

ADULT CONSENT AND SPOUSAL CONSENT IN MALAYSIAN GESTATIONAL SURROGACY

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ABSTRACT

A lacuna exists in the legislation governing ‘assisted reproductive technologies’ (ART) and in particular surrogacy in Malaysia. Since its inception in the twentieth century, ART and surrogacy have unveiled various complex issues that undoubtedly demands comprehensive legal analysis and panacea. This paper aims to examine the legal issues specifically the requirements of adult and spousal consent in surrogacy as compared with conventional medical treatments. In the context of regulation, the paper limits its discussion to gestational surrogacy but makes no distinction between altruistic and commercial arrangements. This paper investigates consent in surrogacy through the perspectives of the individuals concerned in the whole process comprising pre-conception, conception-gestation and finally post-birth. Lessons are drawn from other jurisdictions in order to confer a legal framework suited to the Malaysian context. Informed consent as a legal instrument can serve as a basis to build upon the required legislation to better harness the benefits of surrogacy whilst preventing pitfalls through appropriate regulations. Due to rising demands and its exceptionality to confer the gift of life to an otherwise childless couple, surrogacy will remain an important feature of the Malaysian medical landscape. Hence, it is imperative that such precarious legal lacuna be redressed in order to better protect the rights of intended parents, the surrogate and most importantly the resulting child.

Keywords: adult consent, spousal consent, Malaysia, gestational surrogacy, artificial reproductive technology, legislation, patient autonomy, relational autonomy.

INTRODUCTION

Assisted reproductive technology (ART) is arguably the greatest breakthrough in human fertility treatments of the 20th century and has brought with it a myriad of complex issues. As a form of medical treatment, ART which may also include surrogacy arrangements cannot escape from the inexorable ethical and legal concerns which are present once a doctor-patient relationship is perceived to be established. Surrogacy in particular is peculiar and rather different from the usual medical transaction that typically involves a healthcare provider and a healthcare receiver or the patient alone. Surrogacy treatments may involve (i) the intended parents, either as individuals or a unit; (ii) the surrogate mother, whose position can be likened to a “receptacle” for the implanted embryo; and (iii) most importantly the resulting child, whose welfare rightfully receives utmost emphasis. This paper begins with examining ethical and legal requirements of adult consent for conventional medical treatment and its elements for a valid “informed” consent under Malaysian law. The requirement of spousal consent for conventional medical treatment is also discussed using decided cases in Malaysia. With these basic principles as a backdrop, the requirements for adult and spousal consent in relation to ART and specifically gestational surrogacy is deliberated in order to confer the rationale of the difference in their application as compared to conventional medical treatments. Lastly, the emphasis and requirements of consent in surrogacy for Malaysia is explored through a proposed regulatory framework.

A. Adult consent in medical treatment

Consent is defined in the Merriam-Webster's Dictionary of Lawⁱ as compliance in or approval of what is done or proposed by another. In medical scenarios, it is a form of authorization by healthcare user usually the patient, giving permission before they receive any type of medical interventionⁱⁱ from the healthcare provider.

a. The ethical and legal requirements of adult consent

Consent is born out of the ethical principles of respect for autonomy which has its roots in moralⁱⁱⁱ and philosophical^{iv} ethics. Beauchamp and Childress who provided the dominant theoretical framework for contemporary biomedical ethics further developed and popularised the concept of respect for autonomy which was juxtaposed with paternalism^v, thereby transforming the traditional therapeutic relationship in contemporary medicine^{vi}. Respect for patient's autonomy sought to return the power of choice and determination of one's medical fate to the individual and gave the patient the right to set limits for medical intervention without undue influence or coercion of others^{vii}. Application of the principle of autonomy in real-life healthcare scenarios has contributed to the development of patient's rights, including privacy, confidentiality, self-determination, and primacy of truth-telling. This is consistent with commonly used legal and ethical standards in healthcare, namely informed consent, advance directives, surrogate decision making and the best-interest standard^{viii}.

The standard of consent is upheld in international human rights codes and declarations for medical interventions^{ix} as well as for clinical research^x. Obtaining a patient's consent is a paramount component of good medical practice, not to mention the specific legal requirements to do so. Except in specific circumstances such as an emergency, consent must be obtained from the competent adult patient before medical intervention is undertaken. Failure to do so may be interpreted as a failure to meet the standard of care resulting in a disciplinary inquiry by the Malaysian Medical Council (MMC) or even be construed as a breach of duty of care, potentially resulting in legal action for assault or battery being instituted against the healthcare provider^{xi}.

b. Elements of valid adult consent

The West's Encyclopaedia of American Law^{xii} provides that consent is an intelligent and carefully determined power brought about by thoughtful reflection of a mentally capacitated person to allow the performance of an act recommended by another and is unencumbered by fraud, duress, or sometimes even mistakes. Succinctly, Dr. Puteri Nemie^{xiii} opined that to obtain a legally valid consent, three essential elements need to be satisfied. Firstly, the consent must be 'real' which requires sufficient disclosure of information regarding the proposed medical

intervention. As to what is sufficient, the standard of disclosure is adjudicated by the Law or the Courts as seen in the case of *Foo Fio Na v Dr Soo Fook Mun & Anor*^{xiv} which adopted the 'reasonably prudent patient test' set forth in *Rogers v Whitaker*^{xv}. Secondly, there must be capacity to consent which means that a competent adult patient once properly informed, has both the unassailable legal right to authorise or refuse any or all medical treatment or care as set forth in *St George's Healthcare NHS Trust v S*^{xvi} and *Re MB*^{xvii}. And lastly, the consent must be voluntary given through free will with no duress or undue influence. If consent is given as a result of external influences, it can be nullified as in *Re T (Adult: Refusal of Medical Treatment)*^{xviii}.

