SELECT COMMITTEE ON THE HUMAN REPRODUCTIVE TECHNOLOGY ACT 1991

REPORT

1999
SELECT COMMITTEE ON THE HUMAN REPRODUCTIVE TECHNOLOGY ACT 1991

REPORT

Presented by:
Hon. K.J. Minson, MLA
Laid on the Table of the Legislative Assembly on 22 April 1999

ORDERED TO BE PRINTED
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CHAIRMAN’S FOREWORD

It is with considerable pleasure and satisfaction that I am able to present the Select Committee’s report reviewing the Human Reproductive Technology Act 1991 and proposing a framework for the Parliament to consider the matter of legislation in the controversial area of surrogacy.

The report is the result of nearly two years research, gathering of evidence, interviews and discussion on some of the most difficult areas that Members of Parliament are likely to confront in their political careers - Difficult because the Select Committee was asked to deal with issues such as access to the use of the technology, research involving human embryos, preimplantation genetic diagnosis, cloning and surrogacy.

A consideration of any of these topics will inevitably “cut very close to the bone” in terms of one’s fundamental beliefs and principles and not only did Members have to continually confront their own preconceptions about what are often moral issues but they also had to become “au fait” with some quite detailed technical issues that are seldom static because of new research. At the same time, changes in public opinion on the matter under consideration had to be taken into account, as well as an acknowledgement that the legislation operating in other jurisdictions, inexpensive air travel and the use of the Internet to arrange reproductive technology procedures all means that no legislature can sensibly operate in isolation in this field.

One of the difficulties inherent in legislating in an area such as human reproductive technology is that legislation by its very nature tends to be rigid and is therefore appropriate for a limited amount of time because the area that it seeks to control is extremely fluid both in terms of its scientific technological advance and community opinion. The Select Committee recognised that difficulty and has suggested changes to the legislation that seek to set less prescriptive parameters in the body of the legislation and its regulations and to allow the more changeable aspects of the technology and its use to be governed by the Reproductive Technology Council.

Similarly, in considering surrogacy, the Select Committee was unanimous and strong in its view that the welfare of any proposed child must outweigh the desire of couples to have that child.

I sincerely hope that the Parliament, when dealing with this report, will adopt the same principle.

I want to express my sincere thanks to all of the Select Committee Members. Their intelligent and thoughtful approach to the task as well as willingness to commit large amounts of time has resulted in a report which will, I believe, eventually lead to many sensible and worthwhile changes to the Human Reproductive Technology Act 1991 as well as a sensible, sensitive and morally supportable approach to the matter of surrogacy - A subject, I suggest, that our Parliament can no longer ignore.

In particular, I want to thank the Select Committee’s staff. Sue Laing, our Research Officer, can justly be proud of her work and the Select Committee appreciates that the job done by Sue has been extremely difficult due simply to the nature and scope of the task set us by the Parliament. Likewise the contributions of the Select Committee’s Clerks, Kirsten Robinson and Nici Burgess are greatly appreciated.

HON KEVIN MINSON, MLA
CHAIRMAN
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EXECUTIVE SUMMARY AND RECOMMENDATIONS

On 15 May 1997, a Select Committee was established by the Minister for Health to review the Human Reproductive Technology Act 1991 (HRT Act). On 17 September 1997, the Legislative Assembly expanded the Select Committee’s terms of reference to include surrogacy.

The Select Committee approached the review with an open mind to a field where rapid technological and attitudinal changes occur and tried to focus on the fact that the HRT Act was put in place to help infertile couples to have children.

The Select Committee was mindful of the ethical and moral questions raised by the topic such as the welfare of the child resulting from the procedures and the rights of infertile couples. It was aware that concerns have been aired about the possible risks resulting from multiple pregnancies and some of the new technologies involved.

In reviewing the HRT Act, the Select Committee tried to take a practical approach. Members were aware that “jurisdiction shopping” or “medical tourism” occurred within Australia and overseas. If procedures were prohibited in one state, individuals would go elsewhere to seek treatment. Members discussed whether it would be preferable to allow previously prohibited practices to occur in Western Australia (WA), where they could be controlled and where patients would be given the opportunity to receive information and counselling, rather than have patients travelling to another state where they could receive the treatment legally but without having good access to appropriate follow-up support.

The Select Committee addressed each term of reference by considering the current legislation both in WA and in other jurisdictions. It considered both oral and written submissions received, current literature and other information gathered at meetings and during investigative visits within Australia and overseas.

The Select Committee examined a number of contentious issues such as rights of access to treatment, research using reproductive material, posthumous use of reproductive material, access to donor identifying information and surrogacy.

Chapter One introduces the legislation review process and recommends that another review should be conducted five years after the commencement of amendments to the HRT Act.

Chapter Two presents data on the incidence and outcomes of assisted reproductive technology and recommends that data should be used to examine the long-term impact of reproductive technologies such as intra-cytoplasmic sperm injection.

Chapter Three addresses the welfare of the child. The Select Committee believed that the best interest of the child should be paramount with respect to reproductive technology. In addition, Members felt that research should be conducted to examine the effect of assisted reproductive technology upon the child.

Chapter Four examines the roles and functions of the Reproductive Technology Council (RTC) and its committees, membership and size and the relationships between the RTC, the Minister for Health and the Commissioner of Health. The Select Committee felt that the RTC and its committees should remain. The Select Committee also examined the role of the Commissioner of Health and recommended that he delegate the power to set standards and conditions for licence to the RTC.
Rights of access to treatment are addressed in Chapter Five. The majority of Members agreed that infertility should remain as a criterion for access unless the Minister for Health approves an exemption. The majority of Members agreed that all women should be eligible for treatment if there is any likelihood of them becoming infertile as a result of disease or a medical procedure. In addition, the Select Committee wished to remove the time period specified in the HRT Act for a de facto relationship and believed that de facto couples living in a stable heterosexual relationship should be eligible for access.

The majority of the Select Committee considered that access to treatment should not be available if either party in a couple exceeds 55 years of age.

Members of the Select Committee disagreed about access to in vitro fertilisation (IVF) for single and lesbian women. The majority of Members did not wish to relax eligibility criteria for single and lesbian women, however, they recognised that under certain circumstances - posthumous use of embryos or where there is any likelihood of a woman becoming infertile as a result of disease or a medical procedure - that restrictions to access should be relaxed.

The Select Committee was told that as a result of the HRT Act, there was very little scope for reproductive technology research in WA. Members recognised that previous advances in reproductive technology could not have occurred without research and as a consequence the majority of the Select Committee recommended that the HRT Act be amended to allow some research to occur and to incorporate part of the National Health and Medical Research Council (NHMRC)’s ethical guidelines on research. The Select Committee felt that the ban on the creation of embryos for research should be retained.

Chapter Seven examines preimplantation genetic diagnosis (PGD). The Select Committee believed it is preferable for embryos to be tested prior to implantation if a couple is at risk of passing on a genetic disorder to their child, rather than a woman becoming pregnant, being tested and terminating the pregnancy. The Select Committee recommended amendments to the HRT Act to allow PGD to occur with restrictions.

Rights to gametes and embryos are addressed in Chapter Eight. The Select Committee was particularly concerned about posthumous use of reproductive material. In addressing the issue, Members tried to reflect the situation that would arise naturally if one partner died - they would either no longer be able to impregnate another person or to be impregnated themselves. Members believed that posthumous use of gametes should not be allowed. However, the majority supported the posthumous use of embryos by a surviving partner where written consent of the deceased partner is available and other conditions are met.

Chapter Nine discusses storage of reproductive material. The Select Committee recommended storage times of up to 15 years for gametes and of 10 years for embryos. The Select Committee also examined the problem of embryos stored prior to the HRT Act. Members recommended that they should be covered by the provisions of the HRT Act and that there should be no liability on the part of the clinics if embryos are allowed to succumb when the storage time expires.

The Select Committee recommended that the HRT Act be rewritten in a clear and concise manner. In addition, it felt that there should be a Code of Practice in Western Australia and recommended that it should not be laid before Parliament. Chapter Ten provides detail of the form the Code should take.
Chapter Eleven addresses enforcement, disciplinary provisions, offences and penalties. The Select Committee did not recommend any changes to the current offences. However, it recommended that therapeutic (non-reproductive) cloning should not be prohibited.

Chapter Twelve examines the impact of relevant State and Commonwealth legislation upon the HRT Act. The Select Committee recommended that if the HRT Act is amended to allow access to donor identifying information, that the Freedom of Information Act should also be amended to remove any inconsistencies. In addition, Members felt that development of uniform and/or national legislation on human reproductive technology is important.

Chapter Thirteen addresses the effectiveness of the current licensing regime, including fee structure, reporting requirements and powers of inspection and obtaining information. The Select Committee recommended that the current licencing regime should remain but Members felt that licence renewal should be automatic subject to payment of application fees. The Select Committee noted that fees are low and recommended that a dual fee structure be set up with a flat rate for all licensees and a second fee based upon the number of treatment cycles performed. Members also recommended that inequities with respect to Medicare benefits for assisted reproductive technology be addressed.

The Select Committee recommended that reporting by licensees to the RTC and the Reproductive Technology Accreditation Committee (RTAC) should coincide and that reporting requirements should be simplified and standardised.

Chapter Fourteen examines the management of information registers. The Select Committee felt that information on the registers should be kept indefinitely. In addition to current information, identifying information about siblings conceived using donor gametes should be kept in a central register. A national register would be valuable.

