman, Sorkow's legal

A particular odious effect of in vitro fertilization and surrogate motherhood is its threat to the unity and stability of the family. No one will deny the strong interest of society in the preservation of the traditional family. Indeed, many of the ills of society can be blamed on the loss of traditional family values. Logically then procedures which threaten the stability or integrity of the family also threaten the stability of society at large. It is in this context that we maintain that in vitro fertilization and surrogate motherhood are contrary to the public policy of this State and urge this committee to affirm that policy by rejecting these bills.

tenant, of the right given in all fifty United States and all Western countries to reconsider giving up the child after birth. This right is based upon the recognition of the fact that most mothers become attached to the child and cannot give him or her up. Moreover, the contention that the collection and implantation of sperm is the equivalent of a nine month pregnancy and labor is ludicrous.

A second Sorkow theory, that the surrogate contract is not the trading in human life that is prohibited by the 13th Amendment, is refuted by the terms of the agreement. The contract provides that Mary Beth Whitehead is to be given $10,000, deposited with the Infertility Center of New York to await delivery of the child. For this she is to "assume all risks, including the risk of death." In exchange William Stern can demand (1) cessation of the contract with no payment to Mary Beth Whitehead if there is a miscarriage within the first five months of pregnancy, and (2) medical tests of the fetus between the sixteenth and twentieth week of pregnancy and, if "physiological abnormalities" are detected, abortion "upon demand of William Stern." If the Stern demanded abortion or miscarriage takes place after the fourth month, Mary Beth Whitehead is to receive $1000. The Infertility Center of New York is to be paid a "nonrefundable" fee of $7500 in advance and is exempt from all liabilities if Mary Beth Whitehead does not become pregnant or abide by her "contract" "to surrender custody." These clauses belie Sorkow's claim that this is a contract for services and not for the sale of a delivered baby. Sorkow argues that a man "cannot purchase what is already his." It is, however, the common practice that a joint tenant to property can pay the other tenant to give up his or her rights to that property. Sorkow is once again legally wrong. William Stern contracted to pay not for services but for a baby without "physiological abnormalities." He did not have to accept the child. If such "abnormalities" were detected before the 20th week of pregnancy, he could then demand an abortion. Can a contract that demands that a woman be forced to have an abortion be legal? I realize that the proposed Kern legislation forecloses this possibility. The contract undermines the sentimental aspect of human nature. Decent ordinary people accept what they get when a child is born, loving and nurturing the unhealthy or physiologically imperfect child even more than a healthy or perfect child. They base their efforts in behalf of the child on need. This is the living basis of family life.

Sorkow tacitly approves insurance fraud. The legalized contract states that William Stern is to pay all medical expenses not covered by Mary Beth Whitehead's medical insurance. The insurance in question was a "family" policy attained through Richard Whitehead's employment. Sorkow's theory makes William Stern the sole beneficiary of this "family" contract. No rationalization, no matter how flagrant, could make Stern a part of the Whitehead family.

Here, too, does Sorkow violate the logic of the 1973 decision of the Supreme Court of the United States in Roe v. Wade. This

decision was based upon the "substantive due process" clause of the 14th Amendment and holds that a woman has a right to control her own body and therefore has the right to an abortion in the first three months of pregnancy. It bases this conclusion on an assumption of a woman's right of privacy. As controversial as this decision is, it surely prohibits someone other than the pregnant woman to "demand an abortion" as specified in the surrogate contract. It also should give the woman the right to the product of her body.

Judge Sorkow sweeps aside laws against the sale of children. These laws exist in every civilized society and in the fifty states to protect the exploitation of the needy by the affluent. Sometimes temporary economic or emotional distress causes people to make rash judgments or bad decisions. Laws against the sale of children recognize this human frailty. Mary Beth Whitehead claims she made such a mistake. Sorkow answers that such ideas are "insensitive and offensive to the intense drive to procreate naturally and, when that is impossible, to use what lawful means as possible to gain a child." This statement falsely assumes that surrogate contracts are "lawful means." The "intense drive to procreate naturally" is precisely what laws against the sale of children were designed to control.

But had the Sterns exhausted every means of conceiving naturally? The contract reads: "The sole purpose of this Agreement is to enable William Stern and his infertile wife to have a child which is biologically related to William Stern." Elizabeth Stern is fertile. Her mild case of Multiple Sclerosis, originally self-diagnosed, has not deterred many women who were older and with more severe cases of MS from successfully conceiving and bearing healthy children. In fact, there was medical testimony that Mrs. Stern's "extremely mind" case of MS might even improve during pregnancy. The Sterns never tried to conceive or adopt. One of the tests of parental fitness is the willingness to adopt.