B. Spousal consent in medical treatment

It has been established that consent for medical treatment should be sought solely from the competent adult patient alone. In western societies such as Canada^{xix}, Australia^{xx}, the US^{xxi} and the UK^{xxii}; ethical codes, case law and civil law concerning spousal consent concurs that, where the patient-spouse is competent to give an informed consent, in principle, no one else's including the other spouse's consent is necessary. Similarly, because one spouse is not automatically the agent of the other, therefore the spouse's refusal of consent cannot overcome the patient-spouse's consent. In non-emergent cases, the physician must obtain authorization from the patient and not from someone acting for the patient. Unless the patient lacks the capacity to do so, then a substitute decision maker is required to consent on behalf and depending on the jurisdiction, this may be the spouse or a legal guardian.

a. Malaysian cases – where have we gone wrong?

The rationale of obligatory spousal consent requirement apart from the consent obtained from the primary decision maker or the spouse-patient will be examined using two decided cases in Malaysia. An attempt is made to decide the limits of its application and the corresponding scope of liability upon the healthcare provider. The earlier decision in *Gurmit Kaur Jaswant Singh v Tung Shin Hospital & Anor*^{xxiii} suggests that additional liability may be incurred by a surgeon towards the spouse of his patient, while the latter decision in *In Abdul Razak Datuk*

Abu Samah v Raja Badrul Hisham Raja Zezeman Shah & Ors^{xxiv}, appears to out rightly state as such.

In *Gurmit Kaur*, the plaintiff was admitted for the removal of a fibroid but instead received a hysterectomy. Although she signed a consent form, it was held by the Judicial Commissioner Rosilah Yop, that her consent was not valid as “...the evidence tendered, it was established that the defendants had at no time informed the plaintiff of the effects of the operation”. Her Ladyship^{xxv} was convinced that there was “...inadequate counselling of the plaintiff regarding the type of surgery to be carried out on her” and therefore there was failure “to advise the plaintiff on the treatment options available to her”. This point was adequate to prove negligence but Her Ladyship went on to scrutinise a Form of Consent which was produced before her. Her Ladyship opined:

[64] “After I had scrutinised the consent form, I am of the opinion that, the consent from the husband **should** be obtained especially for this alleged type of operation (i.e., to remove the uterus of the plaintiff and there was no possibility of getting pregnant after the removal of the uterus)”

[68] “Furthermore, both the expert witnesses of the plaintiff and defendant had admitted that this consent form **should** have been signed by the husband which was not done here”

Particular attention is to be paid to the use of the word “should” in her Ladyship’s judgement. It is clear from the outcome of Her Ladyship’s decision that “should” is taken to mean an imperative command as in “shall” rather than as a suggestion or proposal — meaning that a doctor’s duty to advise a patient and obtain her valid consent extends to advising and obtaining her spouse’s valid consent. Also, expert witnesses are in agreement that spousal consent is necessary.

With esteem to her Ladyship and the experts concerned in *Gurmit Kaur*, in law there is no duty of care owed to the patient to obtain spousal consent. In fact, any such notion contradicts what is set out in the dicta in *Foo Fio Na*^{xxvi} and *Rogers*^{xxvii} — that the duty is to properly advise the patient as it is the patient who alone holds the final decision as to what is to be done to her

body. If such advice is rendered in the presence of a spouse, at best, it is merely good practise to ensure that this duty is properly discharged. Any form to be signed by a spouse should be directed towards the objective of securing evidence that a patient was adequately advised and counselled and not towards discharging of this duty of care. Addressing further the expert witness evidence as appreciated by Her Ladyship, it must be remembered that the evidence of experts are merely guides to determine appropriate standard of care required with regard to advice and consent in accordance with the principle in *Rogers*; no judge is bound to accept the evidence of the experts but they are entitled to apply the standards to which the law imposes^{xxviii}.

The MMC guidelines^{xxix} do not provide if spousal consent should be sought but maintains that “sterilisation procedures in a woman or man should be given by the patient concerned... Any discussion between the spouses in this respect does not and should not deny the rights of the patient concerned in making the final decision and giving consent.” Although it has been a usual practice to obtain spousal consent in the government health facilities in Malaysia especially for cases where reproductive function is concerned^{xxx}, the practice should not be seen as setting legally binding precedent. Courts should not automatically apply the rules the profession applies on itself but rather to apply reasonable rules of established law.^{xxxi}

In *Abdul Razak*, the plaintiff’s wife had refused for Ryle’s tube insertion before surgery as it caused her discomfort. This procedure is usual practice pre-operatively to reduce the risk of aspiration pneumonia during general anaesthesia and surgery. The tube was only inserted after the patient was anaesthetised and had lost consciousness. However, while being anaesthetised, the patient regurgitated and aspirated leading to aspiration pneumonia which the patient later succumbed to. Judicial Commissioner Vazeer Alam Mydin Meera pointed out that while the patient was of right-sounding mind and “even though the consent form did not require the plaintiff’s consent to the surgery, the factual matrix of the case indicated that the first defendant had a duty to inform the plaintiff of the nature of the surgery and the inherent and material risks of the procedure especially in view of the patient’s refusal” and that “It was clear from the evidence that the patient depended on the plaintiff to make the decision to proceed with immediate surgery.”^{xxxii}

The circumstances of this case may appear to suggest that spousal consent was necessary. In *Abdul Razak*, the learned judge was clear that “...ordinarily, in a doctor-patient relationship, the duty of care is owed only to the patient...” and admits “however, there are exceptions to this general principle.”^{xxxiii} His Lordship then goes on to list the possible exceptions and firmly states that “one such exception arose in the case of *Gurmit Kaur*...where the High Court held that the consent of the patient herself was insufficient as the consent of the husband was not obtained for a hysterectomy as required under the consent form” and that there is “...the obvious logic for the husband’s consent to be obtained in cases of hysterectomy as it involves the joint reproductive rights of husband and wife”^{xxxiv}. Hence, the court in *Abdul Razak* appears definitive that spousal consent was obligatory under the relevant circumstances.

