Contributors

Authors	Sonia Magri
	Kate Foord
	Mary Polis
	Professor Marcia Neave AO
Editor	Alison Hetherington

Victorian Law Reform Commission

Chairperson	Professor Marcia Neave AO*
Full-time Commissioner	Judith Peirce
Part-time Commissioners	Paris Aristotle AM*
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	The Honourable Justice David Harper
	Her Honour Judge Felicity Hampel*
	Professor Sam Ricketson*
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	The Honourable Justice Tim Smith
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	Mary Polis
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	Sonia Magri
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Victorian
Law Reform
Commission

GPO Box 4637
Melbourne Victoria 3001
Australia
DX 144 Melbourne, Vic

Level 10
10–16 Queen Street
Melbourne Victoria 3000
Australia

Telephone +61 3 8619 8619
Facsimile +61 3 8619 8600
TTY 1300 666 557
1300 666 555 (within Victoria)
law.reform@lawreform.vic.gov.au

www.lawreform.vic.gov.au

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Terms of Reference

The Victorian Law Reform Commission has nine members: the Chairperson Professor Marcia Neave, the Honourable Justice Tim Smith, the Honourable Justice David Harper, the Honourable Vice-President Iain Ross, her Honour Judge Jennifer Coate, her Honour Judge Felicity Hampel, Professor Sam Ricketson, Ms Judith Peirce and Mr Paris Aristotle. The commission advises the Attorney-General on areas of law that he refers to us.

On 11 October 2002 the Attorney-General, the Honourable Rob Hulls MP, gave the commission a reference on the following terms:

1. The Victorian Law Reform Commission is to enquire into and report on the desirability and feasibility of changes to the *Infertility Treatment Act 1995* and the *Adoption Act 1984* to expand eligibility criteria in respect of all or any forms of assisted reproduction and adoption; and make recommendations for any consequential amendments which should be made to the:
   - *Status of Children Act 1974*;
   - *Births Deaths and Marriages Registration Act 1996*;
   - *Human Tissue Act 1982*;
   - *Equal Opportunity Act 1995*; and
   - any other relevant Victorian legislation.
2. In making its enquiry and report, the VLRC is to take into account, to the extent it decides is necessary or desirable:
   (i) social, ethical and legal issues related to assisted reproduction and adoption, with particular regard to the rights and best interests of children;
   (ii) the public interest and the interests of parents, single people and people in same-sex relationships, infertile people and donors of gametes;
   (iii) the nature of, and issues raised by, arrangements and agreements relating to methods of conception other than sexual intercourse and other assisted reproduction in places licensed under the *Infertility Treatment Act 1995*;
   (iv) the penalties applicable to persons, including medical and other personnel, involved in the provision of assisted reproduction (whether through a licensed clinic or otherwise); and
   (v) the laws relating to eligibility criteria for assisted reproduction and adoption and other related matters which apply in other states or countries and any evidence on the impact of such laws on the rights and best interests of children and the interests of parents, single people, people in same-sex relationships, infertile people and donors of gametes.
3. In addition, the VLRC is to consider:
   - Whether changes should be made to the Act to reflect rapidly changing technology in the area of assisted reproduction.
   - The meaning and efficacy of sections 8, 20 and 59 in relation to altruistic surrogacy, and clarification of the legal status of any child born of such an arrangement.

On making its report the VLRC is to consider the relationship between changes to Victorian legislation and any relevant commonwealth legislation, including the *Family Law Act 1975* and the *Sex Discrimination Act 1984,* as well as any international conventions and instruments to which Australia is a signatory.

Abbreviations

AI	artificial insemination
ART	assisted reproductive technologies
cl	clause
Cth	Commonwealth
DHS	Department of Human Services
ed	edition
eg	for example
Fam LR	Family Law Reports
FCR	Federal Court Reports
FSA	Fertility Society of Australia
HCV	Hepatitis C virus
HIV	human immunodeficiency virus
ibid	in the same place (as the previous footnote)
ICSI	intracytoplasmic sperm injection
ie	that is
ITA	Infertility Treatment Authority
IVF	in-vitro fertilisation
n	footnote
NHMRC	National Health and Medical Research Council
para(s)	paragraph(s)
PGD	pre-implantation genetic diagnosis
pt	part (of a statute)
reg/s	regulation/s
RTAC	Reproductive Technology Accreditation Committee
s	section (ss pl)
SA	South Australia
sch/s	schedule/s
sess	session
QC	Queen's Counsel
UK	United Kingdom
UN	United Nations
UN GAOR	United Nations General Assembly
Vic	Victoria
VCAT	Victorian Civil and Administrative Tribunal
VLRC	Victorian Law Reform Commission

Chapter 1
Our Process

INTRODUCTION

1.1 This is the first in a series of position papers to be published by the Victorian Law Reform Commission. The purpose of this Position Paper is to set out the commission's preliminary views on access to, and eligibility for, assisted reproductive technology (ART). The paper also discusses gamete (sperm and ova) donation and posthumous use of gametes. There will be further papers on parentage and adoption (including birth registration and access to information) and on specific issues concerning surrogacy.

1.2 This paper makes interim recommendations which are intended to indicate the direction of the commission's thinking. It is not intended to be a comprehensive report on the findings of our review of the law in this area. The interim recommendations are based on careful consideration of the issues raised in the *Assisted Reproductive Technology & Adoption: Consultation Paper*, published in December 2003;[1] on extensive research by the commission's ART research and policy staff; and on consideration of issues raised in (and responses to) three occasional papers published by the commission.[2] Most importantly, the recommendations have been informed by extensive public consultation, roundtables and the 243 submissions received in response to the Consultation Paper. The commission has weighed all of this information in reaching its interim recommendations. Many of the issues are extremely complex, and prompted lengthy discussion and debate between the commissioners. Most interim recommendations were unanimous. Where there is some difference of opinion on certain issues, we seek the views of the community (see Questions 3 and 9).

1.3 The commission will take account of responses to its interim recommendations in preparing the Final Report, which will be published by the end of this year. The Final Report will contain full details of our consultation process and research findings, a complete list of submissions received and a comprehensive discussion of the broad range of arguments and beliefs about the regulation of assisted reproduction.

WHAT IS COVERED IN THIS POSITION PAPER

1.4 This Position Paper includes:

- an explanation of our consultation process;
- a discussion of the issues relevant to the regulation of access to ART, gamete donation, and posthumous use of gametes; and
- a summary of the findings and arguments that have led the commission to its interim recommendations.

1 Victorian Law Reform Commission, *Assisted Reproductive Technology & Adoption: Consultation Paper* (2003).

2 Dr Ruth McNair, *Outcomes for Children Born of A.R.T. in a Diverse Range of Families* (2004); John Tobin, *The Convention on the Rights of the Child: The Rights and Best Interests of Children Conceived Through Assisted Reproduction* (2004); Adjunct Professor John Seymour and Sonia Magri, *A.R.T., Surrogacy and Legal Parentage: A Comparative Legislative Review* (2004).

1.5 The paper also seeks:

- your comments on the interim recommendations; and
- responses to questions about the practical operation of the system suggested.

THE PROCESS

CONSULTATION PAPER

1.6 In December 2003, the commission published *Assisted Reproductive Technology & Adoption: Consultation Paper*.[3] The Consultation Paper was published to inform people of the scope and nature of our inquiry, invite public comment, and provide people with the necessary background to make informed submissions to the inquiry. It also raised questions which the commission identified as being important to the inquiry. It sought information about the effects of current laws and practices governing assisted reproduction and people's opinions on the range of issues we have been asked to consider.

SUBMISSIONS

1.7 Public interest in this project has been intense and has involved people from all sectors of society. The commission received 243 submissions in response to its Consultation Paper. Of these submissions, 166 referred to issues of access and eligibility, 85 discussed whether it was justifiable for decisions about access to treatment to be based on marital status or sexual orientation, 72 referred to gamete donation and 35 discussed the posthumous use of gametes. All the issues raised in these submissions were carefully considered and weighed and taken into account in decisions about the interim recommendations contained in this Position Paper.

1.8 Many submissions expressed concern about the lack of clear legal rules to determine the parentage of some children conceived through assisted reproduction and supported the right of children to have access to information about their genetic heritage. These matters will be addressed in Position Paper Two. Similarly, those submissions that focused upon issues relevant to surrogacy will be taken into account in Position Paper Three.

1.9 The majority of submissions also emphasised the importance of considering the health and wellbeing of children born as a result of ART. This is the central focus of the interim recommendations which are made in this paper.

1.10 All submissions, including those in response to these interim recommendations, will be considered in making the final recommendations to government, which will be published in our Final Report.

OCCASIONAL PAPERS

1.11 The interim recommendations take account of the information presented in three occasional papers published by the commission. These papers considered outcomes for children born of ART in a diverse range of families,[4] the *Convention on the Rights of the Child* in relation to children conceived through ART,[5] and regulatory models in Australia, Canada, the United Kingdom, and the United States.[6] These papers were launched on 8 September 2004 at a public

3 Victorian Law Reform Commission (2003), above n 1.

4 McNair (2004), above n 2.

5 Tobin (2004), above n 2.

6 Adjunct Professor John Seymour and Sonia Magri (2004), above n 2.

forum. The forum was advertised widely and was attended by over 150 people who made many valuable comments.

1.12 More information about these papers, and/or copies of them, may be obtained from the commission's website, or by contacting us on (03) 8619 8619. The papers are also freely available at all university and legal libraries.

FINAL REPORT

1.13 The recommendations made in the Final Report are made by the commissioners, who take account of the information received and views expressed in our public consultations. The complexity of the issues considered in this paper and the wide variety of views which people hold about them has made it particularly important to give people opportunities to have their say. The commission will consider your responses and comments on the position papers when deciding what should be included in the Final Report to the government.

1.14 We are planning to complete the Final Report in late 2005. It will then be tabled in parliament by the Attorney-General.

Chapter 2
Access and Eligibility

INTRODUCTION

2.1 Victoria is one of three states in Australia that regulates the question of who is eligible to access ART.[7] The Attorney-General has asked the commission to enquire into and report on the desirability and feasibility of changes to the *Infertility Treatment Act 1995* to expand eligibility criteria in respect of all or any forms of assisted reproduction. This Chapter examines the current law that governs access to infertility treatment, including treatment in which donated sperm and/or eggs are used. It considers whether the Act meets its objective of ensuring that the welfare and interests of any person born or to be born as a result of a treatment procedure are paramount.

ACCESS TO TREATMENT UNDER THE PRESENT LAW

2.2 Access to ART treatment procedures in Victoria is governed by the Infertility Treatment Act. The Act sets out criteria which govern access to treatment and contains guiding principles and other provisions relevant to the provision of ART services.

2.3 The requirements that must be met before a woman may undergo artificial insemination or a fertilisation procedure at a licensed clinic are:

- she must be married and living with her husband, or living with a man in a de facto relationship;
- she must have the consent of her husband/partner to the treatment; and
- she must be 'unlikely to become pregnant' with her own ovum or her husband/partner's sperm, other than by a treatment procedure; or
- she must be at risk of having a child with a genetic abnormality.

2.4 As the Consultation Paper explains, the operation of these requirements has been modified by the decision in the Federal Court case *McBain v The State of Victoria.*[8] In *McBain*, the court held that the requirement that a woman be married or in a heterosexual de facto relationship in order to access infertility treatment was inconsistent with the provisions of the federal *Sex Discrimination Act 1984*. When state laws are inconsistent with federal laws they are invalid.[9] This means that marital status may no longer be used as an exclusionary criterion. Women who are single, in same-sex relationships, or in unmarried heterosexual relationships where they do not live with their partner on a genuine domestic basis can now access ART if they meet the other eligibility requirements.

2.5 The court was not required to (and therefore did not) rule on other eligibility criteria. In particular, it did not express any view on how the requirement that a person be 'unlikely to become

7 The other two states are Western Australia and South Australia.

8 *McBain v the State of Victoria & Ors* (2000) 99 FCR 116.

9 *Commonwealth of Australia Constitution Act 1900* (Cth) s 109.

pregnant' should be applied to a woman who does not have a male partner. Two legal opinions have been given on this question. According to one legal opinion, the expression 'unlikely to become pregnant' should be applied in the same way to women who are married or in a de facto heterosexual relationship and to women who do not have a male partner.[10] According to the second opinion, the 'unlikely to become pregnant' criterion applies differently to women in heterosexual relationships and women without male partners.[11] The opinion concluded that the criterion should be determined by reference to the subject matter of the Act, namely the treatment of infertility. This interpretation means that the only explanation for a single woman's inability to become pregnant without treatment can be clinical infertility, whereas the explanation for a married woman's inability to become pregnant without treatment may take account of her husband's circumstances as well.

2.6 The Infertility Treatment Authority (ITA) directed clinics to follow the latter opinion,[12] with the result that the 'unlikely to become pregnant' requirement is now applied more strictly to single women and women in same-sex relationships than to women who are married or in a de facto heterosexual relationship. A clinic can treat a woman who is married or in a heterosexual de facto relationship if she is unlikely to become pregnant for reasons ranging from her or her spouse's clinical (medical) infertility, psychological reasons (eg her or her partner's aversion to penetrative sex), or no apparent/obvious reason despite efforts to become pregnant. On the other hand, unmarried women must be *clinically infertile*, which is generally limited to clinical symptoms preventing conception (such as endometriosis, blocked fallopian tubes, age or a previous diagnosis of infertility). Applying the 'unlikely to become pregnant' requirement differently to married and single women may be inconsistent with the provisions of the federal Sex Discrimination Act, but this issue has not been tested in court.

2.7 In addition to these express eligibility requirements, the Infertility Treatment Act contains a set of guiding principles that must be given effect in the carrying out of activities regulated by the Act, including the provision of treatment procedures. These principles are:

- the welfare and interests of any person born or to be born as a result of a treatment procedure are paramount;
- human life should be preserved and protected;
- the interests of the family should be considered; and
- infertile couples should be assisted in fulfilling their desire to have children.[13]

2.8 Neither the Act nor the conditions of licence set down by the ITA provide any guidance on how these principles are to be given effect in deciding who is eligible for treatment. In the absence of any such guidance, these matters are left to the discretion of individual doctors. During our consultation process, some practitioners reported that if it becomes apparent that a child would be at risk, or there are concerns about the capacity of the parents to care for the child, the decision about whether to proceed with treatment is discussed by a team of doctors, counsellors, a lawyer and anyone else who may have an interest, on a case-by-case basis. The patient is made aware of this process. If the patient does not accept the decision of the team there are processes available for making a complaint.