In Chapter Fifteen, the Select Committee considered access to information about genetic parentage. Members placed emphasis upon the paramount importance of the welfare of the child and recommended that in future all donor offspring will be able to access donor identifying information upon attaining 16 years of age. The majority of Members agreed that donor offspring should have access to donor identifying information retrospectively where a donation was made after the commencement of the HRT Act and where there is clear evidence that the donor was informed that disclosure of identifying information was likely should there be future change in policy or legislation. The establishment of a voluntary register based upon mutual consent between donors who donated prior to the HRT Act and donor offspring was also recommended.

The importance of counselling and consent is addressed in Chapter Sixteen. Members recognised the importance of counselling and believed that it should be encouraged and be mandatorily available. However, the Select Committee also recognised that there are times when counselling should be mandatory - for all gamete donors and recipients, in surrogacy arrangements, and prior to posthumous use of embryos.

The Select Committee felt that availability of counselling could be improved and recommended that an audit of counselling services should be conducted. It also examined services to people living in the country and felt that strategies should be put in place to attract counsellors to country areas.

The Select Committee recommended that standardised consent forms should be developed and that the RTAC’s consent guidelines should be adopted under the HRT Act.
Chapter Seventeen looks at data about gamete donors and recommends that the RTC try to recruit more donors. The Select Committee felt it is essential for donors to be made aware that in future donor offspring will be able to access identifying information if the HRT Act is amended. Donations should remain altruistic with donors only receiving out-of-pocket expenses.

In Chapter Eighteen, the Select Committee examined surrogacy. The majority of Members agreed that surrogacy should be permitted in WA where 100% of the genetic material belongs to the commissioning parents. In addition, the majority of Members agreed that surrogacy using an embryo created from a donor egg and the commissioning father’s sperm should be permitted. However, surrogacy using the surrogate’s egg and donor sperm should not be permitted.

The Select Committee disagreed about other surrogacy scenarios but the majority of Members supported at least a 50% contribution of genetic material for the commissioning couple. The majority of the Select Committee also recommended that IVF surrogacy arrangements using a donated embryo should be permitted.

The Select Committee felt that surrogacy arrangements should be non-commercial, that counselling should be mandatory for all parties including the surrogate’s partner and children, and that there must be carefully considered selection criteria for potential surrogates.

CHAPTER ONE

**Recommendation 1**
That the Human Reproductive Technology Act 1991 be reviewed again five years after the commencement of amendments based upon the recommendations of the Select Committee and that the method of review be at the discretion of the Minister for Health.

CHAPTER TWO

**Recommendation 2a**
That the object of the Human Reproductive Technology Act 1991 (HRT Act) (Section 4(f)(i)) and the role of the Reproductive Technology Council be retained to stimulate debate and facilitate sections 14(1)(d) and (g) of the HRT Act.

**Recommendation 2b**
That a longitudinal study of children conceived by intra-cytoplasmic sperm injection be conducted in Western Australia.

That the Reproductive Technology Council encourage and facilitate use of information from the databases as directed in section 14(1)(d)(i) of the Human Reproductive Technology Act 1991.

**Recommendation 2c**
That the Minister for Health recommend that a longitudinal study of children conceived by intra-cytoplasmic sperm injection (ICSI) be conducted at a national level.

That there be constant review of the world literature relating to ICSI.
CHAPTER THREE

**Recommendation 3a**
That the Reproductive Technology Council in conjunction with the newly established Family and Children’s Policy Office within the department for Family and Children’s Services determine guidelines for defining the “best interests of the child”.

**Recommendation 3b**
That the welfare of the child be paramount in all human reproductive technology procedures and in recognition of that paramountcy, the *Human Reproductive Technology Act 1991* be amended where required to reflect and give priority to that.

**Recommendation 3c**
That the newly established Family and Children’s Policy Office within the department for Family and Children’s Services in conjunction with the Health Department of Western Australia and the Australian Institute of Family Studies, conduct research to monitor the impact upon, development of and welfare of the child resulting from assisted reproductive technology.

CHAPTER FOUR

**Recommendation 4a**
That the Reproductive Technology Council produce a Code of Practice modelled on the UK Human Fertilisation and Embryology Authority’s Code of Practice.

**Recommendation 4b**
That the Reproductive Technology Council continue to function in Western Australia.

**Recommendation 4c**
That section 8 of the *Human Reproductive Technology Act 1991* be amended to ensure that the Reproductive Technology Council comprise a consumer or a person representing consumer interests, an infertility counsellor and a scientist with expert knowledge in reproductive technology.

**Recommendation 4d**
That the size of the Reproductive Technology Council remain at its present size.

**Recommendation 4e**
That the Reproductive Technology Council’s Committees continue to function at the discretion of the Minister for Health and the Reproductive Technology Council.

**Recommendation 4f**
That the Commissioner of Health retain the statutory authority to grant licenses, but that the *Human Reproductive Technology Act 1991* be clarified to enable the Commissioner of Health to delegate powers including the power to set standards and conditions for licences.

That the Commissioner of Health not delegate the power to delegate.

**Recommendation 4g**
That the Western Australian Minister for Health approach all States and the Commonwealth to produce nationally consistent legislation under one authority.
CHAPTER FIVE

Recommendation 5a
That section 23(a) of the Human Reproductive Technology Act 1991 be retained.

That there be an avenue of appeal to the Minister for Health to approve an exemption if he feels there is good and sufficient reason.

Recommendation 5b
That all women be eligible for IVF treatment if there is any likelihood of them becoming infertile as a result of disease or a medical procedure.

Recommendation 5c
That treatment not be available where either of the parties exceed 55 years of age, except in exceptional circumstances as decided on by the Reproductive Technology Council (RTC) and taking as the paramount consideration the welfare of the potential offspring.

That for clients between the ages of 50 and 55 years, clinics assess their suitability for treatment and that the RTC monitor the process.

Recommendation 5d
That section 23(c)(ii) of the Human Reproductive Technology Act 1991 be amended to read “are living in a stable, heterosexual relationship”.

Recommendation 5e
That women be able to access and use their own embryos provided written consent to the use of the embryos was obtained prior to their partner’s death and other conditions outlined in Recommendation 8j are met.

Recommendation 5f
That section 23(c) of the Human Reproductive Technology Act 1991 remain with the amendment proposed in Recommendation 5d.

That access contrary to section 23(c) be allowed for -

(i) posthumous use of embryos where one partner has died and the deceased party’s written consent for use is available;

(ii) the use of technology by people who might become infertile as a result of disease or medical procedures; and

(iii) surrogacy arrangements.

Minority Recommendation 5f (Members for Kalgoorlie and Thornlie)
That section 23(c) of the Human Reproductive Technology Act 1991 be amended to allow access to women regardless of sexual preference or marital status.

Recommendation 5g
That no clinic or practitioner be under any obligation to provide a service.
**Recommendation 5h**
That counselling be mandatory for gamete donors and recipients of donated reproductive material.

**Recommendation 5i**
That current access to artificial insemination be retained.

**CHAPTER SIX**

**Recommendation 6a**
That the power to regulate all research on gametes as provided for in section 20(2)(a)(i) of the *Human Reproductive Technology Act 1991* be retained.

**Recommendation 6b**
That references to an “egg in the process of fertilisation” be removed from the *Human Reproductive Technology Act 1991* except where reference to rights to an egg in the process of fertilisation and storage of an egg in the process of fertilisation exist, in which case an egg in the process of fertilisation be regarded as though it were an embryo.

That in all other circumstances an egg in the process of fertilisation not be regarded as though it were an embryo.

**Recommendation 6c**
That reference to an egg in the process of fertilisation in section 17(b) of the *Human Reproductive Technology Act 1991* be removed.

**Recommendation 6d**
That the National Health and Medical Research Council’s ethical guidelines on research and experimentation, as for the time being prescribed, with the exception of Guideline 6.1, be incorporated into the *Human Reproductive Technology Act 1991* with the following amendments to Guideline 6.4 -

Non-therapeutic research which involves some risk of harm to the embryo, or to its ability to implant should only be approved by the Reproductive Technology Council in exceptional circumstances. Approval requires -

- a likelihood of a significant advance in knowledge or improvement in technologies for treatment as a result of the proposed research;
- that the research involves a restricted number of embryos; and
- the people with the right and responsibility to make decisions about the embryo, to have consented to the specific form of research.

**Recommendation 6e**
That the relevant sections on embryo research within the *Human Reproductive Technology Act 1991* (HRT Act) be redrafted to reflect the intent of the 1996 National Health and Medical Research Council (NHMRC)’s ethical guidelines as amended by the Select Committee in Recommendation 6d. That in particular section 14(2)(a) and (b) of the HRT Act be removed and replaced with the amended NHMRC’s guidelines.

That the Reproductive Technology Council be authorised to grant final approval for research.
Recommendation 6f
That the ban on creating embryos for research continue.

Recommendation 6g
That embryos created for the purpose of implantation but subsequently not required, be allowed to be used for research with the Reproductive Technology Council’s approval and the written consent of the people with the rights and responsibilities to make decisions about the embryos, in accordance with the 1996 National Health and Medical Research Council’s guidelines which have been amended to reflect the Select Committee’s point of view.

That a 14 day limit to embryo development in vitro be retained in Western Australia as provided for in section 7(1)(c) of the Human Reproductive Technology Act 1991.