Sorkow follows with a novel legal theory first expounded by John R. Robertson of the University of Texas. Robertson argues that married couples have a "right to procreate." He bases this right upon the "substantive due process clause" of the 14th Amendment the Supreme Court decision in Roe v. Wade. Sorkow's decision states: "This right of procreation is bottomed in an individual's constitutional right of privacy, secured by the 14th Amendment." Almost all constitutional scholars consider Robertson's theory an absurdity. To rank a so-called "right to procreate" with the 1st Amendment freedoms of speech, press, and assembly places this shallow claim in perspective. Civil liberties are necessary to the proper functioning of a democratic society and should be cherished and fostered. Judge Sorkow's distorted assertion of a right to procreate is a far-fetched assumption in complete opposition to the purpose and logic of the 14th Amendment and Roe v. Wade.

NATIONAL COALITION OF CLERGY AND LAITY

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May 7, 1987

POSITION REGARDING ARTIFICIAL HUMAN PROCREATION
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The National Coalition of Clergy and Laity adamantly rejects all civil legislation which would confer undue legitimation upon practices contrary to the fundamental norms of the moral law in matters concerning human rights, human life and the institution of the family.

The Church teaches that Human procreation requires on the part of the spouses responsible collaboration with the fruitful love of God. The gift of human life must be actualized in marriage through the specific and exclusive acts of husband and wife, in accordance with the laws inscribed in their persons and in their union.

As the recent Vatican document relating to bioethics states; " By comparison with the transmission of other forms of life in the universe, the transmission of human life has a special character of its own, which derives from the special nature of the human person . The transmission of human life is entrusted by nature to a personal and conscious act and as such is subject to the all-holy laws of God: immutable and inviolable laws which must be recognized and observed. For this reason one cannot use means and follow methods which could be licit in the transmission of the life of plants and animals."

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It is our hope, that those who, by reason of their role and their commitment are involved in this issue will avail themselves the excellent instruction contained in the document Respect For Human Life In It's Origin and on the Dignity Of Procreation. It is vital, as emphasized by Joseph Cardinal Ratzinger, Prefect of the Congregation For The Doctrine Of The Faith that, "... all will understand the incompatibility between recognition of the dignity of the human person and contempt for life and love, between faith in the living God and the claim to decide arbitrarily the origin and fate of a human being."

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Eparchy of Passaic

William F. Bolan, Jr.
Executive Director

May 7, 1987

TO: Members, Assembly Judiciary Committee

FROM: New Jersey Catholic Conference

RE: A-3035, A-3036, A-3037, A-3038, A-3039
A-3040 and AJR-76

In the current debate over the legality of reproductive technologies certain basic principles have been overlooked. Specifically, there are inalienable rights of the person which must be recognized and respected by the body politic. Primary among these inalienable rights is every human being's right to life and physical integrity from the moment of conception until death. A human being is a gift from God called into existence through the love and physical union of husband and wife. In fact, we use the term procreation when we refer to the reproduction of a human being. Because it flows from human reason and will procreation makes certain procedures inappropriate for human beings which would be acceptable for the transmission of life of plants and animals. The State should neither promote nor facilitate any procreation outside marriage. It is to married couples alone that the moral law reserves the contribution of the life-giving elements required for procreation. For the welfare of the families and the children involved, civil law should recognize that reservation.

In vitro fertilization is unacceptable because it substitutes a laboratory procedure for the conjugal union of husband and wife. Furthermore, this practice which usually involves the further abuse of the destruction of some embryos, commonly called "spares," which are not transferred to the genital tract of the woman will be done with legislative approval. Regretably, A-3036 explicitly permits a female donor to submit to an abortion if the physician is unable to retrieve an embryo. Thus, for some embryos these procedures will serve as a death sentence. This is clearly a violation of the right of every human being to life.

Equally unacceptable is A-3039 which deals with the ownership of a frozen embryo conceived through in vitro fertilization. Although freezing of embryos is highly debated among practitioners and ethicians, this bill pays no heed to that

debate. The freezing of embryos is offensive to the respect due to human beings because it exposes them to grave risks of death or harm to their physical integrity and deprives them, at least temporarily, of maternal shelter and gestation, thus placing them in a situation in which further offenses and manipulation are possible.

The issue of surrogate motherhood raises the fundamental question of whether it is ethical for someone to create a human life with the intention of giving it up. We think not. Succinctly stated it is the position of the Catholic Bishops of New Jersey that surrogate motherhood is legally wrong because it violates the public policy of this State (by making licit the sale of a child, albeit through the subterfuge of renting the womb of a woman) and is morally wrong because it violates biological and spiritual unity of the husband and wife and the parental relationship of parents and child.

The concept of surrogate motherhood as a legal wrong is firmly grounded in the public policy of this state for a myriad of reasons but most significantly because it exploits a child as a commodity and exploits a woman as a "baby-maker." In the former situation it promotes injustice and, in the latter, it utterly disregards social responsibility.