10 Opinion of Peter Hanks QC, supplied by the Fertility Access Rights Lobby to the Victorian Government and the Infertility Treatment Authority, 18 August 2000.

11 Opinion of Gavan Griffith QC provided to the Infertility Treatment Authority, 4 August 2000.

12 Infertility Treatment Authority, *Conditions for Licence: Applications for Licences by Hospitals and Day Procedure Centres* (5th ed, January 2004) 22.

13 *Infertility Treatment Act 1995* (Vic) s 5.

2.9 The Act contains a number of other provisions aimed at protecting the interests of children. It establishes a regime to enable people born through the use of donated gametes to obtain information identifying their donor.[14] It requires the people undergoing treatment to give informed consent[15] and to have counselling,[16] which provides a forum to discuss the implications of the treatment procedure on people being treated, their partner if they have one and on any child to be born.

2.10 Clinics are also subject to a regulatory framework which governs clinical medical practice. All qualified medical practitioners in Victoria must be registered with the Medical Practitioners Board of Victoria. The board publishes policies and statements to clarify its expectations of the medical profession. One such statement is the Australian Medical Association's Code of Ethics, which articulates and promotes a body of ethical principles to guide doctors' conduct in their relationships with patients, colleagues and society.

2.11 As well as these general provisions, there are specific controls on assisted reproductive treatment procedures which seek to ensure that the treatment will be of the highest possible medical standard, and that patients and children born as the result of treatment are protected from health risks, including the transmission of infectious diseases. Any hospital, day procedure centre, doctor or scientist must apply to the ITA for a licence if they wish to conduct any of the following activities:

- the carrying out of ART treatment procedures or treatment procedures of a particular kind;
- the forming of an embryo outside the body of a woman;
- the storage of gametes or embryos; and
- the undertaking of approved research.[17]

2.12 Licences are granted subject to conditions.[18] Failure to comply with these conditions can result in revocation of the licence or an order for compliance. The ITA has drawn on the *NHMRC ethical guidelines on assisted reproductive technology 1996*,[19] and the Reproductive Technology Accreditation Committee (RTAC) *Code of Practice for Centres using Assisted Reproductive Technology*[20] where those provisions are consistent with the Victorian legislation. These instruments stipulate ethical guidelines for clinical practice and standards to be observed in relation to staffing and resources, counselling, information to be provided to patients (including legal, financial, psychosocial and medical implications of ART), consent, laboratory services, treatment methods, record keeping, ethics and research, quality control and accreditation. Under the ITA's conditions, all licence holders must also be accredited by the Australian Council on Healthcare Standards and the Reproductive Technology Accreditation Committee.

14 *Infertility Treatment Act 1995* (Vic) pt 7.

15 *Infertility Treatment Act 1995* (Vic) s 9.

16 *Infertility Treatment Act 1995* (Vic) s 11.

17 *Infertility Treatment Act 1995* (Vic) s 93.

18 Infertility Treatment Authority (January 2004) above n 12.

19 Note: recently updated to National Health and Medical Research Council, *Ethical guidelines on the use of assisted reproductive technology in clinical practice and research 2004* (2004).

20 Fertility Society of Australia Reproductive Technology Accreditation Committee, *Code of Practice for Centres Using Assisted Reproductive Technology* (revised ed, April 2002). Issued by the Fertility Society of Australia in 1986, and revised in 1992, 1997, 2001. The society is the peak body representing scientists, doctors, researchers, nurses, consumer groups, patients and counsellors in reproductive medicine in Australia and New Zealand. The society states that 'it demands the highest medical and nursing standards and ethical professionalism from its members and accredited centres'.

2.13 The commission regards the above measures as very important safeguards. Our recommendations assume that safeguards designed to ensure the highest standard of clinical practice will continue to apply.

PROBLEMS WITH THE PRESENT LAW

2.14 The present law is unsatisfactory in several respects. Its protection of children is inadequate, it excludes some women and children from the safeguards offered by the system, it has not kept pace with technology and it lacks consistency and clarity.

2.15 Although the principles express a theoretical commitment to the welfare and interests of children conceived through assisted reproduction, there are no provisions explaining how this should be achieved in practice. In particular, the legislation does not explain how the welfare and interests of a child to be born are to be taken into account when a person or couple presents for treatment, or what doctors or counsellors should do if they are concerned that the health and wellbeing of a prospective child is or may be at risk. Although the process adopted by clinics in difficult cases has elements of good practice, it is not formalised and there is no requirement that clinics adhere to it. Clinics are not required to seek advice from child development experts, nor is there any mechanism that would prevent a clinic from treating a person or couple where a child would clearly be at risk. As a result, it is possible for treatment to be provided to people even where it is likely that the health and wellbeing of any child to be born will be compromised. Similarly, it is possible for clinics to refuse to treat people on grounds that cannot be objectively supported. There is a lack of transparency and accountability in the way in which clinics are able to make decisions about whether a person should proceed with treatment.

2.16 The law excludes many women from the benefits and safeguards of the licensed clinic system. Women who are ineligible for treatment (because they do not have a male partner and are not clinically infertile) may self-inseminate or may go interstate or overseas for treatment. If women self-inseminate with semen from a donor who has not been screened for communicable diseases, both their health and the health of any children they conceive may be at risk. The mother of the child and the donor will not receive counselling prior to conception, which may contribute to disputes and litigation about arrangements for the ongoing parenting of the child. If the child is conceived interstate or overseas, information about donors may not be recorded and other safeguards provided by Victorian law may not apply. As a result, children may be unable to trace their genetic origins or to ascertain the identity of their genetic parent(s).

2.17 The current law is also unfair because it applies unevenly. Some women without a male partner will be eligible for treatment in Victoria and others will not. A single woman who has a genetic abnormality which could be transmitted to her child is eligible for treatment. A single woman of 45 may be eligible for treatment because her age has made her clinically infertile. By contrast, a single woman aged 35 who does not have clinical symptoms cannot be treated. These distinctions make no sense and bear no relationship to the concept of the health and wellbeing of the child.[21]

2.18 There are a wide range of views in the community about the eligibility requirements which should apply to people seeking ART treatment. But whatever view is taken it is clear that the operation of the current law produces unfair and irrational results. The Act has been criticised by the Infertility Treatment Authority as lacking a clear policy basis, particularly on issues of access.[22]

21 Other situations in which the requirement produces inconsistent results are discussed in the Consultation Paper, paras 3.19–3.24.

22 Submission 24 (Infertility Treatment Authority).

The Act has not been amended to take account of the *McBain* decision and it is not clear how the 'unlikely to become pregnant' requirement should be applied to a woman without a male partner. This makes it necessary to review the eligibility criteria for people who wish to access ART.

WHY REGULATE ASSISTED REPRODUCTIVE TECHNOLOGY?

2.19 The question of whether, and if so to what extent, the law should govern the use of ART is controversial. Some people think ART should be seen simply as a form of medical treatment which should not be regulated differently from other types of medical treatment. According to this view, ART should be regarded as a treatment decision which is to be made by the treating doctor and the patient, subject to the normal requirement that the doctor exercises a proper standard of care.[23] Moral and ethical decisions should be made by the individuals concerned and not imposed by legislation.

2.20 Others argue that ART is different from other forms of medical treatment and should be regulated because the creation of children raises complex moral and social questions. As one submission commented '[ART] raises profound questions that go to the very core of our understanding of the creation of human life'.[24] The commission agrees with the view that some external regulation of ART is necessary because it results in the creation of new life. The use of ART raises issues which go beyond the interests of particular individuals and may affect the whole community.

2.21 People have a range of views about the ethical and social implications of creating children through the use of ART. This makes it particularly important that ART is open to public scrutiny and the public has the opportunity to express their views about the conditions under which it is provided. Regulation can identify the public interests which must be considered when treatment is provided and give democratic legitimacy to decisions about ethical and moral issues.[25] Self-regulation by scientists and medical practitioners is not transparent and provides limited scope for public debate about issues in which many members of the community feel they have a stake.

2.22 Techniques of assisted reproduction are evolving rapidly. Many of the medical and social consequences of ART are not yet fully understood.[26] Regulation can deal with this uncertainty by monitoring practices, controlling use of particular technologies, and implementing protections against identifiable harms and risks. The regulatory scheme must be able to respond to technological change, to address emerging problems and to respond to shifts in social attitudes. As the experience in Victoria has shown, constant changes and discoveries have made the present legislative scheme difficult to apply.

2.23 The model set out below is intended to provide sufficient flexibility to deal with new technological developments while ensuring that the health and wellbeing of children and people seeking treatment remains the paramount objective of the proposed scheme. The recommendations about access to treatment reflect empirical evidence about protection of children and are intended to ensure that decisions about access are made fairly and consistently.

23 See, eg, Submission 174 (Professor HWG Baker).

24 Submission 166 (Christine Campbell).

25 Helen Szoke, 'The Nanny State or Responsible Government?' (2002) 9 *Journal of Law and Medicine* 470, 477.

26 There is evidence that there are potential negative physical impacts of ART treatments, IVF and ICSI in particular, on children: McNair (2004), above n 2, 31–7. It has also recently become clear that some children conceived from donated gametes have a strong wish to make contact with their genetic parents: McNair (2004), above n 2, 44–45; submissions 60 (Confidential), 91 (Karen Clarke), 234 (C Whipp).

INTERIM RECOMMENDATIONS

2.24 In our view, the current provisions fail to protect effectively the health and wellbeing of children. The recommendations in the present paper therefore propose:

- a new set of guiding principles;
- the implementation of a process for review by a panel or ethics committee when there is a concern that the health and wellbeing of a child may be at risk;
- the introduction of presumptions against treatment to deal with cases where there may be an unacceptable risk of harm to the child;
- the removal of the marital status requirement; and
- clarification of the 'unlikely to become pregnant' criterion.

2.25 We also recommend that the requirements for consent, counselling and the provision of information remain central to access to ART services, and that the regulatory authority retains its licensing and oversight functions.

2.26 Our recommendations seek to strike a balance between allowing patients and clinicians sufficient scope to determine whether ART is appropriate in a particular case, and making clear statements about community standards. We believe that the processes we recommend achieve a fair and workable balance between these two objectives, as well as providing a mechanism for protecting a prospective child from the risk of harm. Discussion of each of our interim recommendations follows.

GUIDING PRINCIPLES

2.27 The commission believes there should be clear statements within the legislation to provide a framework for decision-making—by people who wish to access treatment, their treating doctors, counsellors, ethics committees and other bodies such as our recommended review panel. Guiding principles provide these clear statements. They are also flexible enough to enable the Act to be applied in ways that are appropriate to individual cases and emerging technologies. The commission has reviewed the current guiding principles and believes they should be revised as follows:

- the health and wellbeing of children born as a result of the use of ART must be given priority in decisions concerning the use of such technologies;
- at no time should the use of reproductive technologies be for the purpose of exploiting (in trade or otherwise) either the reproductive capabilities of men and women or the resulting children;
- all children born as a result of the use of donated gametes have a right to information about their genetic parents;
- the health and wellbeing of people undergoing ART procedures must be protected at all times; and
- people seeking to undergo assisted reproductive procedures must not be discriminated against on the basis of their sexual orientation, marital status, race or religion.

HEALTH AND WELLBEING OF CHILDREN

2.28 This guiding principle reflects the predominant concern expressed by people in public forums, in submissions and at the roundtables conducted by the commission. In particular, it reflects the international standard articulated in the *Convention on the Rights of the Child* that '[in] all actions concerning children, whether undertaken by public or private social welfare institutions,

courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration'.[27] It is also consistent with the policy which applies to assisted reproduction in jurisdictions which have legislated to regulate it, such as the United Kingdom, Canada, South Australia and Western Australia.

2.29 The commission makes further recommendations concerning access to ART (see Interim Recommendations 2–10) which are intended to provide a means for giving effect to this guiding principle.

Non-exploitation of Children and Parents

2.30 This guiding principle is intended to make it clear that it is not acceptable to exploit the reproductive capabilities of men and women, or the children resulting from the use of ART in trade or otherwise. It accords with section 38O of the Infertility Treatment Act which prohibits commercial trading in human eggs, human sperm or human embryos. It is also relevant when considering section 59 of that Act which prohibits commercial surrogacy arrangements.[28] A similar provision appears in the guiding principles of Canada's *Assisted Human Reproduction Act 2003*.[29]

Children's Right to Information About their Genetic Parents

2.31 This guiding principle enshrines children's rights to information about their genetic parentage and is consistent with the *Convention on the Rights of the Child*. Further discussion of this principle and children's rights to information about their genetic parents will be presented in our next Position Paper on parentage.

Health and Wellbeing of People Undergoing ART

2.32 People wishing to utilise ART to achieve a pregnancy and subsequent birth of a child should not be exposed to unnecessary risks. This guiding principle draws attention to the nature of the treatment procedures which are provided to a patient. Women should not be exposed to treatment procedures which expose them to a higher level of risk than is necessary to achieve a pregnancy.

2.33 Clinics are required to comply with RTAC's code of practice[30] and the NHMRC ethical guidelines. This principle is consistent with these requirements and is also closely linked to the provisions in the Infertility Treatment Act that require the provision of information to, and counselling and informed consent of donors and patients alike, which serve to protect the health and wellbeing of people undergoing ART.

Non-discrimination

2.34 Australia has ratified the *International Covenant on Civil and Political Rights* and the *Convention on the Elimination of all forms of Discrimination Against Women*. Central to these treaties is the principle that people should not suffer discrimination on the basis of their sex, marital status, race, colour, political or other opinion, birth or other status. The *Convention on the Rights of the Child*, also ratified by Australia, requires parties to protect children from discrimination on the basis of the status, activities, expressed opinions, or beliefs of the children's parents (Article 2). The

27 *Convention on the Rights of the Child*, UN GAOR, 44th sess, UN Doc A/44/736 (1990) Article 3(1).