In *Gurmit Kaur*, the doctor was liable to the patient for failing to advise her spouse of the nature and consequences of the intended treatment; in contrast, with *Abdul Razak*, a doctor would be additionally liable to the patient’s spouse itself as a personal claim. It is humbly opined that the judgment in *Abdul Razak* has stretched the law in relying on the decision in *Gurmit Kaur* which resulted in the creation of another new duty of care, this time to third parties outside the doctor-patient relationship. This could potentially open floodgates to extend case law in the realm of doctor’s duty of care to third parties. In terms of *Abdul Razak*’s dependence theory, it is not difficult to see how it may apply to elderly persons who are frequently accompanied by their children to seek medical treatment and therefore can appear dependent leading to the assumption that the children are to be seen as the decision-makers. With that in mind, it can become a requirement for doctors to also seek consent from the children and advise the children of all material risks as the Courts may deem them liable to do so even though the parent is competent but seen to be “dependent”.

Previous negligence cases suggest that new duties of care have to be created cautiously and slowly. In the realm of tort, other than professional medical negligence, the law has been slow to create new forms of liability^{xxxv}. In *Caparo Industries plc v Dickman*^{xxxvi}, Lord Oliver after studying a line of authorities stated that duty of care needs to be “...reasonably capable of being foreseen...within bound of common sense and practicability” and further states that “...the requirement of what is called a ‘relationship of proximity’ between the plaintiff and the defendants and by the imposition of a further requirement that the attachment of liability from

harm which has occurred to be just and reasonable.” The approach is best summarized in Their Lordships’ most favored passage, cited with such regularity that it must inform the future lines of development: “It is preferable, in my view, that the law should develop novel categories of negligence incrementally and by analogy with established categories, rather than a massive extension of prima facie duty of care restrained only by indefinable consideration which ought to negate, or reduce, or limit the scope of duty or the class of person to whom it is owed.”^{xxxvii} Even in creating liability for nervous shock, the courts were very circumspect and extended the scope of claimable damage and those who could so claim to a very limited class^{xxxviii}.

C. Adult consent and spousal consent in surrogacy

Notwithstanding the common rule that spousal consent is not usually required for medical treatment, there are instances where it might be reasonable to extend this practice. The application and implications of adult consent and spousal consent will be discussed in relation to ART and, more specifically, surrogacy.

a. Surrogacy: Types and limits for discussion

From the first baby that was created via *in vitro fertilization* (IVF) in Oldham on 25 July 1978^{xxxix}, ART has represented one of the most important scientific breakthroughs of the twentieth century. As widespread acceptance towards ART increases, its demands and prevalence has also gained momentum in many countries such as the UK^{xl}. In 2009, the International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO) has revised the glossary of ART terminology whereby ART is defined as “all treatments or procedures that include the *in vitro* handling of both human oocytes and sperm or of embryos for the purpose of establishing a pregnancy.”^{xli}

Surrogacy is the practice whereby a woman (the surrogate) becomes pregnant with the intention that the child should be handed over to the intended parent(s) after birth^{xlii}. A surrogate could simply inseminate herself with the intended father’s sperm. This is known as ‘genetic’ surrogacy, and because pregnancy can be achieved without professional assistance, it is difficult to exercise any control over these arrangements. This form of surrogacy also comes

with a heavier psychological toll and inherent ethical and legal issues as the child born will also have biological relations to the surrogate, thus complicating parentage in many jurisdictions such as Malaysia^{xliii}. ‘Gestational’ surrogacy on the other hand, requires a transfer of a non-biological embryo created via ART usually using the intended parent(s)’ gametes. There is also another distinction between altruistic and commercial surrogacy whereby in altruistic arrangements, the surrogate is reimbursed only for the expenses correlated to the pregnancy and birth of the child and not for the surrogacy itself, while in commercial arrangements, the surrogate receives compensation for bearing the intended parents’ child^{xliv} - essentially, a paid service for renting the womb of a surrogate. As this paper is concerned with legal discussion of consent in surrogacy, it will be limited to gestational surrogacy due to the inherent difficulties in regulating genetic surrogacy as mentioned previously. This paper also does not differentiate between altruistic and commercial surrogacy as it will be apparent that even in jurisdictions that specifically allow altruistic arrangements only such as Greece, Cyprus and Portugal, there are ways of circumventing regulations to form commercial arrangements^{xlv}. Lastly in Malaysia, through the National Council of Islamic Religious Affairs on 12 June 2008, issued a fatwa prohibiting surrogacy^{xlvi} for Muslims as it involves third parties in the reproductive process in a legally binding marriage of a couple. This paper’s focus will be on the civil law surrogacy position *vis-à-vis* non-Muslims.

b. Surrogacy in Malaysia: Demands and current state of regulation

Over the years, ART has increased in prevalence reflecting its demand. The Malaysian government through the Malaysian Healthcare Travel Council (MHTC) sees opportunities for ART for medical tourism and in 2018, had set aside RM30 million in its budget to position Malaysia as a regional fertility and cardiology hub^{xlvii}. With low local fertility rates, the Malaysian government has also introduced various incentives in the form of tax reliefs and Employees Provident Fund (EPF) withdrawals for the purpose of ART^{xlviii}. Despite this, there are no specific legislations or regulations for ART and surrogacy in Malaysia. Surrogacy contracts although not illegal, may be rendered void for being against public policy under section 24(e) of the Contracts Act 1950^{xlix}.

This paper is concerned with the requirements of adult and spousal consent in ART specifically in relation to gestational surrogacy arrangements. This can be better understood from the

perspectives of the individuals (intended parents, gamete donors, surrogate, spouse of the surrogate if any and the resultant child) in relation to the issues throughout the whole process of pre-conception, conception-gestation and finally post-birth.

c. Adult consent requirements in surrogacy

i. Consent to the use of gametes and embryos from intended parents and gamete donors: The UK experience