Children are a gift of God. As such they can never be treated as chattels or commercial pawns or as commodities to be produced as service rendered in exchange for a service fee. The practice of surrogate motherhood is an affront to the human dignity of a child. This human dignity is not only recognized but is protected by the state under the doctrine of "parens patriae," a doctrine that is traceable to our heritage at common law. In conformity with this doctrine the New Jersey adoption laws not only prohibit the payment or the receiving of money or any valuable consideration in exchange for the placement of a child for adoption but also makes the material assistance of an agent, finder or intermediary a criminal act. The entire concept of surrogate motherhood reduces the creation of a child, a human being, to the level of a commercial transaction. The womb is leased to produce rather than to love a child into existence. When the natural mother surrenders her child for financial remuneration, she is exploiting the most precious thing she can bring into existence, her own child.

The rights of the child itself are also violated. Every child has a right to true parents. Surrogate mothering confuses the relationship by introducing a second mother. The natural attachment a woman has with the child in whose creation she has participated is denied. The process destroys the parent-child bond and is a grave injustice to the child.

The concept exploits women as a part of a "human machine." The surrogate mother uses her womb for commercial use.

When her days are accomplished and her contract labor is finished, she is made to surrender an integral part of her life, her child, and with it to surrender any natural claim or bond to the child. She has allowed herself to be used for financial gain and all that remains is the money -- and the broken bond and, perhaps, some broken dreams. The probability cannot be ignored that this concept may also put undue pressure upon poor women to use their bodies to support themselves or their families. It would not be unfair to say that the concept of surrogate motherhood would not be the subject of discussion today if money was not involved; money for the mother; money for the clinics that invented the concept and money for the legal community which has mapped out the particulars of its operation.

Nor should one disregard the fact that the concept of surrogate motherhood is morally wrong. It is morally wrong because it violates the biological and spiritual unity of the husband and wife and the dignity of the person of the child as an object for which the parties negotiate.

Central to the marriage covenant is the joining together of two people for the procreation and education of children. To introduce a surrogate mother as a third party into the marital relationship to assume the procreative role is to threaten the unity of the relationship.

The practice of surrogate motherhood is a threat to the stability of the family. Rather than experiencing a child as a bond between a husband and wife, a child born of a surrogate arrangement can easily be a divisive force. The potential psychological impact of the stress caused by the acts of conception, pregnancy, delivery, surrender of the child and the acceptance by another of the child, involving an individual outside of the marriage relationship, cannot be underestimated. Nor can we underestimate the impact on the family structure within the family of the surrogate mother. The interest of siblings must be considered. How do they react to the fact that their baby brother or sister has been given to a stranger?

The legal and emotional turmoil aroused by the question of a baby's parentage plays out in very human terms the moral dilemma created when the laws of nature are subverted. Who indeed should be considered the child's parent - the man whose sperm artificially inseminated the woman or the woman, acting as a surrogate, who carried the child and gave birth? The question does not submit to a quick or easy answer. Each adult party has something to gain or lose by a decision. It is the child, though, who ultimately bears the most lasting impact. The child has become a pawn whose destiny is determined by the persuasiveness of each side in the dispute.

To some minds, this transfer of a child from a surrogate mother to a biological father and his spouse might

appear to be no different from adoption. One could argue that in a surrogate situation the child has some genetic relationship to the father while in an adoption, no such relationship exists. The differences, however, are vast and are rooted in biology as well as the moral and ethical standards of the human community. A child is placed for adoption because of the circumstances of the mother which prevent her from caring for the child. Her concern for the child's welfare seeks a permanent and stable home for her offspring. In a surrogate situation, a child is deliberately conceived with the intention of transferring all responsibility for the child to others, contrary to ethical norms and without regard for the best interest of the child.

The concept of surrogate motherhood can only be described as a concept that is a legal outrage and a moral disaster. It is totally incompatible with the sanctity of marriage and the nurturing of the family, the basic unit of our societal structure. The creation of human life cannot be reduced to the status of the pecuniary consideration of a contract which by its very terms ignores the essence of the humanity of those involved. Legislatures and courts in other jurisdictions have consistently refused to sanction this concept.

We would hope that not only will the bill or the study resolution not be acted upon in New Jersey but that action will be taken by the Legislature confirming that surrogate parenthood contracts violate the law and the public policy of our state.

We are likewise troubled by A-3040. That measure requires a physician who performs a vasectomy, tubal sterilization or other surgical sexual sterilization procedures to inform the patient of the potential for the operation to fail to result in sterility. Our objection goes to the procedures themselves. We reiterate our long held opposition to human sterilization which violates the unitive and procreative aspects of marriage. We see in non-therapeutic sterilization a parallel to self-inflicted mutilation of a God given power and human integrity, a mutilation which should be abolished by society and society's lawmakers. We note that the finality of sterilization is an increasing problem and the fact that it is often promoted among the poor and minorities argues against any state approval or acceptance. This bill provides only the most minimal regulation.

A-3035 requires a physician to warn a patient of the possible side effects from the use of fertility drugs. We recognize that infertility is a difficult trial for a husband and wife who are unable to attain their legitimate aspirations to motherhood and fatherhood. We applaud and encourage technologies which restore the healthy functioning of the human reproductive system or which help conjugal intercourse achieve its procreative potential.