28 Note: issues surrounding payment for surrogacy arrangements will be addressed in our Position Paper Three.

29 *Assisted Human Reproduction Act 2003* (Canada) cl 2. The Canadian principles and Act reflect many of the recommendations made by the Royal Commission on New Reproductive Technologies in 1993 and prohibit a range of activities considered by many to be contrary to societal values and human dignity.

30 Fertility Society of Australia Reproductive Technology Accreditation Committee (April 2002), above n 20.

principle of non-discrimination has been implemented in federal and state anti-discrimination laws and it is consistent with the inclusive values upon which our community prides itself. On this basis, the commission recommends that the marital status requirement be removed from the Act.

2.35 The commission believes that non-discrimination is not simply an important end in itself, but that its observance in law and practice helps to shift community attitudes and to promote the health and wellbeing of all members of our society. The following comment made in a submission identifies the impact that discrimination in the area of ART can have on children:[31]

> What are the effects on children who have same-sex parents when they hear discussions about whether gay people are fit to be parents?…VicHealth talks about three key areas that are important in determining whether we're mentally healthy or not, and they are: social connectedness, freedom from discrimination and violence, and economic participation. In terms of freedom from discrimination and violence it talks about opportunity for self-determination and control of one's life as being really important in supporting our mental health. So whether it's the single mums or lesbian mums or gay couples or the yet to be born children or existing children who hear about this kind of discussion, we are potentially damaging their mental health when we're suggesting there's somehow something wrong with their family unit.

2.36 The elimination of discrimination in this area will also promote the health and wellbeing of children born to single women and people in same-sex relationships in a direct way, by allowing more women to have access to the benefits and safeguards offered through the licensed clinic system.

! INTERIM RECOMMENDATION(S)

1. The Infertility Treatment Act should set out principles to guide the administration of the Act, and the carrying out of activities regulated by the Act. These principles are:
   - the health and wellbeing of children born as a result of the use of assisted reproductive technology (ART) must be given priority in decisions concerning the use of such technologies;
   - at no time should the use of reproductive technologies be for the purpose of exploiting (in trade or otherwise) either the reproductive capabilities of men and women or the children resulting from the use of ART;
   - all children born as a result of the use of donated gametes have a right to information about their genetic parents;
   - the health and wellbeing of people undergoing ART procedures must be protected at all times;
   - people seeking to undergo assisted reproductive procedures must not be discriminated against on the basis of their sexual orientation, marital status, race or religion.

31 Submission 59 (Ian Seal).

PROTECTING THE HEALTH AND WELLBEING OF CHILDREN

REGULATORY MODELS

2.37 Submissions and consultations show that most people believe that the health and wellbeing of children born through ART should be the paramount consideration in the carrying out of ART. The commission has given considerable thought to the ways in which the law should support this objective. We considered three possible ways in which rules governing access to treatment could safeguard the health and wellbeing of children.

2.38 The first approach would be to rely solely on the principle that the health and wellbeing of children is paramount and to leave it to clinics and people seeking treatment to decide how this should be translated into practice. This approach would treat assisted reproduction in a similar way to natural conception, and the legislation would be silent on the question of who may have access to ART. Proponents of this approach argue that eligibility criteria should not apply to people accessing ART services, in the same way that the State does not interfere in the decision of other members of the community to become parents.[32] The submission made by ACCESS, a national support group for infertile people stated:

> If society believes that instituting a 'fitness to parent' code is necessary to protect the best interests of the child, then the same criteria should be applied equally to fertile people, regardless of the method of conception. To do otherwise would be to treat infertile people as a sub class in society.[33]

This approach is also based on the difficulties of predicting whether a person will be a good parent, or whether a child who has not yet been conceived will be at risk of harm. Arguably, these difficulties make it unjustifiable to restrict access to treatment on the basis of the health and wellbeing of the child, as decisions on this matter inevitably reflect personal value judgments.

2.39 This is broadly the position taken in the recently published report of the UK House of Commons Science and Technology Committee Inquiry into Human Reproductive Technologies and the Law.[34] The report is critical of regulatory approaches that place the welfare of the child at the centre of decisions about access to ART. It concludes that the current welfare of the child provision in the UK *Human Fertilisation and Embryology Act 1990* 'discriminates against the infertile and some sections of society, is impossible to implement and is of questionable practical value in protecting the interests of children born as a result of assisted reproduction'.[35]

2.40 The second approach is to treat assisted reproduction in a similar way to adoption of children, and to require people to be assessed according to a set of criteria aimed at ascertaining whether they will be good parents. People who wish to adopt children must be approved as fit and proper persons to adopt a child.[36] Applicants must undergo a medical examination and police record check, and are assessed according to a range of factors to establish their capacity to provide a secure and beneficial emotional and physical environment for the care of a child.[37] TangledWebs, a group concerned with the impact of ART on people who are conceived with donor gametes, supported use of a similar process to control access to assisted reproduction.[38] TangledWebs argues

32 Submission 192 (ACCESS).

33 Ibid.

34 House of Commons Science and Technology Committee, *Human Reproductive Technologies and the Law*, Fifth Report of Session 2004–05 (March 2005).

35 Ibid 51.

36 *Adoption Act 1984* (Vic) s 13.

37 *Adoption Regulations 1998* (Vic) regs 35, 35A.

38 Consultation, 12 November 2004. It should be noted that the principal policy goal of TangledWebs is to cease the entire practice of donor conception.

that prospective parents should be vetted by the Department of Human Services, not by the medical profession, and that the assessment process should be directed primarily to the capacity of the person to meet the specific needs of a donor-conceived child.

2.41 The third approach, which is the one preferred by the commission, is to implement a fair and transparent process that enables a clinic to investigate concerns about risks to children on a case-by-case basis, and according to identifiable and established risk factors.[39] Such a process would apply only in certain circumstances, and would acknowledge that most people who seek ART services should not be treated any differently from people who conceive without assistance.

Referral of Cases to Ethics Committees

2.42 For the reasons outlined above, the commission takes the view that some degree of external regulation of access to treatment is warranted. However, we believe it would be inappropriate to implement an adoption model for determining access to ART, because assessment in the adoption context is related to the needs of an existing, possibly vulnerable, child for whom the State is responsible. An assessment process as rigorous as that used for adoption would also be unnecessarily onerous in the context of ART. We believe that counselling already fulfils an important educative function and plays a significant role in preparing parents for the needs of donor-conceived children (this issue will be addressed in Position Paper Two).

2.43 Our consultation process indicated that clinics do encounter cases where they are unsure whether to treat a patient because of concerns that a potential child may be at risk. Some practitioners are concerned about the lack of clear processes or avenues for denying treatment to a person or couple seeking ART when there is a concern about the health and wellbeing of a potential child. For example, a person or couple who otherwise meet the current eligibility criteria may have a physical or psychiatric illness, an intellectual disability, or some other problem that raises a concern about their capacity to care for a child. While some people with these conditions may be excellent parents, in cases where a doubt arises there should be a process for decision-making which allows proper assessment of the risk to any child who may be conceived. Doctors and counsellors need a mechanism for determining whether or not to treat the person or couple which is transparent, procedurally fair and allows each case to be evaluated on its own merits.

2.44 The commission recommends a formal system be established to:

- provide guidance and support to doctors and counsellors who are unsure about whether there is any likelihood of harm to a prospective child;
- allow the clinic to seek expert advice from people with relevant disciplinary expertise in assessing risks to children, so decisions are based on factors relevant to the health and wellbeing of the child, rather than purely on medical factors or personal value judgments; and
- implement a decision-making process that is transparent, procedurally fair and consistent.

2.45 We therefore recommend that where a doctor or counsellor believes that a child may be at risk of abuse or neglect, the matter should be referred to the clinical ethics committee of the hospital that holds the licence for advice on whether treatment should be provided. We note that the UK Science and Technology Committee report does acknowledge 'there will be difficult cases but these should be resolved by recourse to clinical ethics committees'.[40]

39 See, eg, D Glasser, *Emotional Abuse and Neglect: A conceptual framework* (2002).

40 House of Commons Science and Technology Committee (March 2005), above n 34, 51.

2.46 The proposed process will ensure that decisions about access to treatment are not based on discriminatory assumptions about the parenting capacity of particular groups of people (eg people with a psychiatric condition). Where a doubt arises about the capacity of a person to care for a child, it will allow case-by-case evaluation to occur in a way which takes account of the health and wellbeing of any future child.

2.47 In proposing the use of a clinical ethics committee, the commission aims to build on a process that already exists in some hospitals and is currently being set up in others. Our proposal is consistent with the requirement in the NHMRC's ethical guidelines that clinical ethics committees be used when difficult decisions need to be made concerning whether or not to proceed with a treatment procedure. Such committees are usually made up of people who have experience and/or expertise in resolving these dilemmas or who have clinical experience in the area. However, because the primary purpose of referring the matter to the committee is to deal with a concern about a prospective child, the committee should include a child development expert, a psychologist or psychiatrist with expertise in the prediction of risk of harm to children, and a clinician with experience in ART.

2.48 We have also recommended that people wishing to undergo ART treatment should have recourse to an independent decision-making body, established under the auspices of the ITA, if they disagree with a decision which has resulted in the denial of treatment. The composition of this body is discussed below.

2.49 The commission therefore recommends the following provisions be inserted into the Infertility Treatment Act:

! INTERIM RECOMMENDATION(S)

2. If, before a woman undergoes treatment, a doctor or counsellor believes that any child that might be born as a result of a treatment procedure may be at risk of physical abuse, sexual abuse, emotional/psychological abuse, or neglect because of:

   (a) an ongoing problem concerning the physical or mental health of the person seeking treatment or that of his or her partner (if any); or

   (b) some other concern the doctor or counsellor has about the person seeking treatment or his or her partner (if any);

   the doctor or counsellor must seek advice about whether or not to proceed with a treatment procedure from a clinical ethics committee within a relevant hospital, which must include a child development expert, a psychologist or psychiatrist with expertise in the prediction of risk of harm to children and a doctor with experience in ART.

3. Where a clinical ethics committee decides that a person or couple should not be treated:

   (a) the person or couple may apply to the ITA review panel to have the decision reviewed; and

   (b) a clinic must not treat that person or couple unless the committee's decision is reviewed by the ITA review panel, and the panel decides there is no barrier to treatment or decides that subject to compliance with certain conditions there is no barrier to treatment.

UNACCEPTABLE RISK OF HARM TO THE CHILD

2.50 In rare cases, a person seeking treatment or their partner may have previously behaved in a way which suggests there may be an unacceptable risk of harm to any child born. For example, a person or their partner may have had a child previously removed from their care by child welfare authorities, or may have committed serious sexual offences or offences involving serious violence. If this occurred many years ago, or the person's behaviour was caused by the circumstances which existed at that time, there may be no risk it will be repeated. For example, people who are convicted of offences involving violence when they were young may be excellent parents in later life.

2.51 However, if the behaviour occurred recently, or if there are other factors which suggest an unacceptable risk to the health and wellbeing of the child, the commission's view is that the person should not be assisted to conceive. The present law does not provide any mechanism for determining whether there is an unacceptable risk of harm. Nor does it provide any process for deciding whether a person should be treated if a doctor or counsellor becomes aware of these issues.

2.52 Some may object that no restrictions of this kind apply to people who become parents by natural conception, and that the same approach should apply to assisted reproduction. If the child is at risk of harm after they are born an application can be made for a child protection order.

2.53 The commission disagrees with this view. Because assisted reproduction is regulated and supported by the State, we believe that the State has a responsibility to identify cases where there is an unacceptable risk of harm. There should be a process for decision-making where the past behaviour of prospective parents suggests there may be a problem. This process should provide a transparent and fair way of making decisions about treatment. There is a substantial body of research on the parental factors which place children at risk of harm.[41] This information should be taken into account when assessing whether a person is eligible for treatment. This will require clinics to put in place procedures to identify whether any of the proposed risk factors are present.

➔ The commission would welcome advice about the best way of doing this.

2.54 Interim Recommendation 4 creates a presumption against treatment where the woman seeking treatment and/or her partner has:

- had charges proven against them for a serious sexual offence;[42]
- been declared a serious violent offender; or[43]
- had a child protection order made in relation to one or more children in their care.[44]

41 See, eg, Victorian Department of Human Services, *An Integrated Strategy for Child Protection and Placement Services* (September 2002); The Allen Consulting Group, *Protecting Children: The Child Protection Outcomes Project: Final Report for the Victorian Department of Human Services* (September 2003); Magistrate Peter Power, *5. Family Division—Child Protection*, Children's Court of Victoria, <www.childrenscourt.vic.gov.au> at 20 August 2004, under Research Materials.

42 Pursuant to ss 38, 39, 40, 44(1), 44(2), 45, 47, 47a of the *Crimes Act 1958* (Vic) or any equivalent offence(s) against a law of the Commonwealth or any place outside Victoria (whether or not in Australia).

43 Pursuant to s 6B(2) of the *Sentencing Act 1991* (Vic), 'a serious violent offender means an offender (other than a young offender) who has been convicted of a serious violent offence for which he or she has been sentenced to a term of imprisonment or detention in a youth training centre'. Serious violent offence is defined in sch 1, cl 3 of that Act and includes murder and certain offences under the *Crimes Act 1958* (Vic) including: causing serious injury intentionally; intentionally causing a very serious disease; threatening to kill; intentionally causing grievous bodily harm or shooting, etc with intention to do grievous bodily harm or to resist or prevent arrest; making demand with threat to kill or injure or endanger life; and/or conspiracy, incitement or attempt to commit any of the above. Note also that convictions for offences against a law of the Commonwealth or any place outside of Victoria (whether or not in Australia) that are substantially similar to those named should also be considered.

44 Pursuant to s 85(1)(a) of the *Children and Young Persons Act 1989* (Vic).

2.55 The presumption against treatment of people in these categories will ensure that careful investigation is undertaken before treatment is provided. We recommend that where this presumption applies to a person or partner, treatment should be refused unless an ITA review panel finds there is no unacceptable risk to a child who is conceived through assisted reproduction.[45] The review process will ensure that a person whose circumstances have changed materially since the offending conduct will not be unfairly excluded from treatment.