CHAPTER SEVEN

Recommendation 7a
That the Human Reproductive Technology Act 1991 be amended to allow pre-implantation genetic diagnosis to occur under restrictions determined by the Reproductive Technology Council.

Recommendation 7b
That pre-implantation genetic diagnosis (PGD) technology not be used for sex selection alone or for the determination of physical characteristics (“designer babies”).

That use of PGD be restricted to clients whose future child would otherwise be likely to be affected by a genetic abnormality or disease as determined by the Reproductive Technology Council.

CHAPTER EIGHT

Recommendation 8a
That section 26(1)(c) of the Human Reproductive Technology Act 1991 be amended by deleting “at the moment fertilisation begins” and substituting “when the oocyte is exposed to the sperm”.

Recommendation 8b
That posthumous use of gametes not be allowed in Western Australia.

Recommendation 8c
That under the Human Reproductive Technology Act 1991, collection of gametes after a person is dead or is no longer capable of giving consent be prohibited.

Recommendation 8d
That gametes not be considered to be property for inheritance purposes.

Recommendation 8e
That licensees keep accurate records of use of gametes imported or exported for the gamete provider’s own use or as donated material.

That the standard of the records be the same as if the gametes were to be used in Western Australia.

Recommendation 8f
That export of gametes for posthumous use be banned but that export of embryos for posthumous use be permitted, if prior written consent by the deceased partner is available.

**Recommendation 8g**
That the National Health Medical Research Council’s ethical guideline 3.2.8, as for the time being prescribed, that states “where disputes arise between couples about storage of embryos, those embryos shall be kept and not allowed to succumb until the dispute has been resolved and a decision taken about the embryos” be incorporated into the *Human Reproductive Technology Act 1991* to include eggs in the process of fertilisation as well as embryos, with the addition of “until a statutory time has elapsed when the embryo would be allowed to succumb”.

**Recommendation 8h**
That where no consent has been given by the parties with rights to and responsibilities for the embryos, embryos be allowed to succumb.

That the Commissioner of Health only permit third party use of embryos if explicit written consent has been given by the couple.

**Recommendation 8i**
That consent forms be altered to ensure that prior written consent be obtained before embryos are created.

**Recommendation 8j**
That posthumous use of embryos by the surviving partner be allowed in Western Australia following:

- prior written consent of the deceased party;
- a sufficient “cooling off” period;
- mandatory counselling;
- consideration of the welfare of the future offspring; and
- satisfying the eligibility provisions of the *Human Reproductive Technology Act 1991*.

**Recommendation 8k**
That all consent forms require couples to consider situations where either or both member(s) of the couple die(s) or become(s) incapable of varying or revoking the consent, prior to the creation of any embryo.

**Recommendation 8l**
That there be no rights for third parties in relation to gametes or embryos.

**CHAPTER NINE**

**Recommendation 9a**
That donated gametes and gametes for self-use be stored for up to 15 years with renewals every 5 years.

That beyond 15 years there be a general discretion for the Reproductive Technology Council (RTC) to extend storage until the gamete provider reaches 55 years of age.

That there be no extension beyond 55 years of age except in exceptional circumstances as decided on by the RTC and taking as the paramount consideration the welfare of the potential offspring.
Recommendation 9b
That in accordance with the National Health Medical Research Council’s ethical guidelines, embryos be stored for 10 years and that clinics contact couples after five years and again at nine years (12 months prior to the termination of the storage period) to determine the couples’ wishes.

That couples be allowed to apply to the Reproductive Technology Council (RTC) for an extension of storage in exceptional circumstances taking as the paramount consideration the welfare of the future offspring.

That in the event that embryos are not used by a couple or consent has not been given for donation, or unless the RTC has determined that special circumstances exist, embryos be allowed to succumb after 10 years.

That in the event that a couple can not be contacted after five years, embryos remain in storage until the 10 year storage period has expired and subsequently be allowed to succumb.

Recommendation 9c
That application for extension of embryo storage time only be made by the people who have the right and responsibility to make a decision about the embryo and that clinics not make an application on their behalf.

Recommendation 9d
That embryos created prior to the operation of the Human Reproductive Technology Act 1991 (HRT Act) be deemed to be covered by the HRT Act.

That there be no liability on the part of the clinics for any action taken in accordance with the provisions of the HRT Act.

That the storage period for such embryos be calculated from the date of their creation.

Recommendation 9e
That the Human Reproductive Technology Act 1991 be amended to ensure that the definition of “gamete” includes immature gametes, primordial follicles and cells at all stages of sperm development in testicular tissue and that appropriate definitions of all of these terms also be included.

Recommendation 9f
That the Human Reproductive Technology Act 1991 be amended to clarify -

(i) the requirement for consent from the gamete provider for any use or storage of immature tissues; and

(ii) the mode by which consent for storage of either immature reproductive tissue or gametes be obtained on behalf of minors who are too young to give their legal consent.

Recommendation 9g
That the Human Reproductive Technology Act 1991 be amended to specify that the parents and the doctor be allowed to consent to storage of tissue for a minor too young to consent.

That in the event of a disagreement, the issue be resolved by the Reproductive Technology Council.
CHAPTER TEN

**Recommendation 10a**
That the *Human Reproductive Technology Act 1991* be rewritten in a clear and concise manner to reflect the recommendations of the Select Committee.

**Recommendation 10b**
That the Reproductive Technology Council, by way of Directions, establish a Code of Practice that will deal with matters of ethics, rules, procedures and guidelines.

That there be no requirement for the Code of Practice to be laid before Parliament but that it be gazetted.

That Regulations continue to be laid before Parliament.

**Recommendation 10c**
That guidelines form part of the Code of Practice.

That the Commissioner of Health have the ability to make guidelines as required.

That the Commissioner of Health delegate the power to make guidelines to the Reproductive Technology Council with the permission of the Minister for Health.

CHAPTER ELEVEN

**Recommendation 11a**
That section 7(5) of the *Human Reproductive Technology Act 1991* (HRT Act) be incorporated into section 6 of the HRT Act.

**Recommendation 11b**
That reproductive human cloning, as defined by the *Human Reproductive Technology Act 1991* remain as a prohibited practice.

That such prohibition not extend to research associated with beneficial medical applications that may result from therapeutic cloning technology such as the develop of tissues and organs for transplantation.

That research into the beneficial medical applications that may come from therapeutic cloning technology be closely monitored and regulated by the Reproductive Technology Council.

CHAPTER TWELVE

**Recommendation 12a**
That gamete donors have no legal responsibilities for offspring and that any conflicting legislation, such as the *Artificial Conception Act 1985*, be amended accordingly.

**Recommendation 12b**
That consequentially upon amendment to the *Human Reproductive Technology Act 1991* to allow access to donor identifying information, the *Freedom of Information Act* be amended to remove inconsistency.
Recommendation 12c
That consistent uniform and/or national legislation on human reproductive technology be developed as a matter of priority and that the Standing Committee on Uniform Legislation and Intergovernmental Agreements be requested to address it.

CHAPTER THIRTEEN

Recommendation 13a
That licence renewal be automatic subject to payment of application fees, unless, in the opinion of the Reproductive Technology Council, there is cogent reason for removal of a licence.

Recommendation 13b
That the current licensing regime under the Human Reproductive Technology Act 1991 remain in place.

Recommendation 13c
That a dual fee structure be adopted comprising a flat rate that will be the same for all clinics and an additional secondary fee based upon the number of treatment cycles performed.

Recommendation 13d
That the Western Australian Minister for Health raise the issue that women who are not infertile but who are unable to bear a child for other reasons are not currently able to access Medicare Benefits for assisted reproductive services, at the Australian Health Ministers’ Council.

Recommendation 13e
That the Western Australian Minister for Health make necessary representations to the Federal Minister for Health to adjust the scheduled Medicare fees so that country couples accessing assisted reproductive technology are not required to pay clinics for ancillary services currently accessed in their home towns at personal costs.

Recommendation 13f
That reporting be mandatory and that clinics be expected to provide more complete information in a standardised format.

That the Reproductive Technology Council supply clear instructions about the information required.

Recommendation 13g
That annual reporting requirements to the Reproductive Technology Council by licensees coincide with reporting to the Reproductive Technology Accreditation Committee.

That a comprehensive program be developed to simplify and standardise reporting requirements.

Recommendation 13h
That the Reproductive Technology Council continue to report to Parliament via the Commissioner of Health.

Recommendation 13i
That power for an authorised officer to inspect records held by licensees be retained in the Human Reproductive Technology Act 1991.
That authorised officers have the same protection as other public servants carrying out similar duties.

CHAPTER FOURTEEN

Recommendation 14a
That records be retained indefinitely by clinicians and central registers under the Human Reproductive Technology Act 1991.

Recommendation 14b
That central registers include identifying information about siblings resulting from donated gametes.

Recommendation 14c
That the Western Australian Minister for Health approach all States and the Commonwealth to establish a national register.

That Western Australia cooperate in the event that a national register is established.

CHAPTER FIFTEEN

Recommendation 15a
That in future, access to donor identifying information be available on request to any donor offspring upon attaining the age of 16 years.

Recommendation 15b
That donor offspring have access to donor identifying information retrospectively where -

(i) the donation was made after the commencement of the Human Reproductive Technology Act 1991; and

(ii) there is clear evidence that the donor was informed that disclosure of identifying information was likely should there be future change in policy or legislation.