In gestational surrogacy, the gametes used for ART (usually IVF) can either be from both intended parents or from one of the intended parents and a donor (either ovum or sperm). Similar to any medical procedure, consent to storage and use of one's gametes must be competent, voluntary and informed. In the UK, there are regulations specifying that the consent to creation of an embryo or use of one's gametes in the treatment of others must be in writing^l. Consent must also include what is to be done to the gametes in the event of donor's death or incapacity, and must specify the maximum period of storage, if this is to be less than the statutory storage period of ten years^{li}. In the UK, gametes and embryos can be used posthumously, only if the gamete provider has explicitly consented to posthumous use. Although there maybe situations where a person is unable to lawfully use their deceased partner's gametes due to a lack of consent, they can seek permission to export them to a country where their use would be lawful such as illustrated in *R v Human Fertilisation and Embryology Authority, ex parte Blood*^{liii} and *L v Human Fertilisation and Embryology Authority*^{liiii}. To safeguard autonomy of the gamete providers, there are also provisions in the Human Fertilisation and Embryology Act (HFEA) 1990 which allow for withdrawal of consent to the use or storage of an embryo^{liv}. In practice, this gives whichever partner the right to veto over their use should there be any disagreement. Challenges to this provision has not been successful as in *Evans v United Kingdom*^{lv} where Miss Evans had sought the use of frozen embryos (obtained through an IVF treatment with her partner at the time) after being sterile following a diagnosis of ovarian cancer. She was denied any relief as the Courts honoured the withdrawal of her partner's consent which ultimately disallowed the use of any of those embryos after they had separated.

ii. Consent from the surrogate: The Indian experience

Surrogacy is a unique form of treatment which the intended end benefits or conceptus are not for the patient-surrogate whilst being subjected to the inherent risks and possible complications of the procedure and pregnancy itself. This has left various potential for abuse and often the groups that suffer most are the socioeconomically vulnerable as in the case of commercial surrogacies in India. Since 2002, India had legalised all forms of surrogacy but due to a lack of comprehensive regulation, various issues and problems led to the tightening of its legislations and ban of commercial surrogacy in 2015 which was later followed by the ban of international surrogacy in 2018^{lvi}. National Guidelines for Accreditation, Supervision and Regulations of assisted reproductive technologies clinic drafted by the Indian Council of Medical Research (ICMR) was approved in 2005 but lack legislative enforcement^{lvii}. Hence, surrogacy arrangements in India were largely unregulated^{lviii}. Without any legal obligations, surrogacy agencies are more inclined to put commercial gains above the protection of the rights and interests of gestational surrogates. There is evidence that surrogate mothers are forced to abide to certain conditions such as living in hostels away from their families^{lix}. In India, many women who opt into surrogacy arrangements are unable to read, have limited education, and are ill-informed on the procedure itself^{lx}. Examining the Indian surrogacy arrangements revealed a troubling aspect of the contracts where surrogates had little or no control over the arrangement and probably did not fully understand the terms which were usually in English. In *AB v CD*^{lxi}, for example which is a case involving a UK same sex couple partaking in a surrogacy arrangement in India, Judge Theis showed concerns about the contractual terms to which the surrogate agreed with her thumbprint only and also suggested that the agreement was not translated to her before authorization. The rights of free and informed consent are impossible to be applied in social circumstances such as extreme poverty and limited education^{lxii}. The Indian experience has shown the importance of safeguarding valid informed consent from the surrogate to protect her rights and to prevent abuse.

d. Spousal consent requirements for surrogacy

Most statutory or case law in the UK, Greece and Cyprus has made it obligatory to obtain spousal consent from a married surrogate before partaking in surrogacy or ART in order to

preserve peace and prevent marital discord in the surrogate's family^{lxiii}. It also has implications in the parentage of the resultant child in the UK, whereby the HFEA 1990 and 2008 treats the surrogate as the mother and the surrogate's husband as the father of the child^{lxiv}. After the child is born, the intended parents must either adopt the child or apply for a parental order under the HFEA 2008 to transfer legal parenthood. Because surrogacy contracts are not enforceable in the UK, if surrogate parents do not consent to parental orders, intended parents can lose out in the legal parental rights of the child as in *Re AB (Surrogacy: Consent)*^{lxv} when the relationship between the parties broke down. Similarly in Malaysia, a surrogate mother who is married is considered to be the legal mother of the child and her husband, the father of the child, based on section 112 of the Evidence Act 1950^{lxvi}, which provides: "The fact that any person was born during the continuance of a valid marriage between his mother and any man ... shall be conclusive proof that he is the legitimate son of that man".

i. Rationalising spousal consent (from surrogate's husband) for surrogacy

It has been established earlier in the paper that no additional spousal consent is required for the conventional medical treatment of another spouse-patient. Similarly, there should also be no avenue for spousal veto against that treatment as discussed previously. However, could it be argued that the spousal consent of the surrogate's husband is required because her participation in a medical treatment (that caused her to be pregnant with another man's child) rendered her services and functions limited in the matrimonial contract? Under the common law of England as well as tort law of Australia, a writ of trespass could be issued for injury done to a servant *per quod servitium amisit*^{lxvii}, and by analogy an action lay in trespass or case for injuries done to a wife *per quod consortium* or *servitium amisit*. This right of action is recognized in many Canadian common law provinces even though married women have been given equal rights with men as to property and otherwise under law^{lxviii}. In the event that physical harm has befallen on his wife as a result of a wrongful act leading to deprivation of her society or services, the husband may sue for negligence against the healthcare provider. The action by the husband for loss of *consortium* is founded on the proprietary right which from ancient time it was considered the husband had in his wife, which included a right to his wife's society as well as to her services. The wife's consent alone cannot expunge total liability of the physician's action, because her consent is irrelevant to the husband's claim for the injury as the breach of

duty is toward the husband who suffered consequential damages independently from those of his wife who can recover for the injury done to her. Therefore, in jurisdictions where the action has not been abolished, it may be good practice to obtain both spouses' consent especially in procedure involving reproductive systems where both spouses may have an invested interest in their matrimony.

Another angle of consideration is the ethical implications of spousal consent in this context. Spousal consent at first instance seems to go against the concept of respecting patient's autonomy. However, this form of individualistic understanding of autonomy has been criticized from different theoretical standpoints leading to conceptualisation of relational autonomy frameworks of consent taking^{lxi}. The problem lies in the misconception of the individual self which promotes the ideas of an atomistic self; sovereign and unified; self-transparent to their individual beliefs and values; and self-interested in their strategic choices. Individualistic ways of looking at autonomy makes decision making stringent but decision making is often not just dependent on the individual alone but at times they may require support from others such as family members to make the most beneficial choices^{lxx}. The importance of particular relationships, such as family, friends, and communities was commonly neglected by individualistic theories. Medical decisions affect others through many consequences, and are affected by others' concerns and opinions. Hence it can be argued that in certain circumstances such as surrogacy, it is not inaccurate to put emphasis on spousal and familial unit considerations in relation to the decisional capacity of one spouse for another.