2.56 The presumption relating to people who have committed serious sexual offences is based on research which shows that some people convicted of serious sexual offences are subsequently convicted of further sexual offences, and a small proportion of sexual offenders are convicted of offences against both adults and children.[46] According to this view, the presumption against treatment of anyone who has been convicted of a serious sexual offence is justified because it takes a cautionary approach which minimises the risk of harm to a child conceived through assisted reproduction. Some commissioners thought this presumption was too broad and should be confined to people who are convicted of offences against children, because the risk that a person convicted of an offence against an adult will offend against children as well is too low to justify the broader presumption. Even if the presumption were confined to child sex offenders, this would not prevent a doctor or counsellor who had concerns about the wellbeing of a child in a particular case referring the matter to a clinical ethics committee.

2.57 The presumption against people who have been declared serious violent offenders also extends beyond people who have been convicted of violence against children. Again, there is research indicating that sexual and other forms of violence often coexist in families[47] and that children brought up in a household with a violent parent are at risk of emotional and psychological harm, even if they were not assaulted themselves.[48]

2.58 During our consultation process we were told that clinics not infrequently encounter cases where a woman who presents for treatment has already had one or more children removed from her care. Child protection orders are made by the Children's Court under the *Children and Young Persons Act 1989* (Vic) after detailed consideration of the needs of the child, and having regard to the need to ensure that intervention into family life should be to the minimum extent that is necessary to secure the protection of the child.[49] The commission views the making of a child protection order as a serious matter that may indicate that there is an unacceptable risk of harm to a child conceived as a result of ART. We therefore recommend the introduction of a presumption

45 A similar review panel operates in South Australia: see *Reproductive Technology (Code of Ethical Clinical Practice) Regulations 1995* (SA), sch, pt 3.

46 G Abel and JL Rouleau, 'The Nature and Extent of Sexual Assault', in WL Marshall, DR Laws, and HE Barbaree (eds), *Handbook of Sexual Assault: Issues, Theories, and Treatment of the Offender* (1990); S Ahlmeyer, K English & D Simons, 'The impact of polygraphy on admissions of crossover offending behavior in adult sexual offenders' (Poster session presented at the 18th annual ATSA Research and Treatment Conference, Florida, September 1999), <www.doc.state.co.us/Sex%20Offenders/pdfs/crsposter.pdf> at 22 March 2005. A study of 174 male sex offenders found that 'sexual reoffending was largely homologous, with 62% of rapists reoffending against adults only and 71% of child molesters repeating their offences against children only. While the results show a degree of specialisation, a sizeable proportion of each group nevertheless switched between child and adult victims': Denise Lievore, *Recidivism of Sexual Assault Offenders: Rates, Risk Factors and Treatment Efficacy*: a report prepared for the Office of the Status of Women by the Australian Institute of Criminology in May 2004.

47 Marie Hume, 'The Relationship Between Child Sexual Abuse, Domestic Violence and Separating Families' (Paper presented at the Child Sexual Abuse: Justice Response or Alternative Resolution Conference convened by the Australian Institute of Criminology, Adelaide, 1–2 May 2003).

48 Department of Human Services [Victoria], *Domestic Violence Policy Advice and Guidelines for Protective Workers* (1994). The Family Court has relied on this research, see *Patsalou and Patsalou* (1995) 18 Fam LR 426, 428–9; *In the Marriage of JG and BG* (1994) 18 Fam LR 255, 260.

49 *Children and Young Persons Act 1989* (Vic) ss 84, 86, 87.

against treatment of people who have had a protection order made in respect of one or more children in their care. Again, the presumption is reviewable, ensuring that people whose circumstances have changed since the making of the order are not excluded unfairly.

2.59 Interim Recommendation 4 emphasises the priority to be given to the health and wellbeing of children, but recognises that decisions to exclude a person from treatment should be subject to proper review and consideration. Because these are processes where the prospective parent may be at high risk of harming the child, the process we recommend confers responsibility for decision-making with the regulatory authority rather than a hospital clinical ethics committee.

! INTERIM RECOMMENDATION(S)

4. A licensee should not treat a person without the approval of the ITA review panel where the person seeking treatment and/or his/her spouse or partner (if any):

   (a) has had charges proven against them in Victoria or elsewhere for a serious sexual offence; or

   (b) has been declared a serious violent offender under the *Crimes Act 1958* (Vic) or any equivalent law of the Commonwealth or any place outside Victoria (whether or not in Australia); or

   (c) has had a child protection order (but not an interim protection order) made in respect of one or more children in their care under a child welfare law of Victoria or any equivalent law of the Commonwealth or any place outside Victoria (whether or not in Australia).

5. The Infertility Treatment Authority should establish a review panel to decide whether or not a person is eligible for treatment where:

   (a) one of the presumptions against treatment in Interim Recommendation 4 applies to a person or his/her partner (if any); or

   (b) a person or couple has applied for review of a clinical ethics committee recommendation that they not be treated because of a concern about the health and wellbeing of any child that might be born as a result of a treatment procedure.

6. The purpose of the ITA review panel will be to consider whether or not a person (or couple) who:

   (a) meets the criteria in recommendation 4 (a, b or c); or

   (b) has been refused treatment by a clinical ethics committee pursuant to recommendation 2 and has made an appeal to the panel,

   may or may not proceed with treatment.

7. The review panel must give the person or couple who may be denied treatment the opportunity to explain why they should be allowed to proceed with treatment.

8. If the review panel decides that a person should not be treated, a clinic must not treat that person or couple.

! INTERIM RECOMMENDATION(S)

9. If the review panel decides that a person should not be treated unless he/she (or partner) meet certain conditions, a clinic must not treat that person (or couple) until those conditions have been met.

10. Where the review panel decides there is no barrier to treatment, or there is no barrier to treatment once certain conditions have been met, the decision of the panel must be conveyed to the clinic and to the person (or couple) seeking treatment. In such circumstances a clinic will not be compelled to treat the person (or couple).

2.60 The commission has developed a tentative model for the composition of the review panel and the factors that should be taken into account when a case comes before it.

➔ We seek your views and comments about these suggestions.

2.61 We suggest the membership of the review panel comprise a:

- child development expert;
- person with expertise in the clinical medical practice of ART;
- member of the Infertility Treatment Authority;
- person with expertise in psychology or psychiatry;
- person with expertise in a relevant area of law;
- person with knowledge of the ethics of clinical medical practice;
- person with understanding of the concerns of people with ongoing disability or illness; and
- layperson sitting in the capacity of a community representative.

➔ We also seek comments about whether the legislation should impose requirements about the proportion of men and women on the panel, as is the case for the South Australian Council on Reproductive Technology.[50]

2.62 When considering cases that come before it, the review panel should consider any relevant research and/or information available, or consult with a person or persons with expertise in a field that relates to the particular concern(s) being assessed. For example, where a person has been convicted of a sexual offence, the review panel could consider information concerning the risk assessment of sexual offenders and the individual likelihood of re-offending.[51]

➔ The commission is interested in hearing from experts about the factors which influence recidivism rates among sexual and violent offenders.

50 *Reproductive Technology (Clinical Practices) Act 1988* (SA) s 5(3).

51 For more information on risk assessment of sexual offenders and predictors of recidivism see Steven Wright, *Managing unacceptable risk: the risk assessment and management of child sex offenders* (Paper presented at the Child Sexual Abuse: Justice Response or Alternative Resolution Conference, convened by the Australian Institute of Criminology, Adelaide, 1–2 May 2003).

THE MARRIAGE REQUIREMENT

2.63 At present, the Infertility Treatment Act requires that a woman be married or in a de facto relationship with a man in order to undergo treatment. As we have already discussed, this requirement no longer applies as a result of the decision in *McBain.*

2.64 Although the marital status requirement is no longer legally valid, the commission received a significant number of submissions from people opposed to the use of ART by anyone other than married couples. They argued that it is not in the best interests of children to be born to parents who are not in a married heterosexual relationship. For example, these submissions included statements that 'ART procedures and IVF should be limited to married heterosexual couples',[52] 'the bests (sic) interests of a child dictate that a mother and father unit, preferably cemented by marriage, is the ideal arrangement',[53] and 'restriction of IVF to married couples is the best way to give children born through IVF procedures the best chance of achieving [adequate and proper parenting]'.[54]

2.65 The commission has reviewed the social research on outcomes for children born to and raised in a diversity of family types. This research does not support the view that the marital status requirement should be retained to safeguard the health and welfare of children.

2.66 There is a growing body of methodologically rigorous studies that demonstrate that it is not family structure that determines emotional, social and psychological outcomes for children, but rather the quality of family processes and relationships. There is sound evidence that children born into families with non-biological parents or same-sex parents do at least as well as other children. Summaries of recent Australian and international empirical studies and a consideration of their methodologies are set out in the occasional paper by Ruth McNair.[55] We have also examined a number of other studies, including those quoted in submissions, which oppose removal of the marital status requirement. McNair's paper also suggests that laws reinforcing social attitudes which stigmatise non-nuclear families may have a negative effect on children born to single women or women in lesbian relationships.

2.67 A person's marital status or sexuality are not factors that are considered by child welfare authorities or experts to be predictors of harm to children.[56] Moreover, our research has shown that the marital status requirement, which excludes a significant number of women from treatment, actually operates to increase the potential for children to be exposed to unacceptable health risks, and to be deprived of the capacity to obtain information about their genetic parents.

2.68 The commission has concluded that the marital status requirement is not only inconsistent with the principle of non-discrimination, but it also bears no relationship to the health and wellbeing of children, which must be the paramount concern of the law governing ART. It is also unsustainable as a result of the decision in *McBain.*

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52 Submission 127 (Salt Shakers).

53 Submission 125 (Australian Family Association).

54 Submission 81 (Suryan Chandrasegaran).

55 McNair (2004), above n 2.

56 Marital status and sexuality are not included in the list of parental characteristics tracked by the DHS, nor are they grounds for initiating child protection proceedings. See Department of Human Services [Victoria], *An Integrated Strategy for Child Protection and Placement Services* (September 2002); Allen Consulting Group, *Protecting Children: The Child Protection Outcomes Project: Final Report for the Victorian Department of Human Services* (September 2003); Magistrate Peter Power, *5. Family Division—Child Protection*, Children's Court of Victoria, <www.childrenscourt.vic.gov.au> at 20 August 2004, under Research Materials.

2.69 The commission therefore recommends that the Act be amended to make it clear that women requiring assistance to become pregnant should not be excluded on the grounds that they have no partner, or have a partner of the same sex. This would bring Victorian law into line with New South Wales, Queensland, Tasmania, Western Australia and the ACT.

! INTERIM RECOMMENDATION(S)

11. The requirement that a woman who undergoes a treatment procedure be 'married and living with her husband on a genuine domestic basis', or 'living with a man in a de facto relationship' should be removed.

12. The Act should otherwise be amended to recognise that some people to whom the Act applies will be married or in a heterosexual de facto relationship, some will be in a same-sex relationship and others will not have a partner.

13. 'Partner' should be defined in section 3 to include a spouse or 'domestic partner'.[57]

THE INFERTILITY REQUIREMENT

2.70 Section 8(1) of the Infertility Treatment Act—which requires a woman to be 'unlikely to become pregnant'—has been interpreted inconsistently for married women, women in heterosexual de facto relationships, and women without legally recognised male partners (whether they are single, in same-sex relationships or in a relationship with a man that is not considered a de facto relationship). The stricter interpretation that is applied to women without legally recognised male partners prevents treatment in Victoria, unless the woman seeking treatment is clinically infertile.

2.71 Inconsistent application of the law in this area is unacceptable. It has no rational basis, is discriminatory, exposes women and children to health risks, and deprives some children of statutory protections afforded to other donor-conceived children. It also places clinics in an invidious position. If the different application of the 'unlikely to become pregnant' requirement was tested in court, it is likely that a clinic which refused to treat a single woman would be found to be in breach of sex discrimination legislation. At the same time, the licensing conditions imposed on clinics require them to discriminate in this way.

2.72 This raises the question of whether there should be unrestricted access for anyone wanting treatment, for whatever reason, or whether there should be some limitation on access that applies consistently to all women seeking treatment.

2.73 We received a number of submissions stating that access to ART should be subject to some constraints. It was argued that an infertility requirement is an appropriate way of setting a threshold for access to limited health resources and a means of encouraging people to explore other options,[58] and that circumventing infertility was the original purpose of ART and the Act and should remain so.[59] Others argued that an infertility requirement might be useful for access to more invasive procedures such as IVF/ICSI, as opposed to donor insemination.[60] Submissions which supported an infertility requirement often said that it should apply to all women equally. As one submission

57 'Domestic partner' of a person should be defined as an adult person to whom the person is not married but with whom the person is living as a couple on a genuine domestic basis (irrespective of gender).

58 Submission 182 (Anonymous).

59 Submission 61 (Neil Ryan).

60 Submission 143 (Bouverie Centre, La Trobe University).

commented 'the level of infertility which is required before ART services are provided should be uniform for all women regardless of their marital status or sexual orientation'.[61]

2.74 The main argument for some kind of infertility requirement was that some ART treatments create health risks for the child and the mother. The fact that some donor-conceived children experience psychological problems was also seen as a reason for limiting access. One donor-conceived person who believes that donor conception involves the unacceptable separation of a child from his or her genetic parent said in a submission:

> Whilst there may be an equal opportunity discrepancy between the applications of 'unlikely to conceive' and 'clinically infertile', these two realities have many different implications for the child/adult. Donor conception already creates a subset generation of people with different rights to those conceived 'the old fashioned way'. Will not expanding the accessibility to donated gametes have more serious and far-reaching consequences?[62]

2.75 On the other hand, some submissions argued that the infertility requirement should be removed. For example, some people argued that an infertility requirement unnecessarily medicalises ART, which has become more than a medical service, and donor insemination in particular.[63] It was also argued that an infertility requirement is discriminatory against lesbian women, because ART services are currently available to fertile women with infertile husbands and these women are not expected to have sex with another man.[64]

2.76 The commission has concluded that it is appropriate to limit access to ART because of its potential effects on the health and wellbeing of women and children. We do not propose that clinical infertility should be required as this would mean that some women who are married or in de facto relationships who are currently eligible for treatment would be excluded. It would also exclude women without male partners. Instead, the commission recommends that a woman be eligible for treatment if she is unlikely to become pregnant, and that her inability to become pregnant (or to carry a pregnancy or give birth to a child, or likelihood of transmitting a genetic abnormality or disease) be assessed on the basis of the circumstances in which she finds herself (be it single, married, in a same-sex relationship, psychologically averse to having sexual intercourse with a man, or otherwise).