Recommendation 15c
That a retrospective voluntary register be established based on the mutual consent between the donor who donated prior to the HRT Act and donor offspring.

CHAPTER SIXTEEN

Recommendation 16a
That Direction 5.2 which states that “the licensee must ensure that the cost of at least one hour with an approved counsellor for each IVF cycle begun, as well as an extra hour when the decision is being made to withdraw from further IVF treatment, is included in the overall cost of treatment” be endorsed and supported.

That wherever counselling is mandatory, the cost of the counselling be included in the overall cost of the treatment.

That the Western Australian Minister for Health approach the Federal Minister for Health to request that the cost of counselling of gamete donors be a fully rebateable Medicare item.
Recommendation 16b
That an audit of counselling services in Western Australia be conducted.

That on the basis of the results of the audit, the Reproductive Technology Council in conjunction with the Health Department of Western Australia and clinics address the obvious need for mid and post-treatment counselling.

Recommendation 16c
That support groups be included as part of the audit referred to in Recommendation 16b.

That at the conclusion of the audit, the support groups be properly resourced.

Recommendation 16d
That the Reproductive Technology Council in conjunction with the Health Department of Western Australia develop strategies to attract and retain approved counselling services in regional areas.

That these services augment the telephone information service that already operates.

That the telephone information service be expanded and promoted statewide and provided with appropriate funding to achieve this outcome.

That there be a telephone line specific to infertility services that is not linked to other sexual health issues.

Recommendation 16e
That the Reproductive Technology Council be supported in its endeavour to ensure that counsellors operating in the area of assisted reproductive technology are eligible for full membership of the Australian and New Zealand Infertility Counsellors’ Association.

Recommendation 16f
That the Reproductive Technology Council be encouraged to refer the need for psychosocial research in the area of reproductive technology to a research facility within the newly established Family and Children’s Policy Office within the department for Family and Children’s Services.

Recommendation 16g
That the consent guidelines contained within the Reproductive Technology Accreditation Committee’s Code of Practice, as for the time being prescribed, be adopted under the Human Reproductive Technology Act 1991’s Code of Practice (referred to in Recommendation 10b).

Recommendation 16h
That the Reproductive Technology Council in conjunction with clinics develop standardised consent forms.

Recommendation 16i
That in light of Recommendation 8j, consent forms be amended to ensure that an election as to whether posthumous use of embryos may proceed is made by the people with rights and responsibilities to make decisions about the embryos.

CHAPTER SEVENTEEN
Recommendation 17a
That the Reproductive Technology Council devise strategies to attract an increased number of semen donors who are prepared for identifying information to be made available to offspring.

Recommendation 17b
That remuneration to gamete donors continue to be confined to reasonable out-of-pocket expenses so that the primary motivation for donation remains altruistic.

Recommendation 17c
That the Reproductive Technology Accreditation Committee be encouraged to determine an upper age limit for gamete donors based upon scientific evidence.

Recommendation 17d
That clinics and practitioners use standardised consent forms to ensure that prospective donors are made aware that in future all donor offspring may elect to have access to donor identifying information.

CHAPTER EIGHTEEN

Recommendation 18a
That the best interests of the child be paramount in any surrogacy legislation and resulting surrogacy arrangement.

Recommendation 18b
That, from the enactment of legislative changes, children born as a result of surrogacy arrangements may elect to have access to identifying information about their surrogate mother and biological parentage, if donor material was used to conceive them, upon attaining the age of 16 years.

That all birth records include donor information.

That a register of children born after surrogacy arrangements be kept in a central location.

Recommendation 18c
That counselling be mandatory for all parties involved in a surrogacy arrangement - the commissioning couple, the surrogate, her partner and her/their children.

Recommendation 18d
That if surrogacy be allowed, it be for medical reasons and after all other avenues, with the exception of adoption, have been exhausted.

That surrogacy be an avenue of last resort and not seen as an alternative to in vitro fertilisation.

That the Reproductive Technology Council consider any applications for surrogacy on a case-by-case basis.

Recommendation 18e
That surrogacy legislation establish a mechanism for setting, reviewing and updating the selection criteria for surrogate mothers from time to time.
That all surrogacy arrangements be non-commercial and that altruism be the only basis for surrogacy arrangements.

That all reasonable expenses be paid for by the commissioning couple.

That in the event that surrogacy is formalised in Western Australia, the Western Australian Minister for Health approach the Federal Government with a view to allowing *in vitro* fertilisation (IVF) surrogacy treatments to be considered by Medicare as any other IVF treatment.

**Recommendation 18g**

That legislation be drafted to provide for surrogacy arrangements as outlined in Chapter Eighteen and to clarify the legal status of surrogate children and their commissioning parents as a matter of urgency.

That the *Adoption Act 1994* be amended to enable adoptions to proceed where surrogate births have occurred in Western Australia pending the introduction of surrogacy legislation.
GLOSSARY OF TERMS

Artificial Insemination

Any procedure in which human sperm are introduced into the reproductive tract of a woman by a non-coital method other than as part of an IVF procedure (as defined below) including artificial insemination by husband (AIH) and donor insemination (DI).*

Assisted Reproductive Technology

Includes a range of methods used to circumvent human infertility, including in vitro fertilisation (IVF), embryo transfer, gamete intra fallopian transfer (GIFT), artificial insemination (AI), all manipulative procedures involving gametes and embryos and treatment to induce ovulation or spermatogenesis when used in conjunction with the above methods. It may be inaccurate to use the term “assisted” when referring to some medical procedures involved in reproductive technology.*

Cloning

The use of reproductive technology for the purpose of producing from one original, a duplicate or descendant that is, or duplicates or descendants that are, genetically identical, live born and viable.#

Cytoplasm

The contents of a cell other than the nucleus.##

Donor Insemination

see “Artificial insemination”.

Egg

The mature female germ cell; also called the ovum or oocyte.##

Embryo

A live human embryo, in the stage of development which occurs from -

(a) the completion of the fertilisation of the egg; or
(b) the initiation of parthenogenesis,

to the time when, excluding any period of storage, 7 completed weeks of the development have occurred.#

Embryo experimentation (interventions/manipulation) -

• Therapeutic

Interventions directed towards the wellbeing of the individual embryo involved.

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* NHMRC. Ethical guidelines on assisted reproductive technology. Commonwealth of Australia 1996.
- **Non-therapeutic** Interventions that are not directed towards the benefit of the individual embryo but rather towards improving scientific knowledge or technical application. Non-therapeutic experimentation includes both non-destructive procedures (which include observation) and destructive procedures.*

**Embryo Flushing** A surgical procedure whereby an egg in the process of fertilisation, or an embryo is flushed from the body of a woman before it has implanted in her uterus.#

**Fertilisation** The process that commences at the moment of inclusion of a sperm head within the plasma membrane of an egg, and is completed with the appearance of a two-cell zygote.#

**Gamete** Egg or sperm

**Gamete Intra Fallopian Transfer** A modification of the classic IVF technique, where fertilisation occurs in the fallopian tube rather than outside the body.

**Intra-cytoplasmic Sperm Injection** A procedure where by a single sperm is injected directly into an egg instead of penetrating the egg in the normal way.

**Institutional Ethics Committee** A committee which is composed in accordance with Supplementary Note 1 of the NHMRC Statement on Human Experimentation, and which otherwise complies with its provisions.*

**In-vitro** In glass; referring to a process or reaction carried out in a test-tube or culture dish.##

**In-vitro Fertilisation** Fertilisation outside the body.

**In-vitro Fertilisation procedure** A procedure, not being a storage procedure, which -

(a) is consequent upon the removal of an egg from the body of a woman, and carried out for one or more of the following purposes -

(i) the fertilisation of that egg, within or outside her body;

(ii) the keeping or use of that egg with intent to derive from it an egg in the process of fertilisation or an embryo; or

(iii) the keeping or use of that egg in the process of fertilisation or embryo so derived;

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* NHMRC. Ethical guidelines on assisted reproductive technology. Commonwealth of Australia 1996.
is directed at the introduction into the body of a woman of -

(i) an egg, whether produced by that woman or by another woman; or

(ii) an egg in the process of fertilisation or an embryo, whether produced by that woman or by another woman and whether or not fertilisation began outside the body into which it is introduced; or

(c) is a procedure in relation to artificially assisted human conception which is prescribed for the purposes of this definition.

**Oocyte**: The mature female germ cell; the egg.

**Parthenogenesis**: In relation to an embryo means development initiated in the absence of, and otherwise than by, fertilisation.

**Person responsible**: In relation to a license or exemption means the individual under whose supervision the storage or practice authorized is, or is to be, carried on.

**Research**: Systematic investigations carried out for the primary purpose of adding to general knowledge but includes the carrying out of an experiment.

**Surrogacy**

- **Traditional**: Sometimes called partial surrogacy. Traditional surrogacy involves insemination of the surrogate with the commissioning husband’s sperm. The surrogate contributes her own genetic material.

- **IVF**: Sometimes called total or gestational surrogacy. IVF surrogacy refers to the implantation of foreign genetic material into a woman who carries the child to full-term for another couple.

**Syngamy**: That stage of development of a fertilised oocyte where the chromosomes derived from the male and female pronuclei align on the mitotic spindle.

**Zygote**: The stages of human development from the commencement of penetration of an oocyte by sperm up to but not including syngamy.