D. Consensual surrogacy in Malaysia – emphasis and regulatory proposal

a. Lessons from other jurisdictions

The ban on foreign commercial surrogacy in India has led to emergence of other destinations, like Cambodia and Vietnam. The pattern is that ART and surrogacy blossoms among inexperienced providers, before being shutdown virtually overnight, leaving parents and surrogates mid-process in a difficult and uncertain position^{lxxi}. India's ban also forced fertility specialists to find ways to 'work around' it by recruiting Kenyan surrogates to come to Mumbai, undergo the IVF then flown back for the births where clients would pick up babies

from Kenya^{lxxii}. Other jurisdictions such as the UK that do not recognise commercial surrogacy arrangements also face problems of legal assurance to the parties involved, which at times lead to regrettable parentage issues threatening the child's welfare^{lxxiii}. Uncertainty in law pushed their citizens to seek international surrogacy arrangements where there are concerns about exploitation of surrogates such as the case in Baby Gammy of Thailand^{lxxiv}, whereby an Australian couple paid a young Thai woman to carry twins but only brought home the healthy girl from the twin, leaving Gammy, the twin brother with Down's syndrome in Thailand with the surrogate mother.

Nevertheless, jurisdictions like the US, Greece, Cyprus and Portugal that have legalised and regulated surrogacy arrangements have shown better results. Greece chose to legalise and regulate surrogacy in the last 18 years and continues to be regarded as a success with high social acceptance of surrogacy^{lxxv}. Through comprehensive legislation and subsidiary regulation, Greek surrogacy arrangements and the parties involved have to meet certain requirements while the process continues to be monitored by an authoritative regulating body^{lxxvi}. Similar to the US which utilizes pre-birth parental orders^{lxxvii}; Greek laws assign legal parenthood to the intended parents already at the time of birth and do away with legal uncertainty. This prevents the child from becoming the object of a dispute or be seen as a transaction. The surrogate can avoid dilemma and come to terms with the arrangement from the outset while protecting the expectations of the intended parents and also compels them to take responsibility for the child in any case.

b. A need to regulate surrogacy in Malaysia

A report in 2017 showed that Malaysia's total fertility rate is below the replacement level of 2.1 babies with medical experts witnessing obvious increase in the number of couples who are unable to conceive^{lxxviii}. Due to its benefits for infertile couples, ART and surrogacy is likely to remain permanent features of the Malaysian medical landscape. Unfortunately, legislation in Malaysia for surrogacy remains rudimentary. In light of the issues discussed above, this paper humbly proposes a simple legal framework to legalise gestational surrogacy in Malaysia whether it be altruistic or commercial in nature. The law should first set out to apply to Malaysian citizens prior to allowing international surrogacy arrangements. Intended parents

should be married couples who meet suitability screening criteria set out by a relevant medical body specialised in ART. A surrogate mother if married should seek spousal consent not strictly for the authorization of the procedure per se but to maintain marital harmony and avoid issues of parentage. Set-up of a relevant authoritative medical and regulatory board is recommended to furnish up-to-date guidelines, especially for informed consent of all parties while continuing to enforce regulations under the relevant act. Surrogacy arrangement contracts must be approved via court order to ensure rights of all parties are being upheld. A pre-birth parentage order must be made by the court for every surrogacy arrangement for reasons as discussed above.

CONCLUDING REMARKS

ART and surrogacy are forms of medical treatment that are complex as it not only involves a patient but at times treatment is rendered for a couple as a unit, another person who serves as a “vessel” and most importantly it results in the creation of another living being. The usual legalities and rules of informed consent should serve as a foundation for supplemental requirements such as spousal consent to build upon, as it represents unique and special circumstances. Individualistic views of autonomy should similarly be supplemented by relational autonomy considerations in decision making for consent of this form of treatment.

Surrogacy arrangements should not be condemned but seen for what it is – affording childless couples a miracle of life. Although surrogacy arrangements can sometimes go devastatingly wrong, this is the exception. Interviews with surrogates^{lxxxix} and the latest report of the Surrogacy UK Working Group on Surrogacy Law Reform^{lxxx} reveal that the majority of the arrangements have been positive experiences. Surrogacies in better regulated countries like the US and Israel also confirms favourable attitudes with most surrogates seeing their role as helping the baby’s parents to realize their ‘dream’ and maintain that the child always belongs to the intended parents^{lxxxii}. There is also evidence that children born through surrogacy are unconcerned about being born this way and hence fare just as well as children born conventionally^{lxxxii}.

A lot of attention and emphasis is often put on the exploitation of surrogates and bias towards protecting the resulting child's welfare. However, it should not be disregarded that intended parents are also worthy of protection. Surrogacy is often an option only for persons who cannot have a child in the natural way, due to a medical condition rather than for convenience or other arbitrary drivers. Reports reveal that in practice, intended parents not only went through multiple failures of conventional and assisted methods of reproduction, but also faced frustrations of adoption^{lxxxiii} before deciding to proceed to surrogacy. On this basis, it is not veracious to assume that the surrogate is always and necessarily the weak party of the agreement.

Clearly, comprehensive legislation is necessary to address precarious legal lacuna in Malaysia by learning from shortcomings and pitfalls in other jurisdictions in order to better protect rights of intended parents, the surrogate and the resulting child. This paper has suggested a legal framework that should be applied step-wise to citizens first before embarking on international surrogacy arrangements which will add another layer of complexity in dealing with international law. Lastly, it is hope that surrogacy is seen in a positive light and that it helps to 'light the darkness of despair' by one to another, as quoting Mother Theresa: "The greatest good is what we do for one another."