2.77 There will be some situations in which treatment may be desirable for a woman who does not satisfy the requirement of being unlikely to become pregnant, or likely to transmit a genetic abnormality or disease. An example is the case where a woman who has a living child, who is suffering from a genetic condition or other disorder, wishes to conceive a child who is a genetic match for the living child. The child who is conceived through assisted reproduction may be able to donate bone marrow or some other tissue which could save the life of the other child. The conception of a child to act as a 'saviour sibling' is controversial and the particular circumstances of the case would need to be carefully considered to ensure protection of the health and welfare of that child. As technology develops there may be other situations where treatment may be desirable, but the woman does not meet the statutory criteria. We recommend that the ITA review panel proposed above should be able to approve treatment for a woman who cannot satisfy the requirement of inability to become pregnant. The review panel will have the capacity to address the medical, social and ethical issues which are relevant to the particular case. The provision will also ensure the legislation is sufficiently flexible to respond to new problems.

61 Submission 156 (Law Institute of Victoria).

62 Submission 60 (Confidential).

63 Submission 88 (Deborah Dempsey).

64 Submissions 82 (Anonymous), 171 (Fertility Access Rights).

The commission therefore recommends the following:

! INTERIM RECOMMENDATION(S)

14. Before a woman undergoes a treatment procedure[65] a doctor must be satisfied that the woman is:

    (a) in the circumstances in which she finds herself, unlikely to become pregnant other than by a treatment procedure; or

    (b) unlikely to be able to carry a pregnancy or give birth to a child without a treatment procedure; or

    (c) likely to transmit a genetic abnormality or a disease to a person born as a result of a pregnancy conceived other than by a treatment procedure (including where the woman's partner is the carrier of the genetic abnormality or disease which is likely to be passed on to a child conceived other than by a treatment procedure).

    For the purpose of (a), the doctor may be satisfied that a woman is unlikely to become pregnant other than by a treatment procedure if she does not have a male partner.

    For the purpose of (c), the doctor must seek advice from another doctor who has specialist qualifications in human genetics or infectious diseases.

15. Where a woman does not satisfy these requirements she may apply to the ITA review panel, which may authorise the clinic to provide the treatment procedure. In deciding such applications the review panel should have regard to the guiding principles of the Act.

ETHICAL DILEMMAS

2.78 Several submissions raised ethical concerns about the potential for ART to be used for purposes other than to achieve a pregnancy. These concerns were predominantly related to the practice of pre-implantation genetic diagnosis (PGD). One submission argued that PGD amounts to eugenics and has negative implications for those people in the community who live with a disability.[66] PGD is used by parents who wish to avoid passing a serious genetic disease to their children. Embryos are examined to determine if they are affected by a particular disease or disorder and only unaffected embryos will be transferred to the mother. There is a tension between the capacity of PGD to assist in the avoidance of specific genetic disorders and its potential to address a broader range of parental objectives. A number of ethical considerations arise in the broader application of a service such as PGD. As technology develops there are likely to be more treatments and services available to people which also raise ethical considerations. The commission believes it is important for these developments to be subject to public scrutiny and discussion.

2.79 The ITA has already established an ethics panel but the existence, function and composition of this panel is not specified in the legislation. The commission recommends that the Act provide for an ITA ethics committee which may consider and advise on ethical concerns raised about a new development in treatment or a new use of treatment.

65 Note that a treatment procedure includes both artificial insemination of a woman with sperm from a man who is not the partner of the woman, and a fertilisation procedure.

66 Submission 166 (Christine Campbell).

! INTERIM RECOMMENDATION(S)

16. Where an approved doctor, scientist, counsellor or the Infertility Treatment Authority considers that a new development in treatment or a new use of treatment raises ethical concerns, the matter must be referred to the ITA ethics committee for advice. In reaching a decision, the ITA ethics committee must consult with clinics and may choose to undertake further public consultation.

2.80 The commission has developed a tentative model for the composition of the ITA ethics committee.

➔ We seek your views and comments about these suggestions.

2.81 We suggest that the membership of the review panel comprise:

- the Chairperson of the ITA;
- a person with knowledge of the ethics of clinical practice;
- a person who has expertise in law;
- a person who has experience in public health;
- a person who has experience in social research;
- a person who has experience in the clinical medical practice of assisted reproduction;
- a person who has experience in nursing or allied health practices;
- a person with understanding of health consumer issues;
- a person with understanding of the concerns of people with a disability;
- a person with expertise in philosophy and applied ethics; and
- a layperson sitting in the capacity of a community representative.

2.82 The commission does not believe that the ethics committee should necessarily include a representative of a religious organisation, though it is likely that some members of the committee will hold religious beliefs. The diversity of religions in Australian society, and the broad range of opinions about ART which they hold, would make it difficult to identify which religion in particular should be represented.

Consent, Counselling and Information

2.83 There was general consensus in submissions, consultations and research conducted by the commission on the importance of the consent, counselling and information provisions of the Act. These provisions all contribute to the process of ensuring that people make decisions that are right for them, and for any child that may be born as the result of treatment. As we have identified principles that should guide and inform all aspects of ART, we believe those principles should be incorporated into the pre-treatment processes. It would also be necessary for prospective patients to be given information about the processes and mechanisms established to protect the interests of children, their right to have decisions reviewed, and their right to be heard by the ITA review panel.

Consultation

2.84 The commission seeks your views and comments on the processes recommended in this part of the Position Paper.

➔ We would be particularly interested in your thoughts on what steps clinics should take to find out whether a prospective patient falls into one of the categories where there is a presumption against treatment.

Chapter 3
Self-insemination

INTRODUCTION

3.1 Artificial insemination is a procedure that involves the transferring of sperm into the vagina, cervical canal or uterus of a woman. It may be used to assist a woman with a male partner to conceive where the woman has failed to become pregnant, either because the man is infertile or for some other reason. It may also be used to enable a woman who does not have a male partner to become pregnant. Self-insemination is artificial insemination done by a woman to herself. This Chapter considers whether clinics should be able to provide services to assist women who wish to self-inseminate, and whether self-insemination which is done without such clinical support should attract criminal penalties.

PRESENT LAW AND ITS CONSEQUENCES

3.2 At present, women who do not have male partners are not eligible for treatment under the Infertility Treatment Act, unless they are clinically infertile.[67] For this reason, they may make private arrangements with a male friend or acquaintance to donate sperm so they can self-inseminate. These arrangements may take place without counselling of the woman or the donor and without medical or legal advice. While this may sometimes be done without adverse effects, it also has the potential to create serious health and other problems for the woman and any child who is conceived as a result. These may include:

- harmful effects on the physical health of the mother and her child as the result of self-insemination by a donor who has not been screened for communicable diseases;
- failure to record information about the identity of the donor which may make it difficult for the child to obtain access to this information in the future and cause the child psychological harm;[68]
- the potential for conflict between the donor, the birth mother and any partner she may have about involvement in the life of the child—which might have been prevented by counselling; and
- the possibility the woman and her partner may be committing a criminal offence by self-inseminating, which may make them less willing to seek advice about the legal and other effects of conception.

3.3 Clinics have attempted to address these concerns within the restrictions imposed by the present law, by allowing single women and women in same-sex relationships to store sperm from a

67 See paras 2.5–2.6.

68 However, women who self-inseminate often tell the child about the circumstances of conception and/or the identity of the donor. This is common in the gay and lesbian community where known donors are often used. It may be less common for heterosexual couples who rely on anonymous donors.

known donor and use it to inseminate themselves outside the clinic.[69] Licensed clinics do this under interim licensing conditions issued by the ITA which require clinics to satisfy similar requirements to those which apply when a person is treated in a clinic.[70]

3.4 These include:

- screening and testing of donors for communicable diseases and quarantining of sperm prior to its use;
- provision of counselling and information to:
  - the man who provides the sperm and his spouse or domestic partner (if any); and
  - the woman wishing to utilise the sperm and her spouse or domestic partner (if any) pursuant to the requirements of the Infertility Treatment Act;[71]
- consent of the donor and his spouse to the storage of sperm and recording of any conditions the donor wishes to place on length of storage; and
- obtaining the donor's consent to lodge his details with the clinic so that the ITA can record them if a child is born.

3.5 In addition, the release of the sperm is conditional on the woman signing an agreement that she will use the sperm in accordance with the donor's consent and that she will notify any birth to the ITA so that the details can be entered on the Central Register.

SHOULD CLINICS PROVIDE SELF-INSEMINATION SERVICES?

3.6 Conditions imposed on clinics with storage facilities provide some protection to women and to children conceived through self-insemination by sperm from a known donor, and to donors and their spouses. If the law is changed to give single women and women in same-sex relationships access to artificial insemination, these safeguards will apply to all those involved in treatment by a clinic or approved doctor. In this situation, there is less need to allow clinics to store sperm from known donors and provide it to women so they can inseminate themselves outside a medical environment.

3.7 Some may argue that self-insemination should not be treated as a medical procedure and women should be free to self-inseminate if they wish to preserve their privacy. Allowing clinics to store screened sperm and provide it to women who want to inseminate themselves could minimise potential harm to these women, their children and to donors by allowing storage subject to conditions, as is presently the case.

3.8 However, there are also strong arguments against encouraging women to take sperm away from a clinic. We have recommended that access to treatment procedures be expanded to include women who do not have male partners. If access to treatment in clinics is made available to single women and women in same-sex relationships, it is likely that the incidence of self-insemination will decrease. The commission's view is that in these circumstances, the law should discourage self-insemination. Once the semen is removed from the premises no controls exist on its use. For example, there is no guarantee the semen will be used to inseminate the woman who has obtained it. The semen could be mixed with semen from another donor who has not been screened. Although the women must agree to provide birth details to the ITA, there is no guarantee this will

69 See *Infertility Treatment Act 1995* (Vic) s 106, 110. The ITA obtained legal advice that allowing storage subject to conditions was not contrary to the Act. Storage for this purpose is subject to conditions imposed by the ITA.

70 See Infertility Treatment Authority, *Storage of sperm by women using known donors for the purposes of self-insemination Interim Conditions imposed under s 106, Infertility Treatment Act 1995* (November 2004).

71 *Infertility Treatment Act 1995* (Vic) ss 18, 19, 103, pt 7.

occur. If the ITA is not advised of the birth, the child may be denied access to information about paternity. For this reason, the commission believes that the practice of clinics providing semen to women so they can inseminate themselves should be discontinued.

! INTERIM RECOMMENDATION(S)

17. If access to artificial insemination is extended to single women and women in same-sex relationships, clinics should no longer store sperm from screened donors for the purposes of providing it to women to self-inseminate.

CRIMINAL LIABILITY

3.9 Section 7 of the Infertility Treatment Act states:

> (1) A person may only carry out artificial insemination of a woman using sperm from a man who is not the husband of the woman at a place other than a hospital or centre licensed…for the carrying out of donor insemination if he or she—
>
> (a) is a doctor who is approved…to carry out donor insemination; and
> (b) is satisfied that the requirements [concerning consent, information and counselling] have been met.

Breach of section 7 attracts a criminal penalty of up to four years imprisonment and/or a fine of 480 penalty units (currently equal to $52,800).

3.10 Doubts have arisen about whether this provision applies to women who inseminate themselves. The reference to 'another person' indicates the section was not intended to apply criminal penalties to those who self-inseminate, but the point is not beyond doubt.[72] It is also likely that the partner of a woman who assists her to inseminate is guilty of a criminal offence under the section.

3.11 Concerns about the effects of potential criminal liability were expressed in some submissions.[73] One submission noted:

> Would my partner or I be guilty of an offence by virtue of s.7 of the *Infertility Treatment Act 1995* if we [use self-insemination]? We both have jobs where police checks and evidence of good character are required. Could the simple act of attempting to fall pregnant compromise our future employment? Are we willing to take a risk, trust in the fact that such a prosecution has not been initiated before? We are in the position of having to commit an offence to become pregnant. This places us in an extraordinary conflict, as a woman who wants to parent[,] self-insemination is a possible avenue to achieve this.[74]

3.12 In addition other submissions revealed that some women:

- fear seeking appropriate health or legal advice because of the assumption that self-insemination is illegal and subject to penalties; and

72 The Infertility Treatment Authority has advised clinics and approved doctors that self-insemination is not regulated by the Infertility Treatment Act.

73 Submissions 82 (Anonymous), 89 (Ministerial Advisory Committee on Gay and Lesbian Health), 112 (A&H), 143 (Bouverie Centre, La Trobe University), 149 (Prospective Lesbian Parents), 171 (Fertility Access Rights), 179 (Mary Danckert), 198 (Dr Elizabeth Short).

74 Submission 82 (Anonymous).

- are unable to obtain information from doctors who also assume it is illegal to provide information that will assist women to self-inseminate.[75]

SHOULD THE LAW CRIMINALISE THOSE WHO SELF-INSEMINATE AND THEIR PARTNERS?

3.13 Section 7 is necessary to ensure that the safeguards provided by the Infertility Treatment Act apply, by providing that only licensed clinics and approved doctors can carry out artificial insemination. This is achieved by penalising health professionals or others who do not satisfy the requirements in the Act. Should criminal penalties also apply to those who self-inseminate or their partners?

3.14 It is in the best interests of women and their children to be inseminated in a clinic or by an approved doctor. While women should be encouraged to use a clinic or a doctor because of the associated safeguards, the commission does not believe it is necessary or desirable to criminalise women who self-inseminate or the partners who help them. Expansion of eligibility requirements provides a strong incentive to seek treatment under the Act and makes it likely that fewer single women or women in same-sex relationships will self-inseminate.