**Infertility Treatment Act 1995 (Victoria).**

**Human Reproductive Technology Act 1991.**

**Australian Academy of Science. On human cloning. A position statement. 4 February 1999.**

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<td>Australian Capital Territory</td>
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<tr>
<td>AF</td>
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<td>Acronym</td>
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1. **ESTABLISHMENT OF THE COMMITTEE AND THE TERMS OF REFERENCE**

The Minister for Health moved on Thursday 15 May 1997 -

(1) That a Select Committee be appointed to inquire into and report on the adequacy of the *Human Reproductive Technology Act 1991* (the Act) in fulfilling its stated objectives, in controlling the practice of, the procedures used in, and the ethics governing, human reproductive technology, and in regulating the use of reproductive technology in artificially assisted human conception and in research, and in particular, the Committee is to consider -

(a) the matters specified for review under section 61 of the Act, namely -

(i) the effectiveness of the operations of the Western Australian Reproductive Technology Council (the Council) and the committees of the Council; and

(ii) the need for the continuation of the functions conferred on the Council and on the Commissioner of Health respectively by the Act;

(b) rights of access to procedures, with particular regard to impacts of the Commonwealth *Sex Discrimination Act 1984*;

(c) research and experimentation on gametes, eggs in the process of fertilisation and embryos;

(d) pre-implantation diagnosis and genetic testing of embryos;

(e) rights to stored gametes and embryos, including -

(i) rights upon the separation or divorce of donors, the death of one or both donors or the physical or mental incapacity of one or both donors; and

(ii) rights of third parties such as subsequent spouses, both heterosexual and of the same sex, and the rights of other relatives;

(f) the storage of gametes, eggs in the process of fertilisation and embryos (including the duration of storage and procedures for extension of storage periods);

(g) the appropriateness and effectiveness of the Council’s obligation to compile a Code of Practice, the Commissioner of Health’s power to issue directions, and the power to make regulations, and the scope and effect of existing directions and regulations under the Act;

(h) the effectiveness of powers of enforcement and disciplinary provisions under the Act, and the adequacy of offences and penalties;
(i) the impact on the Act of relevant Commonwealth and State legislation, and aspects of legislation of other jurisdictions which could be incorporated into the Act;

(j) the effectiveness of the current licensing regime, including fee structure, reporting requirements, powers of inspection and powers of obtaining information;

(k) management of information registers including -

   (i) confidentiality of information;
   (ii) use of data research;
   (iii) use of data for purposes of national data collection; and

(l) access to information about genetic parentage.

(2) (a) To enquire into the current status and incidence of surrogacy arrangements in Western Australia with particular reference to human reproductive technology; and

   (b) to determine what legislation, if any, is required.

(3) That the Committee have power to call for persons and papers, to sit on days over which the House stands adjourned, to move from place to place and to report from time to time.

(4) That the Committee finally report on 17 December 1998.

2. AMENDMENT TO TERMS OF REFERENCE

On Wednesday 17 September 1997, the Terms of Reference were amended by the following motion -

To insert in the Terms of Reference for the Select Committee on the Human Reproductive Technology Act 1991 after paragraph (1) a new paragraph (2) -

(2) (i) To enquire into the current status and incidence of surrogacy arrangements in Western Australia with particular reference to human reproductive technology; and

   (ii) to determine what legislation, if any, is required.

3. REPORTING DATE

The original motion on Thursday 15 May 1997 set the date for presentation of the Committee’s report as 17 December 1998.

4. EXTENSION OF REPORTING DATE
(1) On Tuesday 24 November 1998, the Legislative Assembly passed the following motion -
That the date for presentation of the final report of the Select Committee on the Human Reproductive Technology Act 1991 be extended to Thursday 25 March 1999.

(2) On Thursday 25 March 1999, the Legislative Assembly passed the following motion -
That the date for presentation of the final report of the Select Committee on the Human Reproductive Technology Act 1991 be extended to Thursday 22 April 1999.

5. APPOINTMENT OF COMMITTEE MEMBERS

The Minister for Health moved on Thursday 15 May 1997 -

That the following Members be appointed to the Committee -

- the Member for Kalgoorlie (Ms M.I. Anwyl, MLA)
- the Member for Joondalup (Mr C.J. Baker, MLA)
- the Member for Carine (Mrs K. Hodson-Thomas, MLA)
- the Member for Thornlie (Ms S.M. McHale, MLA)
- the Member for Greenough (Hon. K.J. Minson, MLA)

The Hon. K.J. Minson was elected Chairman of the Committee on Thursday 29 May 1997. Mr Minson was re-elected to the position of Chairman on Wednesday 9 September 1998.

6. APPOINTMENT OF COMMITTEE STAFF

The Clerk of the Legislative Assembly appointed Ms Kirsten Robinson as Clerk to the Committee. Ms Robinson completed her role with the Committee on Wednesday 4 March 1998. Ms Nicole Burgess was subsequently appointed Clerk to the Committee. Mrs Sue Laing was seconded from the Health Department of Western Australia, to act as Research Officer to the Committee.

7. COMMITTEE ACTIVITIES

Meeting dates

The Select Committee met on the following occasions -

- Thursday, 29 May 1997
- Thursday, 12 June 1997
- Monday, 23 June 1997 (Included visit to Concept Fertility Centre, King Edward Memorial Hospital)
- Thursday, 21 August 1997
- Thursday, 28 August 1997
- Thursday, 11 September 1997
- Wednesday, 24 September 1997 (Included visit to PIVET Medical Centre and Perth Andrology)
- Thursday, 13 November 1997
- Thursday, 18 December 1997
- Monday, 9 February 1998 (Included visit to the Reproductive Medicine Research Institute, Queen Elizabeth II Medical Centre)
- Wednesday, 4 March 1998
Oral evidence was taken at several of these meetings. The Select Committee acknowledges the assistance of *Hansard* reporting staff and typists in providing transcripts of evidence. A list of witnesses who provided verbal evidence can be found in Appendix A.

**Investigative Tours**

**Intrastate investigative visits**

The Select Committee visited various clinics in the metropolitan area. These were -

- Concept Fertility Centre, King Edward Memorial Hospital;
- PIVET Fertility Clinic;
- Perth Andrology (now called Fertility West);
- The Reproductive Medicine Research Institute, (now called the Keogh Institute for Medical Research), Queen Elizabeth II Medical Centre.

A list of the people who met with the Select Committee can be found in Appendix C.

**Interstate investigative tour (23 - 26 March 1998)**
The Select Committee travelled to Melbourne, Sydney and Canberra to meet with legislators, policy makers, clinicians, scientists and consumers.

A list of the people who met with the Select Committee can be found in Appendix D.

**Overseas investigative tour (17 July - 6 August 1998)**

Some Members of the Select Committee travelled to France, the United Kingdom, Canada and the United States of America. Members met with legislators, policy makers, clinicians, scientists and consumers in different countries to obtain a broad view of approaches to reproductive technology legislation.

A list of the people who met with the Select Committee can be found in Appendix E.

8. **SUBMISSIONS**

The Select Committee wishes to thank all the people and organisations who responded to the call for public submissions. Submissions numbered 87. A list of submissions can be found in Appendix B.
MINISTERIAL DIRECTION

Pursuant to Standing Order 378(c), the Select Committee directs that the Minister for Health and the Minister for Family and Children’s Services be required, within not more than three months, or at the earliest opportunity after that time if Parliament is in adjournment or recess, to report to the House as to the action, if any, proposed to be taken by the Government with respect to any recommendations of the Select Committee which fall within their jurisdictions.
CHAPTER ONE

INTRODUCTION

1.1 DEVELOPMENT OF THE HUMAN REPRODUCTIVE TECHNOLOGY ACT 1991


The HRT Act was passed “at a time of considerable community disquiet about the ethical implications of human reproductive technology advances”.\(^3\) In the preamble, the HRT Act is described as -

an Act to establish the Western Australian Reproductive Technology Council; to require the compilation of a Code relating to the practice of, the procedures used in, and the ethics governing, human reproductive technology; to make provision with respect to the use of that technology in relation to artificially assisted human conception and for the regulation of certain research; and for related purposes.

Under the HRT Act, the following Regulations, Directions and Guidelines have been issued -

- The Human Reproductive Technology (Licenses and Registers) Regulations 1993, providing for applications for exemptions and licenses under the Act including forms and fees, registers of identity and the Certificate of Identity to be issued to authorised officers;
- The Human Reproductive Technology (Licenses and Registers) Amendment Regulations 1995, providing for a register for the export of human reproductive material;
- Directions given by the Commissioner of Health to set standards of practice under the Act, on the advice of the Western Australian Reproductive Technology Council (RTC).\(^4\)

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\(^3\) Submission 20 - Ms Astrid Norgard, Executive Director, Women’s Policy Development Office.

\(^4\) *Western Australian Government Gazette* # 48. 22 March 1993.
advice to the Commissioner of Health from the RTC, revised Directions were published in 1997.\(^5\)

- Draft Guidelines to assist compliance with Directions issued by the Commissioner of Health under the Act, on the advice of the RTC.\(^6\)

In 1996, the HRT Act was amended by passage of the *Human Reproductive Technology Amendment Act 1996* to allow, for special reasons, case-by-case extensions to the three year embryo storage limit set by the principal Act.