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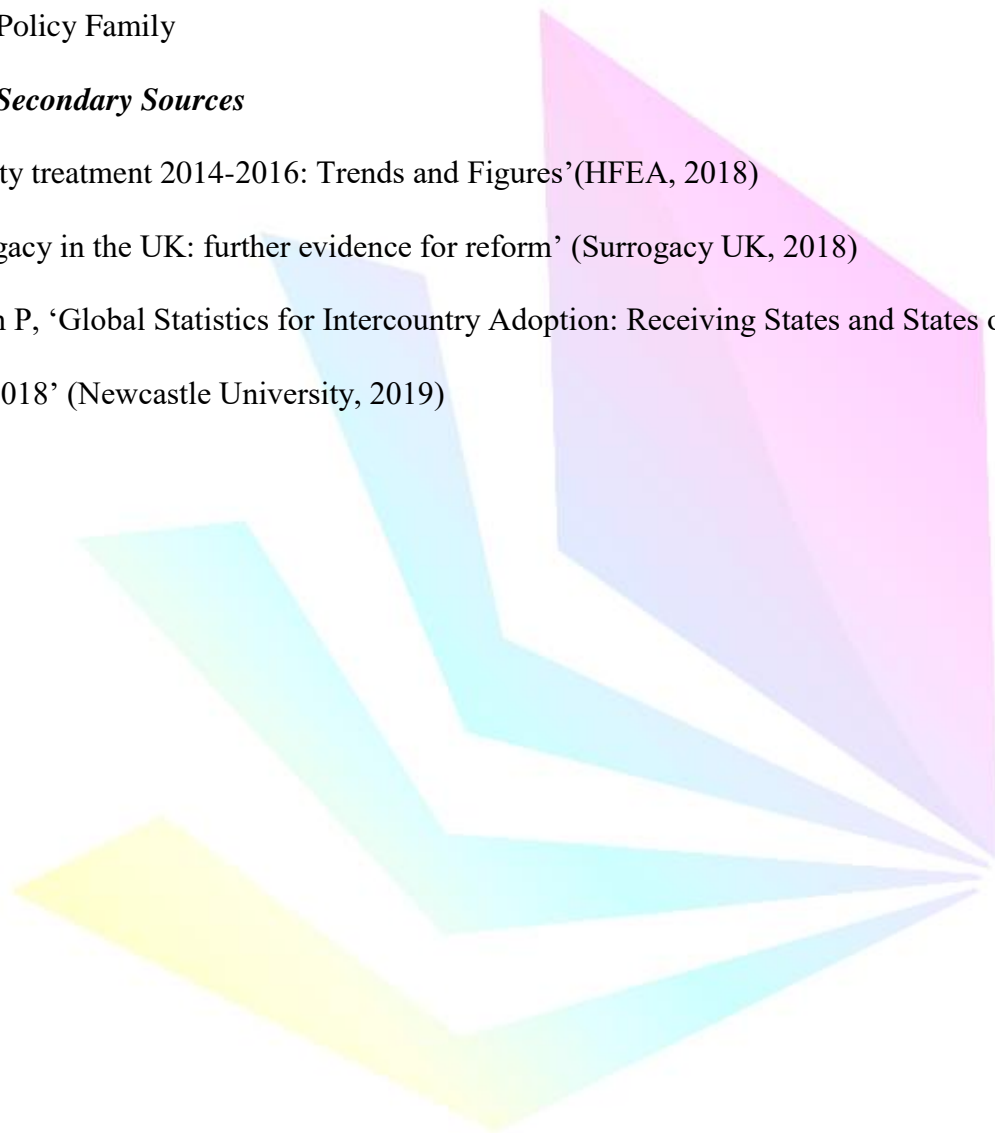
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ⁱⁱⁱ Oliver Sensen, *Kant on Moral Autonomy* (Cambridge University Press 2013), The Kantian model opined that autonomy is the moral right one possesses, or the capacity we have in order to think and make decisions for oneself providing some degree of control or power over the events that unfold within one's everyday life.

^{iv} Iain King, *How to Make Good Decisions and Be Right All the Time* (Continuum 2008) 100, The philosopher Iain King developed an 'Autonomy Principle', which he defines as "Let people choose for themselves, unless we know their interests better than they can".

^v Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (8th edn, OUP 2019)

^{vi} Mark S Komrad, 'A defence of medical paternalism: maximising patients' autonomy' (1983) 9(1) *J Med Ethics* 38

^{vii} Leslie J Blackhall and others, 'Ethnicity and attitudes toward patient autonomy' (1995) 274(10) *JAMA* 820; John Nessa and Kirsti Malterud 'Tell me what's wrong with me: a discourse analysis approach to the concept of patient autonomy' (1998) 24(6) *Journal of Medical Ethics* 394

^{viii} Carlos Gómez-Virseda, Yves de Maeseneer and Chris Gastmans, 'Relational autonomy: what does it mean and how is it used in end-of-life care? A systematic review of argument-based ethics literature' (2019) 20(1) *BMC Med Ethics* 76

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^x World Health Organization, 'Declaration of Helsinki' (2001) 19(4) *Bulletin of World Health Organization* 373

^{xi} MMC Committee, 'Malaysian Medical Council Guideline: Consent for Treatment of Patients by Registered Medical Practitioner' (MMC 2016)

^{xii} West's Encyclopedia of American Law (2nd edn, 2008)

^{xiii} Puteri N Jahn Kassim, *Law and Ethics Relating to Medical Profession* (International Law Book Services 2007) 20

^{xiv} [2007] 1 MLJ 593

^{xv} (1992) 175 CLR 479, Under the reasonable prudent patient test, the scope of a doctor's duty of disclosure is "to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of a particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that a particular patient, if warned of the risk, would be likely to attach significance to it. This is subject to therapeutic privilege".

^{xvi} [1998] 2 FLR 728, The Court of Appeal found that the trial Judge had been wrong in authorizing a cesarean section because the woman was fully competent and had refused to consent to treatment. It was held that "Even when his life depends on receiving medical treatment, an adult of sound mind is entitled to refuse it."

^{xvii} [1997] 2 FCR 541, Similarly "The law is clear that a competent woman who has the capacity to decide may, for religious reasons, or other reasons, or for no reasons at all, choose not to have medical intervention, even though the consequences might be death or serious handicap of the child she bears or her own death."