3.15 Criminal sanctions may themselves have adverse effects on the health of women or children. The Australian Infertility Support Group commented that:

> We believe that criminal implications of self-insemination only serve to place a woman accessing unscreened sperm for the purpose of self-insemination at significant health risk. If there were fewer impediments to women accessing AI in a normal clinic environment, regardless of the woman's sexual orientation, greater scope to protect her & any prospective child/ren would exist…Because not all locations are ideal, implements are not always sterile; self-insemination introduces a number of variables, which could endanger the woman. All clinics have a number of qualified staff members of both sex [sic], if the woman has issue with one or other sex, it is possible to offer her a suitable clinician to perform her procedure in the most ideal conditions with properly screened gametes. Whilst we believe that self-insemination should be discouraged we do not believe that their [sic] needs to be legislation or criminal consequences applied to the act.[76]

3.16 Similarly, Victoria Legal Aid opposed imposition of penalties involving a custodial sentence for self-insemination.[77]

3.17 If a woman and her partner are determined to carry out insemination outside a clinic environment, criminal penalties are unlikely to deter them, as detection of the offence and prosecution is extremely unlikely. Penalties may also discourage people from seeking advice, which could help minimise harm to the woman and any child who is born. For these reasons, the commission recommends that criminal penalties should not apply to women who self-inseminate or partners who assist them, though every effort should be made to encourage women to seek treatment in a licensed clinic or by an approved doctor.

75 Submissions 88 (Deborah Dempsey), 89 (Ministerial Advisory Committee on Gay and Lesbian Health), 133 (Women's Health West), 143 (Bouverie Centre, La Trobe University), 149 (Prospective Lesbian Parents), 171 (Fertility Access Rights), 179 (Mary Danckert).

76 Submission 132 (Australian Infertility Support Group).

77 Submission 231 (Victoria Legal Aid).

! INTERIM RECOMMENDATION(S)

18. Section 7(1) of the Act should be amended to read:

1) A person may only carry out artificial insemination of another woman using sperm from a man who is not the husband of the woman at a place other than a hospital or centre licensed for the carrying out of donor insemination if he or she:

a) is a doctor approved under Part 8 to carry out donor insemination; and

b) is satisfied that the requirements of Divisions 2, 3 and 4 and section 36 (ie the counselling, consent and information provisions of the Act) have been met.

2) It is not an offence for a woman or her spouse or domestic partner (if any) to carry out artificial insemination of that woman.

Chapter 4
Directed Donations

INTRODUCTION

4.1 People who donate gametes and embryos to an unknown recipient may wish to specify the characteristics of the person or couple who will benefit from the donation. For example, they may wish to direct that the gametes are only made available to a person of a particular race or who is in a particular kind of family. This Chapter considers whether or not directed donations should be permitted. It also considers whether changes should be made to provisions governing eligibility to donate gametes.

PRESENT LAW

4.2 As noted in paragraphs 2.11–2.12, all Victorian clinics must be licensed by the ITA.[78] The conditions of licence say:

> There may be donors who wish to exclude their sperm from use by single women or lesbian women, or embryo donors who wish to specify the type of person to whom their donation can be made. Donors should be advised that they may not specify who may use their gametes or embryos.[79]

The ITA obtained an opinion from the Victorian Government Solicitor on whether a clinic may or may not act on a donor's specification of a particular class of persons to which his or her donated gamete should be supplied.[80] The Government Solicitor's opinion was that a clinic may not pay regard to such a specification on the part of the donor. Treating potential recipients less favourably by decreasing the available pool of donor gametes on the basis of race, sexual preference, marital status and age would be likely to be in breach of the *Equal Opportunity Act 1995* (Vic), and on two of these bases it would also be in breach of Commonwealth Acts—the *Racial Discrimination Act 1975* (Cth) (if it was on the basis of race) and the *Sex Discrimination Act 1984* (Cth) (if on the basis of marital status).

4.3 Clinics are also required by the ITA to have RTAC accreditation. RTAC requires clinics to follow its code of practice, which also supports the ban on discrimination. The RTAC code of practice states that donors in Australia should not 'be given the opportunity to direct or limit the

78 *Infertility Treatment Act 1995* (Vic) s 6, pt 8.

79 Infertility Treatment Authority (January 2004), above n 12, para 2.2.6.

80 Opinion by Victorian Government Solicitor, 8 August 2000, supplied to the Victorian Law Reform Commission by the Infertility Treatment Authority. The Victorian Government Solicitor noted that, in coming to this conclusion, his advice differed from the advice given to reproductive medicine units by the South Australian Council on Reproductive Technology. That advice was that, provided there were always donor gametes available for single people and treatment was not totally refused, donors could place conditions on donations and clinics could act on those conditions.

use of their material to certain categories of recipients, for example heterosexual couples, or specific cultural and religious groups'.[81]

4.4 The NHMRC ethical guidelines, however, recommend that clinics should not use gametes in a way which is contrary to the wishes of the donor[82] unless state law indicates otherwise.

4.5 Melbourne clinics do not appear to have a consistent approach about directed donations. Counsellors at one clinic do not ask donors to express any preference about who should receive their gametes and embryos. The other clinic explores preferences during counselling, though it is not clear whether these preferences are always given effect.

4.6 The ITA conditions of licence only apply where people donate to unknown recipients. If a donor wishes to donate to a particular person or couple (known donor donation), there is nothing to prevent them from doing so. Known donor donation is permitted under the Infertility Treatment Act. People are allowed to seek a donor by advertisement authorised by the Minister for Health.[83]

SHOULD DIRECTED DONATIONS BE PERMITTED?

GAMETE DONATION

4.7 In making recommendations on this issue, the commission has taken account of two guiding principles proposed in this Position Paper. The first is the principle that the law should protect the health and wellbeing of any child who may be born. The second is the principle that assisted reproduction processes should not discriminate against people on the basis of their sexual orientation, marital status, race or religion.

ARGUMENTS IN FAVOUR OF ALLOWING DIRECTED DONATIONS

4.8 Two main arguments are made in favour of allowing people to specify who should be able to use their gametes. The first argument is that this protects the wellbeing of the child to be born. Some submissions said that if the donor and the biological child later met and formed a relationship, the child might be psychologically harmed because the donor disapproved of the child's parents. For example, a young person whose parents are in a same-sex relationship would find it distressing if the donor disapproved of such relationships.[84] It is argued that this justifies allowing donors to direct donations of gametes to a person or couple whose values they share.

4.9 The second main argument in favour of allowing directed donations is that donating gametes differs from other types of tissue donation because it results in the creation of a child. For this reason, it is suggested that both donors and recipients of gametes should have the right to express their wishes and to have those wishes respected.[85] Some infertility counsellors expressed the view that the discretion to direct donations is to the benefit of all concerned and that it is 'crucial that all concerned can express their views and feel comfortable with the situation'.[86]

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81 Fertility Society of Australia Reproductive Technology Accreditation Committee (April 2002), above n 20, Attachment H, para 20.

82 National Health and Medical Research Council (2004), above n 19, para 6.9.

83 The *Human Tissue Act 1982* (Vic) s 40, requires that when advertisements are placed for tissue donors, those advertisements must have the approval of the Minister for Health. If approved, the advertisement must include a statement that it has been approved by the Minister for Health.

84 Submissions 73 (Lauren Andrew), 183 (Jacinta Weston).

85 Submission 52 (Helen Kane).

86 Submission 155 (Victorian Infertility Counsellors Group).

4.10 A subsidiary argument in favour of allowing directed donations is that if people cannot make directed donations they may decide not to donate at all, so that the supply of gametes available for donation will be reduced and fewer people will be able to have treatment.

Arguments Against Allowing Directed Donations

4.11 Most submissions which commented directly on the issue of directed donations argued against allowing this practice. The main argument against directed donations is that giving effect to a donor's wishes may require clinics to discriminate against people of a particular racial origin and people in particular types of families. Submissions said that clinics which allow directed donations are in breach of federal anti-discrimination law[87] as well as international human rights instruments.[88] Several submissions remarked on the important role of law in changing prejudicial community attitudes and argued that allowing discrimination in any form diminishes us as a community.[89] The Equal Opportunity Commission submitted that there should be further debate on the issue of directed donations, but commented that guidance should be given to service providers to enable them to avoid potentially discriminatory practices.[90]

4.12 The Law Reform Commission's view is that donors should not be able to direct that their gametes be used only for particular types of recipients, for example, those belonging to a particular race or religion, or having a particular sexual orientation or family type. A person who donates blood cannot specify that it should only be used to transfuse a white person or a heterosexual. A similar principle should apply to gamete donation. While gametes are not the same as other human cells, it does not follow that the unique capacity of these cells to contribute to creating a child should enable a person who wishes to donate them to do so in a way that discriminates against others.

4.13 We are not convinced that the objective of protecting the welfare of children conceived through the use of donated gametes is served by permitting this form of discrimination. Donor-conceived children and adolescents have a variety of attitudes about whether they want to know or meet donors. They often do not want to meet or have a relationship with their donor, although they generally do want information about him or her, including photographs.[91] Where identifying information is available, many children choose not to meet the donor. Children conceived through donor insemination do not necessarily regard the donor as their parent. While some may meet the donor and/or form a relationship with him/her, this is relatively rare and if they do so it usually occurs when they are adults.

4.14 We do not think that the remote possibility that children who meet a donor may be adversely affected by a donor's attitude to their parents justifies breaching the guiding principle of non-discrimination which we have recommended. Nor are we aware of evidence supporting the view that preventing directed donations discourages people from donating to unknown recipients. In the absence of any evidence that allowing directed donations is necessary to protect the wellbeing of children, we recommend that clinics should only accept donors who are willing to donate to any patient approved by the clinic for a treatment procedure.[92]

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87 Submissions 177 (Australian Lawyers for Human Rights), 191 (Equal Opportunity Commission Victoria).

88 Submission 177 (Australian Lawyers for Human Rights).

89 Submissions 74 (Caitlin Coleman), 131 (Anonymous), 135 (Rebecca Olsen).

90 Submission 191 (Equal Opportunity Commission Victoria).

91 McNair (2004), above n 2, 44.

92 Submissions 38 (Jacqueline Tomlins), 82 (Anonymous), 99 (Susan Koska), 133 (Women's Health West), 137 (Melinda & Lisa), 143 (Bouverie Centre, La Trobe University), 149 (Prospective Lesbian Parents), 171 (Fertility Access Rights), 184 (Anonymous), 198 (Dr Elizabeth Short).

4.15 We note that this recommendation does not prevent people from donating to a known individual or family whom they identify through their own contacts.

EMBRYO DONATIONS

4.16 The commission also considered whether an exception to this principle of non-discrimination should apply in the case of embryo donations. People donating embryos to others have usually been successful in conceiving a child through the use of ART. The embryos may be genetic siblings of their existing children. Some submissions argued that directed donations should be possible in this case.[93] This is also the view of counsellors at one of the clinics in Victoria.

4.17 The commission does not agree. The law allows a person to donate embryos to a known recipient whom they find through their own contacts. Where the donation is made to an unknown recipient, the commission believes that the principle of non-discrimination should apply to donation of embryos in the same way that it applies to gamete donation. We therefore recommend the law should not permit directed donations of embryos.

! INTERIM RECOMMENDATION(S)

19. Donors should not be allowed to specify qualities or characteristics of the unknown recipients of their donated gametes and embryos.

ELIGIBILITY TO DONATE GAMETES

4.18 The Consultation Paper published by the commission discussed the principles governing eligibility to donate gametes. Some submissions said clinics' current practices prevent some people who wish to donate gametes from doing so, even where there is no risk they will transmit a communicable disease to a woman or her child. It was also argued that current practices for screening donors may prevent a woman using a known donor whom she prefers.[94]

HEALTH ISSUES

4.19 Clinics have a number of procedures which are intended to prevent recipients of gametes and their children from being infected with diseases which could be transferred during fertilisation.

- Donors of gametes must complete a Tissue/Semen Donation Statement.[95] This statement requires the donor to answer questions about sexual activity and drug use, amongst other things.
- Donors of gametes must be tested for human immunodeficiency virus (HIV) and Hepatitis C virus (HCV) and sperm must be quarantined for six months before use.[96]
- FSA guidelines recommend screening out from donor programs on the basis of certain medical conditions and behaviours. However, the screening recommended by the FSA is not mandatory.[97]

93 Submission 78 (Andrew McLean).

94 Submissions 73 (Lauren Andrew), 82 (Anonymous), 88 (Deborah Dempsey), 133 (Women's Health West), 149 (Prospective Lesbian Parents), 171 (Fertility Access Rights), 198 (Dr Elizabeth Short).

95 *Health Act 1958* (Vic) s 133. The Tissue/Semen Donation Statement can be found in *Health Regulations 2001* (Vic) sch 8.

96 *Health Act 1958* (Vic) s 133.

97 'It must be remembered that these are only recommendations and do not constitute a dictate from the Fertility Society of Australia. Certain practitioners may not wish to carry out all the tests listed in this document. However, if that should be the

4.20 The commission received a number of submissions which argued that the current processes regulating sperm donation discriminate against homosexual men. They said the donation statement prescribed by the *Health Regulations 2001* and the Lifestyle Declaration prescribed by the FSA are discriminatory because they exclude people based on their sexual orientation, rather than because they have been involved in activities which create a high risk of infection. These declarations were said to stigmatise particular groups in the community and to be based on the misconceptions that gay men are inherently diseased.[98] Submissions argued that the lifestyle declaration should be redrafted to require people to focus on participation in activities which create a high risk of infection with a transmissible disease, rather than seeking information on whether a potential donor is a member of a particular group.[99]

4.21 Changes in clinic practices appear to have met these concerns. The ITA advised clinics on 20 September 2001 that the recruitment of homosexual men is not automatically excluded under Victorian legislation. The ITA received advice from the Director of Public Health, Professor John Catford, that the *Health Act 1958* does not indicate that a 'yes' answer to the question on the Tissue/Semen Donation Statement requires the person to refrain from donating until their health status is ascertained. Professor Catford advised the ITA that this 'is a matter for risk assessment by the medical practitioner or other person dealing with tissue donation'.[100] It is therefore at the discretion of the doctor to accept donors even if they say yes to some aspects of the Tissue/Semen Donation Statement. The directive also leaves to the discretion of the doctor a decision about any person who admits to having injected non-prescribed drugs.