### 1.2 REVIEW PROCESS

A review process was incorporated within the HRT Act. On 5 February 1996, Cabinet gave its support for “the establishment of a Parliamentary Select Committee, after the next State election, to inquire into and report upon the question of storage of embryos”.\(^7\)

The State Election was held in December 1996 and on 15 May 1997, the Minister for Health moved a motion to establish a Select Committee to conduct a review of the operation and effectiveness of the Act as soon as was practicable after the expiry of five years from its commencement and to report back to Parliament. Under section 61 of the HRT Act, the following issues were to be considered -

1. the effectiveness of the operations of the Council (RTC) and the committees of the Council;
2. the need for the continuation of the functions conferred, on the Council and on the Commissioner of Health respectively by this Act; and
3. such matters, other than those referred to in paragraphs (a) and (b), as appear to the Minister to be relevant to the operation and effectiveness of this Act.

The Select Committee approached its task with an open mind to a field where rapid technological and attitudinal changes occur and tried to focus on the fact that the HRT Act was put in place to help infertile couples to have children. The preamble to the HRT Act states that -

> in enacting this legislation Parliament is seeking to give help and encouragement to those eligible couples who are unable to conceive children naturally or whose children may be affected by a genetic disease.

The Select Committee was mindful of the ethical and moral questions raised by the topic such as the welfare of the child resulting from the procedures and the rights of infertile couples. It was aware that concerns have been aired about the possible risks resulting from multiple pregnancies and some of the new technologies involved such as intra-cytoplasmic sperm injection (ICSI).

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\(^5\) *Western Australian Government Gazette* # 171. 3 October 1997.

\(^6\) *Western Australian Government Gazette* # 47. 22 March 1993.

\(^7\) Commissioner of Health, Health Department of WA. Briefing notes to the Select Committee. 14 July 1997.
In reviewing the HRT Act, the Select Committee tried to take a practical approach. Members were aware that “jurisdiction shopping” or “medical tourism” occurred and was increasing. If procedures were prohibited in one state, individuals would go elsewhere to seek treatment. Members discussed whether it would be preferable to allow previously prohibited practices to occur in Western Australia (WA), where they could be controlled and where patients would be given the opportunity to receive information and counselling, rather than have patients travelling to another state where they could receive the treatment legally but without having good access to appropriate follow-up support.

The Select Committee addressed each Term of Reference by considering the current legislation, both in WA and in other jurisdictions. It considered both oral and written submissions received, current literature and other information gathered at meetings and during investigative visits within Australia and overseas.

The Select Committee acknowledged that community attitudes to the area of reproductive technology change. “Less than a century ago, people were appalled by the artificial insemination of animals. Twenty years ago, the birth of the first test-tube baby created a storm of controversy. Now IVF is just another acronym in the dictionary”. The Select Committee agreed with submissions that called for another review of the HRT Act to occur in five years’ time, in order to keep up-to-date with changing views and technology. The timing of the review should be five years from the commencement of amendments made following the Select Committee’s recommendations.

The Select Committee was impressed by the method of review employed in the United Kingdom (UK) for recent work on consent in relation to reproductive technology and on surrogacy. In both cases, eminent academics were appointed to conduct the review and to present the relevant findings to the UK Ministers of Health.

**Recommendation 1**

That the Human Reproductive Technology Act 1991 be reviewed again five years after the commencement of amendments based upon the recommendations of the Select Committee and that the method of review be at the discretion of the Minister for Health.

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CHAPTER ONE - RECOMMENDATIONS

Recommendation 1

That the Human Reproductive Technology Act 1991 be reviewed again five years after the commencement of amendments based upon the recommendations of the Select Committee and that the method of review be at the discretion of the Minister for Health.
CHAPTER TWO

ATTITUDES TOWARDS INFERTILITY AND INCIDENCE AND OUTCOMES OF REPRODUCTIVE TECHNOLOGY PROCEDURES IN WESTERN AUSTRALIA AND AUSTRALIA

2.1 INTRODUCTION

The following chapter provides some background information on current attitudes towards infertility and examines the incidence and outcomes of assisted reproductive technology procedures in WA and Australia. The Select Committee was aware that the demand for reproductive technology will continue to exist and acknowledged that previous options such as adoption are becoming more difficult. In the first two years of the operation of the Adoption Act 1994, there were only 31 placements of children for local, unrelated-adoption. In 1996-97 and 1997-98, very few children were placed for adoption (Table 1).

Table 1: Number of adoption placements in Western Australia in 1996-97 and 1997-98.

<table>
<thead>
<tr>
<th>Type of Adoption</th>
<th>1996-97</th>
<th>1997-98</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locally born, unrelated adoption</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>Overseas born, unrelated adoption</td>
<td>21</td>
<td>19</td>
</tr>
</tbody>
</table>


2.2 INFERTILITY

Infertility is defined by the World Health Organization as “the inability of a couple to achieve conception, or to bring a pregnancy to term, after a year or more of unprotected intercourse”. In the UK, one in six couples will experience difficulty conceiving at some time during their reproductive lives. Webb and Holman (1992) found that 3.5% of couples studied were affected by current

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infertility and 67.9% of the couples had a “reproductive disability” meaning that they could not achieve their desired level of reproductive function.  

The average monthly chance of conceiving in “normal” couples is 20-25%, so success rates for treatment (which may be up to a 25% success rate per cycle of treatment) are comparable. In 1993, an international review found a 15% live-birth rate from over 200,000 cycles of treatment.

### 2.2.1 Causes of infertility

There are many factors that can influence a couple’s chance of successful conception. The Select Committee believed that it was important to highlight that infertility may be a result of problems for either the male or female partner, despite the fact that in the past, inability to have children was usually attributed to the woman. According to Fleming, et al. (1994), a “male factor” is responsible for more than 30% of the cases in which a desired pregnancy is not achieved. Factors influencing fertility include the age of the woman, menstrual cycle pattern, tubal patency, sperm quality, frequency and timing of intercourse, duration of unprotected intercourse, contact with sexually transmissible diseases (STDs), previous obstetric history, smoking and drinking habits, exposure of men to occupational factors such as heavy metals, and chemicals such as pesticides, and previous injuries to the testes.

It is very rare for someone to be completely infertile and as the effectiveness of technology increases there will be fewer and fewer people who will be regarded as totally infertile.

### 2.2.2 Support for people with infertility

Infertility may also be defined as a social condition. Some of the desire to have children and the social stigma and emotional pain that is felt by many infertile couples result from strong social or religious pressure on couples, and especially on women, to reproduce. Pfeffer (1987) argued that it is necessary to lift the stigma associated with infertility. She asserted that even though many people might regret their infertility as a loss of potential, the assumption that infertile people are necessarily...

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desperate for offspring cannot be defended adequately and cannot be used to justify “the Western concentration on developing reproduction-assisting technologies”.

According to Health Canada -

steps should be taken to encourage the belief that to have or not to have children are equally acceptable alternatives, and to lessen the social pressure on couples to bear children. Non-medical solutions to infertility such as counselling, adoption, fostering ... should be encouraged.22

The Select Committee was told that there should be more help for couples to come to terms with infertility and childlessness. Mrs Henny Ligtermoet stated that24 -

it would be better to accept that a small percentage of women cannot bear children and support them in that condition rather than force them to look for unnatural designs, either because of our attitude or the vested interests of certain parts of the community.

In February 1991, the former Deputy Prime Minister and Minister for Community Services and Health, Brian Howe, said that “as a society we need to be better in acknowledging that women make a valuable contribution in a variety of roles”.25 He continued that “we must also direct resources to the provision of individualised assistance for infertile couples (for example counselling) to enable them to explore positive life choices which include childlessness”.

2.2.3 Prevention programs

The Select Committee was told that it is necessary to have programs to help people not to become infertile in the first place26 27 and to conduct research into the causes and prevention of all types of human infertility.28 Health Canada indicated that “prevention of infertility is one of several key goals of any national approach. At the same time, steps should be taken to encourage the belief that to have or not to have children are equally acceptable alternatives, and to lessen the social pressure on couples to bear children”.29

The Select Committee noted the object of the HRT Act (section 4(f)(i)) “to provide a forum whereby debate by the community on reproductive technology issues may be conducted” and the functions of the RTC under section 14(1)(d) and (g) of the HRT Act that relate to research into the cause, prevention and treatment of infertility, and the promotion of public debate -

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24 Submission 11 - Mrs Henny Ligtermoet.
26 Submission 8 - Dr ED Watt, Right to Life Australia.
27 Submission 12 - Mr John Barich.
28 Submission 25 - Ms Kath Smith.
14(1)(d) subject to paragraph (e), to encourage and facilitate, research -

i. into the cause, prevention and treatment of all types of human infertility, adequate attention being given both to female and to male infertility; and

ii. as to the social and public health implications of reproductive technology;

14(1)(g) to promote informed public debate, and to consult with bodies representing the public or sections of the public, on the ethical, social, economic and public health issues that arise from reproductive technology.

The Select Committee favoured the need for public debate and research into the area of infertility. It supported the object of the HRT Act (Section 4(f)(i)) and the RTC’s functions as set out in section 14(1)(d) and (g).

Recommendation 2a

That the object of the Human Reproductive Technology Act 1991 (HRT Act) (Section 4(f)(i)) and the role of the Reproductive Technology Council be retained to stimulate debate and facilitate sections 14(1)(d) and (g) of the HRT Act.