^{xviii} [1992] 3 WLR 782, "In some cases doctors will not only have to consider the capacity of the patient to refuse treatment, but also whether the refusal has been vitiated because it resulted not from the patient's free will, but from the will of others. It matters not that those sought, however strongly, to persuade the patient to refuse, so long as in the end the refusal represented the patient's independent decision. If, however, his will was overborne, the refusal will not have represented a true decision".

^{xix} Health Care Consent Act 1996, s 10 (Canada); Kenneth G. Evans, 'Consent: A guide for Canadian physicians' (*CMPA* May 2016) <<https://www.cmpa-acpm.ca/en/advice-publications/handbooks/consent-a-guide-for-canadian-physicians>> accessed 3 July 2020

^{xx} Australian Law Reform Commission, *Informed consent to medical treatment* (ALRC Discussion Paper 81, 2014)

^{xxi} 'Code of Medical Ethics: Consent, communication & decision making' (AMA 2019)

^{xxii} Christian P Selinger, 'Consent: patients and doctors making decisions, General Medical Council; The right to consent: Is it absolute?' (2009) 2(2) *BJMP* 50

^{xxiii} [2012] 4 MLJ 260

^{xxiv} [2013] 10 MLJ 34

- ^{xxv} *Gurmit Kaur* (n23) 272
- ^{xxvi} *Foo Fio Na* (n14) 601, Siti Norma Yaakob FCJ declared that the basis of a duty owed by a doctor to a patient to be as follows: “At common law, the duty of care owed by a doctor arises out of his relationship with his patient. Without the doctor and patient relationship, there is no duty on the part of the doctor to diagnose, advice and treat his patient”.
- ^{xxvii} *Rogers* (n15), Further, the test as enunciated in *Rogers* is as follows: “... the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill. But that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade. Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the Bolam principle has not always been applied. Further, and more importantly, particularly in the field of non-disclosure of risk and the provision of advice and information, the Bolam principle has been discarded and, instead, the courts have adopted the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to ‘the paramount consideration that a person is entitled to make his own decisions about his life’”.
- ^{xxviii} *ibid*, Particularly in the field of non-disclosure of risk and the provision of advice and information, the Bolam principle has been discarded and instead, the courts have adopted the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to the “paramount consideration that a person is entitled to make his own decision about his life”.
- ^{xxix} *MMC Committee* (n11) 12
- ^{xxx} Melissa Chi, ‘Reproductive rights: Married women have less say than their husbands’ *The Malay Mail* (Malaysia, 17 Dec 2015) <<https://www.malaymail.com/news/malaysia/2015/12/17/reproductive-rights-married-women-have-less-say-than-their-husbands/1024497>> accessed 4 July 2020
- ^{xxxi} Sarjeet Singh Sidhu, ‘Spousal Consent and Medical Negligence: A Bridge Too Far?’ [2014] 4 MLJ cix
- ^{xxxii} *Abdul Razak* (n 24) 53
- ^{xxxiii} *ibid* 13
- ^{xxxiv} *ibid* 13
- ^{xxxv} Rodney Nelson Jones and Burton Frank, *Medical Negligence Case Law* (LexisNexis Butterworths 1995) 50
- ^{xxxvi} [1990] 1 All ER 568
- ^{xxxvii} *Sutherland Shire Council v Heyman* [1985] 59 ALJR 564 (HCA) 588
- ^{xxxviii} *Mcloughlin v O’Brian* [1983] 1 AC 410 (CA) 431
- ^{xxxix} Lousie Brown and Martin Powell, *Louise Brown: my life as the world’s first test-tube baby* (Bristol Books 2015)
- ^{xl} ‘Fertility treatment 2014-2016: Trends and Figures’ (HFEA, 2018)
- ^{xli} Fernando Zegers-Hochschild and others, ‘The International Glossary on Infertility and Fertility Care, 2017’ (2017) 32(9) *Human Reproduction* 1786, This includes, but is not limited to, in vitro fertilization and embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer, tubal embryo transfer, gamete and embryo cryopreservation, oocyte and embryo donation, and gestational surrogacy. ART does not include assisted insemination (artificial insemination) using sperm from either a woman’s partner or a sperm donor.
- ^{xlii} Emily Jackson, *Medical Law: Text, Cases, and Materials* (5th edn, OUP 2019) 861
- ^{xliiii} Goh Siu Lin, ‘The potential risks of surrogacy arrangements in Malaysia’ (2015) *Family Law Newsletter* 44
- ^{xliiv} Louise Anna Helena Ramskold and Marcus Paul Posner, ‘Commercial Surrogacy: How Provisions Of Monetary Remuneration And Powers Of International Law Can Prevent Exploitation Of Gestational Surrogates’ (2013) *J Med Ethics* 397
- ^{xliv} Eleni Zervogianni, ‘Lessons Drawn from the Regulation of Surrogacy in Greece, Cyprus, and Portugal, or a Plea for the Regulation of Commercial Gestational Surrogacy’ (2019) 33(2) *Int J Law Policy Family* 160, The Greek experience which only allowed for altruistic surrogacy showed that there are pitfalls in the regulation of its practice, whereby there are evidence that prove most surrogates who claim to be ‘best friends’ of the intended parents are of foreign nationality and also there are sound reasons to believe that the amount actually paid to surrogates well exceeds the provisions of the law.
- ^{xlvi} ‘The 80th Muzakarah (Conference) of the Fatwa Committee National Council of Islamic Religious Affairs Malaysia’ (2008) <www.e-fatwa.gov.my/fatwa-kebangsaan/hukummenggunakan-kaedah-khidmat-ibu-tumpang-surrogatmotherhood-untuk-mendapatkan> accessed 1 July 2020, The Committee has decided that surrogacy is forbidden in Islam even if the sperm and ovum were taken from a married couple as this will bring genetic confusion to the unborn baby.