4.22 It has not been clear to people wishing to access clinical services that a clinic may accept donors who answer 'yes' to some questions on the Lifestyle Declaration. In light of the confusion regarding the criteria for eligibility to donate, particularly in relation to gay men but also to people who have ever injected non-prescribed drugs, the commission recommends the Tissue/Semen Donation Statement be reviewed and clinics provide information to people seeking to donate about the way clinics use answers to questions in the statement.

Quarantine Period

4.23 The commission has received advice that the current state of knowledge of HIV and HCV detection supports the reduction of the six-month quarantine period prescribed in the Health Act.[101] The commission therefore recommends the Department of Human Services and the Infertility Treatment Authority seek advice on the quarantine period which should apply to donated gametes.

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case, then a full explanation as to why these tests on the semen donors have been omitted from their screening process ought to be supplied to each of the recipients of that semen. Full documentation of the consulting process and signed records must be kept': Fertility Society of Australia Reproductive Technology Accreditation Committee (April 2002), above n 20, Attachment H.

98 Submission 59 (Ian Seal).

99 Submissions 43 (Ian Coutts), 82 (Anonymous), 83 (Sexuality Law Reform Committee, Melbourne University Law Students Society), 89 (Ministerial Advisory Committee on Gay and Lesbian Health), 133 (Women's Health West), 149 (Prospective Lesbian Parents), 164 (Confidential), 171 (Fertility Access Rights). An example of a question raising concern was whether the person had ever had male-to-male sex, because it was over-inclusive. People who use condoms, or people engaging in male-to-male oral sex or non-penetrative sexual activities are at minimal risk of infection with HIV.

100 Information given to the commission by Jenny Blood, Senior Counsellor, Melbourne IVF.

101 Information provided to the commission by Professor Gordon Baker, Melbourne IVF.

OTHER REQUIREMENTS APPLICABLE TO DONORS

4.24 The Infertility Treatment Act requires gamete and embryo donors, and any spouse or partner, to consent to use of their gametes in a treatment procedure.[102] We do not propose any change to this provision, other than in accordance with Interim Recommendation 13 which expands the definition of partner to include a domestic partner.

4.25 Section 41 of the Act prohibits the use of gametes or embryos produced from the gametes of a person younger than 18 years. This provision should continue to apply.

102 *Infertility Treatment Act 1995* (Vic) ss 12, 13, 14.

Chapter 5
Posthumous Use of Gametes

INTRODUCTION

5.1 The Infertility Treatment Act controls the use of gametes and embryos after the death of the person or persons from whom they originate. The commission has been asked to consider whether to allow this use and if so, under what conditions. There are four situations where conception of a child may involve posthumous use of gametes.

- A person who has been involved in a treatment program has gametes in storage at a clinic. If that person dies, the surviving partner may want to use the stored gametes in a treatment procedure. At present, this usually occurs when a woman wants to use her partner's stored semen for fertilisation after the partner has died.[103]
- A person who has donated gametes to a clinic for use by unknown recipients dies.
- A person whose gametes have been used to create an embryo dies after the embryo is created and it is proposed to implant a woman with the embryo.
- A person is dying or has just died. The person's partner seeks to take gametes from the body for use in a treatment procedure after the death. For example, a woman may want to have the semen of her partner removed so it can be used to create a child.[104]

PRESENT LAW

5.2 At present, the law does not permit use of the *gametes* of a person who has died, but there is no prohibition on implanting a person with an *embryo* which was created using gametes from a person who has subsequently died. This is explained in more detail below.

GAMETES

5.3 The present law applies the same principle in the first and second cases: stored gametes or donated gametes cannot be used if the person who has provided them has died. Section 43 of the Infertility Treatment Act prohibits:

- inseminating a woman with sperm from a man known to be dead; and
- transferring to a woman a gamete from a person known to be dead.

This prevents insemination of a woman with sperm from a man known to be dead, and also transfer into a woman of an ovum from another woman who is dead.

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103 In the future it may also arise in relation to stored ova.

104 The prospect of achieving a pregnancy with sperm extracted from a dead or dying man depends on the amount and quality of the sperm obtained. The underlying condition of the patient and events surrounding death may have impaired sperm production and quality, reducing its viability. At present, it is generally not possible to retrieve ova from a dying or dead woman. While it may be theoretically possible to store and then use unfertilised oocytes (egg cells produced in the ovary) in a treatment this has not yet been done in humans: information supplied by Professor Gordon Baker, Melbourne IVF.

EMBRYOS

5.4 Although the Act prohibits posthumous use of gametes, there is no ban on a woman being implanted with an embryo which was formed from the gametes of a person while they were alive, but who died after the fertilisation procedure. It is a condition of clinic licences that counselling which addresses relevant issues is given to a woman whose husband has died and who wishes to use the couple's stored embryos, and to recipients of donor embryos where the donor has died.[105]

ANOMALY IN THE LEGISLATION

5.5 Apparently, the Act does not prevent an embryo being created outside a woman's body using gametes from a dead person and that embryo being implanted into the woman. This seems to be an unintentional consequence of a 2003 amendment to the Infertility Treatment Act.[106] This is currently being tested in the Supreme Court of Victoria.[107] If our interpretation is correct, there will be a clear anomaly in the Act: it will not be possible to inseminate a woman with her partner's sperm after he dies, but it will be possible to use his sperm to create an embryo outside her body and implant it into her.

REMOVAL OF GAMETES FROM A PERSON WHO IS DEAD OR DYING

REMOVAL FROM A DYING PERSON

5.6 If a man is dying but able to communicate he can agree to the removal of semen for use to inseminate his partner. If the man is incapable of consenting, it is arguable that the *Guardianship and Administration Act 1986* allows the Victorian Civil and Administrative Tribunal (VCAT) to authorise removal of semen from him. However, the Infertility Treatment Act would prevent use of the semen to inseminate the man's partner once he had died. Again, it appears the Infertility Treatment Act does not prevent it being used to create an embryo for implantation in the woman.

REMOVAL FROM A DEAD PERSON

5.7 The *Human Tissue Act 1982* regulates the removal of tissue from a person who is dead. This includes the case of a person whose heart is still beating, where there has been 'irreversible cessation of all brain function'. Sections 25 and 26 allow removal of the tissue for transplantation or other therapeutic purposes if the person consented to removal of the tissue before his/her death, or if the 'senior available next of kin' of the person consents to the removal. If the person has a spouse or domestic partner they are the senior available next of kin.[108] This means that the person's spouse or partner could authorise the removal of sperm from a man who is dead. In the case before the Supreme Court, the court made an order allowing a doctor to remove sperm and associated tissue from a woman's dead husband.

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105 Infertility Treatment Authority (January 2004), above n 12, para 2.2.2.

106 The Act was amended by the *Health Legislation (Research Involving Human Embryos and Prohibition of Human Cloning) Act 2003* (Vic) s 22(4)(d)(ii). These amendments, made to bring the Victorian act in line with the *Prohibition of Human Cloning Act 2002* (Cth) and *Research Involving Human Embryos Act 2002* (Cth), resulted in a change to the definition of 'embryo' which resulted in turn in the repeal of all references to zygote in the Victorian Act. This had the following effect on section 43: previously there was a prohibition on the use of gametes from a person known to be dead for the formation of a zygote. With the repeal of the reference to zygotes, this prohibition was repealed. Therefore, it is now possible to use a gamete from a dead person to form an embryo, provided the woman is eligible for treatment and provided consent has been given to the use of the sperm for a treatment procedure.

107 In *AB v Attorney-General*.

108 *Human Tissue Act 1982* (Vic) s 3.

PROBLEMS WITH THE PRESENT LAW

5.8 The operation of the current law leads to a number of anomalies and inconsistencies:

- If the prohibition against posthumous use of gametes reflects concerns about the health and welfare of a child who is conceived after the death of one parent, the distinction between posthumous use of gametes and posthumous use of embryos cannot be justified.[109]
- There is no way of ensuring that the gametes of a dead donor are never used, as clinics will not necessarily be notified in all cases of a donor's death. This may mean that a woman involved in treatment before her husband died cannot be inseminated using her dead husband's sperm, but if she remains eligible for treatment she could be inseminated with the sperm of an unknown dead donor if the clinic does not know he has died.[110]
- Courts in Victoria have allowed semen to be taken from the body of a man who is dead for intended use in a reproductive procedure, despite the prohibition on the use of such semen in a treatment procedure. Some submissions argued that it was anomalous to allow removal of the semen, but not to permit its use.

5.9 The anomalies and inconsistencies in the present law make reform necessary. The questions addressed below are:

- Is there a justification for retaining the existing prohibition on posthumous use of sperm or ova, or should it be permitted, and if so under what circumstances?
- Should the law continue to allow posthumous use of embryos, and if so under what conditions?
- In what circumstances, if at all, should it be possible to remove gametes from a dead or dying person for use in an infertility procedure? Who should have to consent to such removal?

PRINCIPLES

RESPECT FOR WISHES OF DECEASED

5.10 Policy on posthumous use of gametes should take account of the wishes of the deceased. Posthumous use of gametes without a person's consent could be seen as breaching the principle that a person's reproductive capacity should not be exploited, which is discussed in Chapter 2.

5.11 There are a number of ways in which these wishes could be taken into account. Some submissions suggested that *express* consent of the deceased person should be required before gametes (and/or embryos) could be used.[111] A second approach would be to assume consent to posthumous use of gametes by the person's partner, unless the person explicitly said he/she did not want this to be done.[112]

5.12 Another approach proposed in submissions was to infer consent in some situations (eg where a couple was involved in treatment before one of them died).[113] Some people said requiring

109 This was argued in submissions 90 (Diane Blood), 126 (Confidential), 224 (Victorian Biotechnology Ethics Advisory Committee).

110 Submissions 90 (Diane Blood), 126 (Confidential).

111 Submissions 19 (Anita Stuhmcke), 78 (Andrew McLean), 224 (Victorian Biotechnology Ethics Advisory Committee), 231 (Victoria Legal Aid).

112 Submissions 90 (Diane Blood), 126 (Confidential), 183 (Jacinta Weston), 192 (ACCESS).

113 Submissions 90 (Diane Blood), 126 (Confidential), 192 (ACCESS).

express consent discriminated against couples where a partner died suddenly and had made no provision for consent. It was argued that requiring express consent created an inconsistency in the law by allowing some women to use gametes after their partner's death and preventing others from doing so, simply because they had not happened to turn their mind to the issue of posthumous use. These submissions argued that the current ban on posthumous use prevents consideration of the circumstances of the person seeking treatment. It was also suggested that it should be possible to infer a person's intention or desire to become a parent from the circumstances. It was pointed out that the women who wish to become pregnant using their dead partner's gametes may have the support of their late partner's family.[114]

Health and Wellbeing of the Child to be Born

5.13 There is little research on whether the health and welfare of a child is adversely affected by being conceived after the death of one biological parent. Some submissions raised concerns about the consequences of posthumous conception for the child. Some have suggested that where the couple were involved in a treatment program before the man dies the woman's grief at the death of her partner may affect her parenting capacity. One submission commented that this issue could be addressed by counselling the woman to postpone treatment until she has worked through issues relating to the death.[115] Another concern is that children conceived from posthumous use of gametes may suffer psychological harm because they will be prevented from knowing or making contact with their biological father. However, this situation is not limited to the case of children conceived posthumously but could also apply if gamete donors who were alive at the date of conception die before the child is old enough to seek them out.

5.14 Submissions that dealt with the substantive issues raised by the question of whether or not to allow posthumous use were generally in favour of allowing such use.[116]

5.15 In Chapter 2 we argued that the health and wellbeing of children born as the result of assisted reproductive technology should be given priority. It follows that this principle must be taken into account in policies relating to posthumous use of gametes and embryos.

Recommendations

5.16 The commission has found the issue of posthumous use of gametes and embryos a particularly difficult area to decide on. A number of submissions argued posthumous use of gametes should be permitted. On the other hand, there are legitimate concerns about the potential consequences for children of a practice about which we know very little. Although we recommend that posthumous use of gametes and embryos should be permitted in some circumstances, we believe the wellbeing of children born as a result should be monitored. As noted above, there is limited information available about the effects of posthumous conception; future policy decisions would be helped by knowledge of the psychological and developmental impacts of the practice on children.

Posthumous use of Gametes

5.17 The commission recommends that posthumous use of gametes should be permitted, subject to the requirement that the person be counselled about the issues which arise in the context of

114 Submissions 90 (Diane Blood), 126 (Confidential).

115 Submission 192 (ACCESS).

116 See submissions 19 (Anita Stuhmcke), 90 (Diane Blood), 126 (Confidential).

posthumous use (including the possible effect on the child and how it should be dealt with) and provided that the other requirements discussed below are satisfied.

5.18 In particular, we recommend that the express written consent of the person who has died or is dying is necessary before a person's gametes can be used posthumously. Requiring express consent provides certainty for clinics, the surviving partner and other family members of the deceased about whether the gametes can be used. If the law allowed consent to be inferred from the circumstances it would be necessary to apply to a court for a determination about whether gametes could be used.

5.19 The proposed approach recognises that allowing one's gametes to be used to create a child is a deeply personal decision. Some people may have no objections to their gametes being used to create a child after their death, while others may believe that use should be limited to the period while they are alive. The creation of a child through posthumous use of gametes may affect other members of the deceased person's family, for example, it could affect the property rights of other children or of the deceased's brothers and sisters. This should not be done without the deceased person's express consent. This emphasis on express consent is consistent with the NHMRC ethical guidelines on posthumous use, which recommend that express prior consent is the only condition upon which gametes can be used posthumously.[117]

5.20 The commission recommends inserting provisions into the relevant sections of the Infertility Treatment Act which would require people who are either donating gametes or having gametes stored to make express provision about what should be done with their gametes if they die. This is a practice recommended by the FSA.[118] However, Melbourne clinics do not generally ascertain the wishes of people with gametes in storage with respect to posthumous use because of the ban in the Infertility Treatment Act on their use after death.