2.3 INCIDENCE AND OUTCOMES OF ASSISTED REPRODUCTIVE TECHNOLOGY PROCEDURES IN WESTERN AUSTRALIA AND AUSTRALIA

Western Australian (WA) clinics and practitioners submit data on all assisted fertilisation treatments and outcomes to the IVF and Donor Registers established under the HRT Act. Additional information on procedures carried out is submitted to the Reproductive Technology Council (RTC) for its annual report to the Minister for Health. Data from the 1997-98 RTC Annual Report are presented below. In addition, clinics are required to send data to the National Perinatal Statistics Unit (NPSU) of the Australian Institute of Health and Welfare (AIHW) which compiles a national profile of incidence and outcomes of reproductive technology.

In 1997-98, 2,185 treatment cycles for IVF and related procedures were reported in WA. The majority of these (1,210) were ovarian stimulation cycles for IVF, 913 were for frozen embryo transfer (FET) and 62 were for gamete intra fallopian transfer (GIFT). While the proportion of IVF cycles has remained steady over time, the relative importance of FET is increasing and GIFT is declining. Of the 1,272 cycles begun for fresh IVF or GIFT, 86.6% proceeded to oocyte retrieval and 78% proceeded to transfer of fresh embryos or gametes. Of the 913 FET cycles begun, 82.9% proceeded to transfer. In 602 cycles where successful oocyte retrieval occurred, some embryos were stored.

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2.3.1 Use of donor material

In 1997-98, donated human reproductive material was involved in 4% of all IVF or GIFT oocyte retrieval cycles (2.4% involved donor semen and 1.6% involved donor eggs) and 5.1% of all FET cycles begun during the year. Donor embryos were used in 0.5% of all FET cycles.\(^\text{31}\)

2.3.2 IVF and GIFT pregnancies

From 1979 - 1995, there was a total of 1,319 IVF pregnancies in WA. As with other Australian States, there was an increase in the number of IVF pregnancies in WA in 1995 (242 pregnancies) compared to 1994 (165 pregnancies).\(^\text{32}\)

From 1985 - 1995, there were 673 GIFT pregnancies in WA. The number of GIFT pregnancies in WA declined from 62 in 1994 to 30 in 1995.\(^\text{33}\)

2.3.3 Success rates

In 1996, there were 230 clinical pregnancies after IVF in WA (Table 2) following the transfer of 857 embryos.\(^\text{34}\) Live-birth was the outcome in 173 pregnancies (228 live-births). There were 25 clinical pregnancies resulting from GIFT after 89 eggs were transferred. Live-birth resulted in 80% of the pregnancies (26 live-births). In addition, there were 103 clinical pregnancies following FET (596 embryos were transferred) and 47 clinical pregnancies after 440 donor insemination (DI) procedures.

Table 2: Number of clinical pregnancies and live-births following different reproductive technology procedures in Western Australia, 1996.

<table>
<thead>
<tr>
<th>Clinical Procedure</th>
<th>Number of Clinical Preganacies</th>
<th>Number of Clinical Preganacies with Live-births</th>
<th>Number of Live-births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fresh embryo transfer IVF-ET</td>
<td>230</td>
<td>173</td>
<td>228</td>
</tr>
<tr>
<td>GIFT</td>
<td>25</td>
<td>20</td>
<td>26</td>
</tr>
<tr>
<td>Frozen embryo transfer (FET)</td>
<td>103</td>
<td>75</td>
<td>90</td>
</tr>
<tr>
<td>Donor insemination (DI)</td>
<td>47</td>
<td>41</td>
<td>51</td>
</tr>
</tbody>
</table>


\(^{\text{31}}\) ibid.


\(^{\text{33}}\) ibid: 51.

In 1995, the total of 2,920 births in Australia after IVF and GIFT represented 1.1% of national births.\(^{35}\)

### 2.3.4 Multiple pregnancies

A number of research articles reported that the main effect of infertility treatment was a rise in the incidence of multiple births.\(^{36,37}\) From 1993-1995, WA had one of the highest multiple pregnancy rates in Australia (24.1%).\(^{38}\) There were relatively more triplets and other higher order multiple births in Queensland (4.2%) and WA (3.2%) than in the other States. Multiple pregnancy rates were higher in GIFT pregnancies than in IVF pregnancies. In 1996, 29% of live IVF births in WA were multiple.\(^{39}\)

In the past, large numbers of embryos were transferred into the uterus in the hope that one or two might survive. In cases where implantation rates are higher than average, the mother could end up carrying a high order multiple pregnancy.

The Reproductive Technology Accreditation Committee (RTAC) requests that all clinics consider carefully the need to transfer more than two embryos or oocytes in each treatment cycle. The RTAC’s guidelines state that “up to three and, in exceptional circumstances, four embryos or oocytes may be transferred in any one cycle must not be exceeded in women younger than 40 years ... For women 40 years and older the low implantation rate makes it permissible to transfer even more than 4 embryos or oocytes”.\(^{40}\)

In WA, up to three embryos can be transferred during an assisted reproductive technology procedure. Under Direction 1.1 to the HRT Act, practitioners in WA must ensure that “the minimum standards maintained for practice ... are those set by ... RTAC and the National Association of Testing Authorities (NATA)”.

In 1996, the mean number of embryos replaced per fresh embryo transfer in WA was 2.4 (median was 2).\(^{41}\) This was similar to figures obtained for Australia and New Zealand. However, the Select Committee was told that the proportion of multiple live IVF births in WA appears to be substantially higher (29% in 1996) than in all Australian and New Zealand clinics combined (19.4% of live-births in 1995). In addition, the RTC pointed out that the three WA clinics appear to have different protocols

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for determining the number of embryos transferred.\textsuperscript{42} In one clinic more than two embryos were replaced in only 14\% of transfers, while the other two clinics replaced more than two embryos in about 75\% of transfers. This difference did not appear to affect the overall proportion of multiple births in each clinic but it had a large effect upon the proportion of higher order multiple births (the clinic range of higher order multiple births was 1.2\% - 9.0\%).

In WA, in 1996, the perinatal mortality rate among all IVF births following fresh embryo transfer was 30.2 per 1,000 total IVF births and the majority of these (85.7\%) occurred in multiple births.\textsuperscript{43} In comparison, the 1996 perinatal mortality rate for all babies born in WA was 8.2 per 1,000 total births.\textsuperscript{44}

2.3.5 Impact of infertility treatments on the newborn and children

Addor, \emph{et al.} (1998) showed that an independent effect of infertility treatment on neonatal morbidity could not be ruled out but most of the impact appeared to be related to multiple births and prematurity. The authors suggested that “reducing the number of medically-induced multiple pregnancies is the most effective prevention of neonatal morbidity related to infertility treatments”.\textsuperscript{45}

2.3.6 Intra-cytoplasmic Sperm Injection (ICSI)

In 1993, ICSI was introduced in WA as a new form of IVF with apparent success for couples who had not been able to conceive using conventional IVF procedures. ICSI involves the injection of a single sperm into the cytoplasm of an egg using a micro needle.

Use of ICSI in WA

In 1997/98, over a third (36.3\%) of all IVF treatment cycles with successful oocyte retrieval used ICSI.\textsuperscript{46} This was similar to the proportion reported in 1996/97 and follows a dramatic increase in the use of ICSI since its introduction. The high use of ICSI was offset by the relatively low use of donor sperm in IVF and GIFT procedures (2.4\% in 1997/98 compared with 7.5\% in 1993/94).

Outcomes of ICSI

The Select Committee heard conflicting views about the benefits of ICSI.\textsuperscript{47} As a result of the early success of ICSI, the technique has rapidly been accepted as the treatment of choice by many centres. However, some researchers are concerned that there is little information about the long-term outcome for children. A Belgian study concluded that the prevalence of major birth defects in live-born infants

\begin{itemize}
\item \textsuperscript{42} \textit{ibid.} Appendix 3: iii.
\item \textsuperscript{43} \textit{ibid.} Appendix 3: ii.
\item \textsuperscript{44} Health Department of Western Australia. \textit{Perinatal statistics in Western Australia.} Fourteenth Annual Report of the Western Australian Midwives’ Notification System 1996. October 1998.
\item \textsuperscript{45} Addor V, \textit{et al.} 1998.
\item \textsuperscript{46} RTC. Annual Report, July 1 1997 - 30 June 1998: 23.
\item \textsuperscript{47} Ragg M. \textit{Fear and fertility.} The Australian. February 13-14, 1999.
\end{itemize}
conceived by ICSI was “within the normal range”. While Kurinczuk and Bower (1997) found that the infants in the Belgian study were twice as likely as Western Australian infants (not conceived through ICSI) to have a major birth defect, Bonduelle, et al. (1997) disagreed about the categorisation of major defects used.

Bowen, et al. (1998) compared medical and developmental outcome at one year of age for children conceived by ICSI and for those conceived by routine IVF or naturally. The authors showed that there was an increased risk of mild delays in development for children conceived by ICSI and said there was “the need for ongoing follow-up of children conceived by ICSI to see whether they are at increased risk of intellectual impairment or learning difficulties at school age”. In addition, some researchers believe that the technique can transmit inheritable infertility problems from a father to a son.

Dr Jennifer Kurinczuk of the TVW Telethon Institute for Child Health Research, drew the Select Committee’s attention to the opportunity that exists in WA to continue to collect “high quality population-based information”. She said that the proposed link between the IVF registers and the WA Birth Defects Registry will determine how many ICSI babies in WA have birth defects compared with babies conceived following IVF (not involving ICSI) and spontaneously conceived babies. The Select Committee noted that Dr Kurinczuk and Dr Carol Bower received funding to carry out a follow-up study of longer term outcomes after ICSI.