- xlvii 'Malaysia wants chinese IVF medical tourists' (IMTJ 2018) <<https://www.imtj.com/news/malaysia-wants-chinese-ivf-medical-tourists/>> accessed 5 July 2020
- xlviii Audrey Vijandren, 'Fertility rate continues to drop' *NST Online* (Malaysia, 25 October 2019) <<https://www.nst.com.my/news/nation/2019/10/533155/fertility-rate-continues-drop>> accessed 5 July 2020
- xlix Contracts Act 1950, s 24(e), 'the court regards it as immoral, or opposed to public policy... Every agreement of which the object or consideration is unlawful is void'
- ^l Human Fertilisation and Embryology Act 1990, Sch 3
- ^{li} The Human Fertilisation and Embryology (Statutory Storage Period for Embryos and Gametes) Regulations 2009, Section 4
- ^{lii} [1997] 2 WLR 806 (CA), Mrs Blood has obtained her husband's sperm sample while he was in a coma. Because there was lack of consent, the sample cannot be lawfully used in the UK. Mrs Blood requested to export them to Belgium to which she succeeded by exercising her rights under European law to receive treatment in another Member State.
- ^{liii} [2008] EWHC 2149 (Fam) Similar to Mrs Blood's case, sperm samples were obtained posthumous rendering it unlawful to be used for treatment. Charles J however permitted export to another European country that would allow its use.
- ^{liv} Human Fertilisation and Embryology Act 1990, Sch 3, para 4
- ^{lv} *Evans v United Kingdom* App no 6339/05 (ECtHR 2007)
- ^{lvi} Saptarshi Ray, 'India bans commercial surrogacy to stop 'rent a womb' exploitation of vulnerable women' *The telegraph* (United Kingdom, 20 December 2018) <<https://www.telegraph.co.uk/news/2018/12/20/india-bans-commercial-surrogacy-stop-rent-womb-exploitation/>> accessed 2 July 2020
- ^{lvii} Tarishi Verma, 'What are the Surrogacy Laws in India: Here is Everything you need to Know' *The Indian Express* (India, 5 May 2020) <<https://indianexpress.com/article/research/karan-johar-surrogate-children-yash-roohi-what-are-the-surrogacy-in-laws-in-india-here-is-everything-you-need-to-know-4555077/>> accessed 3 July 2020
- ^{lviii} Nicole F. Bromfield and Karen Smith Rotabi, 'Global Surrogacy, Exploitation, Human Rights and International Private Law: A Pragmatic Stance and Policy Recommendations' (2014) *Global Social Welfare* 123
- ^{lix} Sharvari Karandikar and others, 'Economic necessity or noble cause? A qualitative study exploring motivations of gestational surrogacy in Gujarat, India' (2014) *Affilia* 224
- ^{lx} George Palattiyil and others, 'Globalization and Cross-Border Reproductive Services: Ethical Implications of Surrogacy in India' (2010) 53(5) *International Social Work* 686
- ^{lxi} [2015] EWFC 12
- ^{lxii} Sozos J Fasouliotis and Joseph G Schenker, 'Social Aspects of Assisted Reproduction' (1999) 5(1) *Human Reproduction Update* 26
- ^{lxiii} *Zervogianni* (n 45)
- ^{lxiv} Human Fertilisation and Embryology Act 1990, s 28; Human Fertilisation and Embryology Act 2008, s 28
- ^{lxv} [2016] EWHC 2443 (Fam)
- ^{lxvi} The Evidence Act 1950, s 112 applies to both Muslims and non-Muslims
- ^{lxvii} *Black's law dictionary* (11th edn, Thomson West 2019)
- ^{lxviii} Law Reform Commission of British Columbia, *Report on the Action Per Qoud Servitium Amisit* (CanLIIDocs 24, 1986)
- ^{lxix} *Gómez-Virseda, Maeseneer and Gastmans* (n 8)
- ^{lxx} Sharon Ikonomidis and Peter A Singer, 'Autonomy, liberalism and advance care planning' (1999) 25(6) *J Med Ethics* 522
- ^{lxxi} Helen Prosser and Natalie Gamble, 'Modern Surrogacy practice and the need for reform' (2016) 4 *Journal of Medical Law and Ethics* 257
- ^{lxxii} Sharmila Rudrappa, 'India outlawed commercial surrogacy – clinics are finding loopholes' (2017) *The Conversation* 24
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- ^{lxxiv} Amanda Meade, 'Gammy: Australian Parents Wanted a Refund and Would Have Aborted Him' *The Guardian* (Australia 10 August 2014) <<http://www.theguardian.com/world/2014/aug/10/baby-gammy-parents-interview-aborted-downs-syndrome-australia>> accessed 5 July 2020
- ^{lxxv} *Zervogianni* (n 45)
- ^{lxxvi} Law 32/2006, Art 8, para 4; Greek Civil Code and Law 3305/2005 Art 1458
- ^{lxxvii} Uniform Parentage Act of 1973, s 7633, that empowers Courts to give pre-birth parentage orders, which is a court-ordered judgment that assigns the legal parentship to the intended parents in a surrogacy arrangement. Pre-

birth parentage orders affirm the legal parentship of the intended parents to the world and they should be treated as such.

^{lxxviii} Bernama, 'Infertility on the rise in Malaysia, says expert' Malaysiakini (Malaysia, 4 December 2017) <<https://www.malaysiakini.com/news/404261>> accessed 2 July 2020

^{lxxix} Susan Imrie and Vasanti Jadva, 'The long –term experiences of surrogates: relationships and contact with surrogacy families in genetic and gestational surrogacy arrangements' (2014) 29 *Reproductive BioMedicine Online* 424

^{lxxx} 'Surrogacy in the UK: further evidence for reform' (Surrogacy UK, 2018)

^{lxxxi} Elly Teman and Zsuzsa Berend, 'Surrogate non-motherhood: Israeli and US surrogates speak about kinship and parenthood' (2018) *Anthropology & Medicine* 1-15.

^{lxxxii} Sophie Zadeh and others, 'The perspectives of adolescent conceived using surrogacy, egg or sperm donation' (2018) 33 *Human Reproduction* 1099

^{lxxxiii} Peter Selman, 'Global Statistics for Intercountry Adoption: Receiving States and States of origin 2005-2018' (Newcastle University, 2019), the trend shows in Western countries the children put up for adoption are few, while at the same time the number of children that are available for international adoption is constantly decreasing.