5.21 If donors have consented to posthumous use, the recipient of their gametes should be counselled that it is possible the donor may be dead and that this may affect children's capacity to satisfy their desire to obtain information about the donor.

5.22 Where donors do not consent to posthumous use, the clinic should seek their agreement to leave instructions in their will that the clinic should be informed in the event of their death. While this may not always occur, it will reduce the possibility that gametes of a donor who has not consented to posthumous use will be used in the future.

! INTERIM RECOMMENDATION(S)

20. Where people have expressly consented to the use of their gametes to treat their partner or an unknown recipient after their death, the clinic should be able to use those gametes in a treatment procedure after the person has died.

21. Where a person has died leaving express written instructions that his/her gametes are not to be used in a reproductive treatment procedure, then the clinic may not use those gametes.

22. Clinics should ensure that people's wishes about posthumous use of their gametes are recorded. This should apply to donors and to people who are involved in treatment programs.

117 National Health and Medical Research Council, *Ethical Guidelines on the Use of Reproductive Technology in Clinical Practice and Research: Draft for Public Consultation* (2003) para 6.15.

118 Fertility Society of Australia Reproductive Technology Accreditation Committee (April 2002), above n 20, Attachment D, para 10.2.

! INTERIM RECOMMENDATION(S)

23. Clinics should contact all people whose gametes are already in storage to ascertain their wishes with respect to posthumous use.

24. Donors who do not consent to posthumous use of gametes should be advised to make arrangements for the clinic to be notified if they die.

POSTHUMOUS USE OF EMBRYOS

COUPLES INVOLVED IN A TREATMENT PROCEDURE

5.23 Since 2001, it has been lawful to use a stored embryo posthumously.[119] We have recommended above that clinics should not be able to use gametes posthumously except with the express consent of the person from whom they came. Should this principle also apply to embryos created before a person dies?

5.24 We recommend that people whose gametes were used to create an embryo while they were alive should be required to indicate whether they consent to their partner using this embryo after their death. If express consent was given, the surviving partner should be able to use the embryo. This will require clinics to discuss the use of the embryo after death at the time of obtaining consent to treatment.

5.25 At present, the creation of embryos for use in a reproductive treatment procedure requires the people involved to have consented to the kind of treatment procedure specified in the consent form, and for that consent not to have lapsed by the time of the treatment procedure.[120] The individual or couple must have had counselling prior to giving consent.[121] A woman who has an embryo stored which was created from her own ovum and her dead husband's sperm can have the embryo implanted after his death. If she forms a new relationship, and in that context wishes to use the embryo formed with her ovum and her dead partner's sperm, the dead partner must have consented to the use of the embryo in this circumstance. It is a condition of licence that clinics ascertain the wishes of a person with respect to the posthumous use of embryos by a surviving partner who forms another relationship.[122] Licence conditions require that the counselling process includes an explanation that the person who dies would become a donor to the couple in this circumstance.

5.26 At present, clinics record a person's wishes with respect to posthumous use of embryos in varying degrees of detail. The commission recommends that these consent forms be modified, where necessary, to explain the law with regard to posthumous use in all circumstances, so that people can make informed decisions. In particular, the following circumstances should be highlighted:

- the surviving partner remains single and wishes to use the embryos;
- the surviving partner re-partners and wishes to use the embryos in the context of the new relationship;

119 *Infertility Treatment Act 1995* (Vic) s 43.

120 *Infertility Treatment Act 1995* (Vic) s 9.

121 *Infertility Treatment Act 1995* (Vic) s 11.

122 Infertility Treatment Authority (January 2004), above n 12, para 2.2.2.

- the surviving partner wishes to donate the embryos for use by another person or couple; and
- the deaths of both members of the couple.

DONORS

5.27 An embryo may be created from gametes donated to an unknown recipient. Our earlier recommendations will require the donor to give express consent to posthumous use of the gametes. This consent can be revoked at any time prior to the formation of embryos. However, we consider that the fate of any embryos formed from donor gametes, including their use after the death of the donor, should be subject to decisions and consents made by the recipient woman or couple. This reflects the situation in current law, where a donor of gametes has no right to make decisions with respect to the embryos formed from his or her gametes[123] and has no rights or responsibilities in relation to any child born. No child born in this circumstance, for example, could make a claim on the deceased person's estate.

! INTERIM RECOMMENDATION(S)

25. Where a person involved in a treatment procedure has expressly consented to his/her partner using an embryo created from his/her gametes and the gametes of another person, or to the donation of the embryo to another person after his/her death, the clinic may use that embryo after the person has died in the ways stipulated in the consent.

26. Where an embryo has been created from donated gametes, with the consent of the donor, the clinic may use that embryo in a treatment procedure after the donor's death.

RETRIEVAL OF GAMETES FROM A PERSON WHO IS INCAPACITATED OR DEAD

5.28 People may be critically injured or die suddenly as the result of an accident. Unless they or their partner were having assisted reproductive treatment before death they are unlikely to have had any reason to express their intentions about use of their gametes after death. The person's surviving partner may wish to have gametes extracted from the injured or dead person and use the gametes to create a child.

5.29 It follows from the recommendations made above, that the commission believes gametes should only be removed from a person who lacks decision-making capacity or who has died, if that person expressly consented to such a procedure.

5.30 In the case of people who are incapacitated, the law should be clarified so a doctor is only able to remove gametes from people who are incapable of consenting where they consented in writing to the procedure while they were capable of doing so. It should not be possible for VCAT or any other body to make an order for the removal of gametes where people have not expressed their intentions about removal or use of their gametes.

5.31 In the case of a person who has died, gametes should only be removed posthumously if the deceased person expressly consented to their removal and use to create a child.[124] The Human

123 A donor must agree in writing to the particular procedure to be carried out, and can withdraw consent up until that procedure or action is carried out: *Infertility Treatment Act 1995* (Vic) s 14, 37.

124 Sperm collection after death is also quite an invasive procedure: it generally involves wide exposure of the male genital tract: information supplied by Professor Gordon Baker, Melbourne IVF.

Tissue Act should be amended to make it clear that the senior next of kin cannot consent to the removal of gametes from the body of the deceased person.

! INTERIM RECOMMENDATION(S)

27. A medical practitioner should be able to remove gametes from a living person where that person has expressly consented to such removal, but not in any other circumstances.

28. It should only be possible for gametes to be removed from a person who is dead if the deceased person expressly consented during his/her lifetime to the removal of gametes after death and to their use by the surviving partner to create a child.

CONDITIONS FOR POSTHUMOUS USE OF GAMETES AND EMBRYOS

5.32 People who are proposing to become pregnant using the gametes of a dead partner should be assisted to think through the possible consequences of conception and the effect this may have on any child born. Victorian clinics are already required under their conditions of licence to ensure that a person using an embryo formed with the gametes of a person who has died receives counselling.

5.33 This should also apply when a person uses the gametes of a person who has died. Counselling should include discussion of the possible effects on a child of this type of conception and the advisability of delaying treatment for a period of time after the death of the partner.

! INTERIM RECOMMENDATION(S)

29. If a person intends to use the gametes of his/her deceased partner in a treatment procedure, the person must receive appropriate counselling before the treatment procedure is carried out.

5.34 The commission also believes it might be appropriate to set time limits for the use of gametes after a person has died. The NHMRC's ethical guidelines advise clinics to allow adequate time for the surviving spouse to grieve before commencing a treatment procedure using the deceased's gametes,[125] although no time period is specified. We also considered the potential impact on a child of having been conceived many years after his or her parent's death and came to the view that it would be appropriate to set an outer time limit for the posthumous use of gametes.

➔ The commission would be particularly interested in comments about what time periods should apply.

5.35 It is likely that only a very small number of children will be conceived posthumously. However, as noted above, the commission thinks it would be desirable to monitor the effects of posthumous use of gametes and embryos on children.

125 National Health and Medical Research Council (2004), above n 19, para 6.16.

! INTERIM RECOMMENDATION(S)

30. The ITA should monitor research on the effects on children born as a result of posthumous use of gametes and embryos.

EXPORT OF GAMETES

5.36 Section 56 of the Infertility Treatment Act prohibits export of gametes from Victoria without the approval of the ITA. If our recommendations on posthumous use are implemented, a clinic may be storing gametes which it cannot use in a treatment procedure after the death of the donor because the donor did not consent to posthumous use. In this situation, the partner of the deceased may apply for permission to export the gametes so they can be used for treatment in a state where consent to posthumous use is not required. The proposed requirements for express consent to posthumous use and counselling would be undermined if people were allowed to export gametes interstate or overseas to a place where these requirements did not apply. We recommend that export should not be permitted in this situation.

! INTERIM RECOMMENDATION(S)

31. If a person is not permitted to use the gametes of a deceased partner or an embryo formed using the gametes of a deceased partner in a treatment procedure in Victoria, he/she should not be permitted to export those gametes to a state or territory which does not impose conditions on posthumous use of gametes.

TRANSITIONAL PROVISIONS

5.37 Clinics may currently be storing gametes or embryos of people who have died and who did not have the opportunity to express their intentions about the use of their gametes after their death, either because they died suddenly or because there was no requirement for them to record their consent in writing. If the law is changed to enable posthumous use of gametes and embryos, but only where the deceased person gave express consent to such use, an issue will arise about whether gametes and embryos stored prior to the introduction of the requirement for consent should be able to be used by the deceased's surviving partner.

➔ The commission seeks your views about whether there should be a transitional provision to enable such use, and if so in what circumstances.

Other VLRC Publications

Disputes Between Co-owners: Discussion Paper (June 2001)

Privacy Law: Options for Reform—Information Paper (July 2001)

Sexual Offences: Law and Procedure—Discussion Paper (September 2001)
(Outline also available)

Failure to Appear in Court in Response to Bail: Draft Recommendation Paper (January 2002)

Disputes Between Co-owners: Report (March 2002)

Criminal Liability for Workplace Death and Serious Injury in the Public Sector: Report (May 2002)

Failure to Appear in Court in Response to Bail: Report (June 2002)

People with Intellectual Disabilities at Risk—A Legal Framework for Compulsory Care: Discussion Paper (June 2002)

What Should the Law Say About People with Intellectual Disabilities Who are at Risk of Hurting Themselves or Other People? Discussion Paper in Easy English (June 2002)

Defences to Homicide: Issues Paper (June 2002)

Who Kills Whom and Why: Looking Beyond Legal Categories by Associate Professor Jenny Morgan (June 2002)

Workplace Privacy: Issues Paper (October 2002)

Defining Privacy: Occasional Paper (October 2002)

Sexual Offences: Interim Report (June 2003)

Defences to Homicide: Options Paper (September 2003)

People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care (November 2003)

Assisted Reproductive Technology & Adoption: Should the Current Eligibility Criteria in Victoria be Changed? Consultation Paper (December 2003)

People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care: Report in Easy English (July 2004)

Sexual Offences: Final Report (August 2004)

The Convention on the Rights of the Child: The Rights and Best Interests of Children Conceived Through Assisted Reproduction: Occasional Paper by John Tobin (September 2004)

A.R.T., Surrogacy and Legal Parentage: A Comparative Legislative Review: Occasional Paper by Adjunct Professor John Seymour and Ms Sonia Magri (September 2004)

Outcomes of Children Born of A.R.T. in a Diverse Range of Families by Dr Ruth McNair (September 2004)

Workplace Privacy: Options Paper (September 2004)

Defences to Homicide: Final Report (October 2004)

Review of Family Violence Laws: Consultation Paper (November 2004)

Review of the Laws of Evidence: Information Paper (February 2005)

Call for Submissions

It is important to us that all members of the community have the opportunity to express their views on this important area of the law. The Victorian Law Reform Commission therefore invites your comments in relation to the interim recommendations made in this Position Paper, and seeks your responses to the questions that are raised before we write our final report to the government. The ways in which you can tell us your views are set out below. If you would like a copy of the commission's *Assisted Reproductive Technology & Adoption: Consultation Paper*, or any of our other publications, please contact the commission on (03) 8619 8619. All commission publications are also available on our website: <www.lawreform.vic.gov.au>.

How to Make a Submission

A submission may be made in writing or by phone or in person.

You may choose to comment on all of the recommendations or alternatively only those recommendations in which you have expertise or a specific interest. There is no particular form or format you need to follow.

You may also choose to answer the questions set out in this insert. This list of questions is available on the commission's website at <www.lawreform.vic.gov.au>.

Written submissions may be forwarded:

- by mail—Victorian Law Reform Commission, GPO Box 4637, Melbourne Vic 3001;
- email—law.reform@law.reform.vic.gov.au; or
- fax—8619 8600.

Confidentiality

Submissions are public documents and may be accessed by any member of the public. If you wish to retain confidentiality you must clearly advise us whether:

- you wish your submission to be quoted or sourced but your name not to be disclosed (anonymous); or
- you do not wish your submission to be quoted or sourced to you in a commission publication (confidential).

Deadline for Submissions

Monday 6 June 2005

NAME _____

ADDRESS _____

EMAIL _____

Would you like your submission to be confidential? YES NO

Would you like your submission to be anonymous? YES NO

QUESTIONS

As highlighted in the main body of this paper, the commission would be grateful for your responses to the following questions. You are also welcome to make a submission that addresses any other aspect of the commission's interim recommendations.

1. Do the commission's recommendations adequately protect children from unacceptable risks?

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2. Do the commission's recommendations leave sufficient room for clinical discretion in the majority of cases?

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3. Are the situations where a presumption against treatment applies appropriate? Should the presumptions be expanded or restricted?

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4. What steps should clinics take to find out whether a prospective patient falls into one of the categories where there is a presumption against treatment?

5. What categories of people should be appointed to the ITA review panel and ethics committee?

6. Should the legislation impose requirements about the proportion of men and women on the review panel and ethics committee?

7. Should posthumous use of gametes and embryos be permitted, and if so in what circumstances?

8. If a person is permitted to use the gametes of his/her deceased partner in a treatment procedure, should there be a period of time within which the gametes must be used?

9. Should there be a transitional provision to deal with cases where gametes or embryos of a deceased person are already in storage, but the person did not express his/her intentions about posthumous use and the surviving partner wishes to use the gametes or embryos in a treatment procedure?

10. Do you have any other comments about the interim recommendations?