In 1997-98, the RTC began a process of consultation with the clinics to ascertain their responses to several widely reported papers on the outcomes for ICSI offspring. The Select Committee was informed that clinics were reminded of their ongoing need for vigilance in the monitoring of outcomes and updating of their patient information, as good studies add to the available information about ICSI.

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52 Vogt PH. Genetic aspects of artificial fertilization. Human Reproduction 1995; 10 (suppl 1); 128-137.

53 Submission 30 - Dr Jennifer Kurinczuk.

The Select Committee acknowledged the debate surrounding ICSI both within Australia and overseas.\textsuperscript{55} Members expressed concern about the possibility of men transmitting an inheritable disorder linked to infertility to a future offspring when the welfare of the child is of paramount importance. The Select Committee felt that future studies on the longitudinal effects of ICSI upon children should be conducted and that WA is well placed through availability of IVF registers and the WA Birth Defects Registry to study these effects. Members also felt that there should be constant review of the world literature relating to ICSI since there is considerable interest world-wide.

\textbf{Recommendation 2b}

That a longitudinal study of children conceived by intra-cytoplasmic sperm injection be conducted in Western Australia.

That the Reproductive Technology Council encourage and facilitate use of information from the databases as directed in section 14(1)(d)(i) of the \textit{Human Reproductive Technology Act 1991}.

\textbf{Recommendation 2c}

That the Minister for Health recommend that a longitudinal study of children conceived by intra-cytoplasmic sperm injection (ICSI) be conducted at a national level.

That there be constant review of the world literature relating to ICSI.

\textsuperscript{55} Western Australian Reproductive Technology Council. \textit{ICSI - The proceedings of the seminar. Weighing up the benefits and risks of this innovative treatment for male infertility.} Webb S (ed). 22 June 1996.

\textsuperscript{56} Health Council of the Netherlands: Committee on \textit{in vitro} fertilization. \textit{Assisted fertilization: ICSI}. 1996.
CHAPTER TWO - RECOMMENDATIONS

**Recommendation 2a**

That the object of the *Human Reproductive Technology Act 1991* (HRT Act) (Section 4(f)(i)) and the role of the Reproductive Technology Council be retained to stimulate debate and facilitate sections 14(1)(d) and (g) of the HRT Act.

**Recommendation 2b**

That a longitudinal study of children conceived by intra-cytoplasmic sperm injection be conducted in Western Australia.

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**Recommendation 2c**

That the Minister for Health recommend that a longitudinal study of children conceived by intra-cytoplasmic sperm injection (ICSI) be conducted at a national level.

That there be constant review of the world literature relating to ICSI.
CHAPTER THREE

WELFARE OF THE CHILD

3.1 INTRODUCTION

The Select Committee believed that the welfare of the child should be considered in all aspects of assisted reproductive technology (ART). This chapter examines legislation that addresses child welfare and introduces the issue of the impact of ART on children who are the non-consenting parties in the procedures. The rights and welfare of the child are also discussed in subsequent chapters.

The United Nations (UN) Convention on the Rights of the Child establishes a solid framework for considering the welfare of the child. Article 3.1 of the Convention states 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.

Articles 7 and 8 address rights to identity and to be known and cared for by parents. They are discussed further in Chapter Fifteen.

3.1.1 Definition of the best interests of the child

The Select Committee felt that there was some need for a further definition of the meaning of the best interests of the child. Members were told by witnesses that they had some doubts about the actual meaning of the term. The Family Law Act 1975 (section 68F), as amended, sets out the matters to be considered by a Judge of the Family Court when deciding what is in the best interests of the child. Under section 68F(2), the court must consider -

(a) any wishes expressed by the child and any factors (such as the child’s maturity or level of understanding) that the court thinks are relevant to the weight it should give to the child’s wishes;

(b) the nature of the relationship of the child with each of the child’s parents and with other persons;

(c) the likely effect of any changes in the child’s circumstances, including the likely effect on the child of any separation from -

(i) either of his or her parents; or
(ii) any other child, or other person, with whom he or she has been living;

(d) the practical difficulty and expense of a child having contact with a parent and whether that difficulty or expense will substantially affect the child’s right to maintain personal relations and direct contact with both parents on a regular basis;

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(e) the capacity of each parent, or of any other person, to provide for the needs of the child including emotional and intellectual needs;

(f) the child’s maturity, sex and background ... and any other characteristics of the child that the court thinks are relevant;

(g) the need to protect the child from physical or psychological harm caused, or that may be caused, by -
   (i) being subjected or exposed to abuse, ill-treatment, violence or other behaviour; or
   (ii) being directly or indirectly exposed to abuse, ill-treatment, violence or other behaviour that is directed towards, or may affect, another person;

(h) the attitude to the child, and to the responsibilities of parenthood, demonstrated by each of the child’s parents;

(i) any family violence involving the child or a member of the child’s family;

(j) any family violence order that applies to the child or a member of the child’s family;

(k) whether it would be preferable to make the order that would be least likely to lead to the institution of further proceedings in relation to the child;

(l) any other fact or circumstance that the court thinks is relevant.

One of the most vexed areas considered by the Select Committee concerned the need to balance competing interests with respect to the best interests of the child. On the one hand is the view that all embryos should be gestated to birth while on the other there exist fears that some of the family situations a child is born into may affect that child’s welfare, e.g. where both parents are elderly or where one parent has passed away. The issues of posthumous use of gametes and embryos, as discussed in Chapter Eight, exemplify this dilemma.

The Select Committee is hopeful that some further consideration can be given to the concept of a definition of just what is in the best interests of a child, be it emotional, environmental, or financial. The Select Committee recommended that the RTC in conjunction with the newly established Family and Children’s Policy Office within the department for Family and Children’s Services should determine guidelines for defining the “best interests of the child”.

**Recommendation 3a**

That the Reproductive Technology Council in conjunction with the newly established Family and Children’s Policy Office within the department for Family and Children’s Services determine guidelines for defining the “best interests of the child”.

### 3.2 LEGISLATION

As early as 1985, the Senate Standing Committee on Constitutional and Legal Affairs said that a long-term goal should be uniformity in consolidated legislation dealing with the status of all children whether
born through the application of reproductive technology or entirely naturally. 58 Ms Leigh Newman told the Select Committee that a formal mechanism is necessary to address the issue of protection of the interests and welfare of the child. 59 According to Dr Edda Simeoni, “the welfare and interest of the child and the child as an adult should be the fundamental principle for any change to legislation”. 60 A number of states have included child welfare issues in their reproductive technology legislation.

3.2.1 Western Australia

The welfare of the child is addressed in several sections of the HRT Act.

Section 4(d)(iv) states -

that the prospective welfare of any child to be born consequent upon a procedure to which this Act relates is properly taken into consideration.

The Western Australian Reproductive Technology Council’s Counselling Committee (RTCCC) recommended that the term “child” should be extended to “offspring” because “many of the outcomes may have an impact on those born from [assisted reproductive technology] ART throughout their lives”, (i.e. beyond childhood). 61 Although the Select Committee felt that the intent of use of the term “child” is clear and there is no need to change it, members did endorse the notion that welfare issues do extend into adulthood.

Membership of the Reproductive Technology Council

Section 9(2)(a)(i) states that -

in recommending persons for membership of the Council the Minister shall endeavour to ensure that the Council has available to it from its membership adequate representation of the interests of women, of parents, of the children born of reproductive technology, and of participants in reproductive technology.

IVF procedures

Section 23(e)(ii) states that -

an in vitro fertilisation procedure may be carried out where consideration has been given to the welfare and interests of any child likely to be born as a result of the procedure.

3.2.2 South Australia

Statutory declaration

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58 Report by the Senate Standing Committee on Constitutional and Legal Affairs on national uniformity in laws relating to the status of children born through the use of in vitro fertilisation. AGPS, Canberra 1985.


60 Submission 50 - Dr Edda Simeoni.

61 Submission 66 - Western Australian Reproductive Technology Council Counselling Committee (RTCCC).
Section 10(2) of the South Australian *Reproductive Technology Act 1998* states that -

the welfare of any child to be born in consequence of an artificial fertilisation procedure must be treated as of paramount importance, and accepted as a fundamental principle, in the formulation of the code of ethical practice.

Persons seeking treatment in South Australia (SA) must sign a statutory declaration°2 -

that as at the date of signing the declaration they are not subject to a term of imprisonment or to outstanding charges for an offence for which imprisonment may be imposed on conviction;

that they have not been found guilty of a sexual offence involving a child or an offence involving violence; and

whether they have had a child permanently removed from their guardianship other than by adoption. If a person has had a child removed, an assessment of their parenting skills is required.

This is a method of assuring “that the basic safety of children born of reproductive technology is not compromised”.°3

**Consideration of licensee**

Under clause 13 of the South Australian *Reproductive Technology (Code of Ethical Clinical Practice) Regulations 1995* -

a licensee must, in deciding whether or not to give infertility treatment to any person, or to accept the donation of reproductive material from any person for the use in infertility treatment, treat the welfare of any child that may be born in consequence of the treatment as the paramount importance.

**Counselling**

Under clause 11(4)(a) of the South Australian *Reproductive Technology (Code of Ethical Clinical Practice) Regulations 1995* -

a licensee must not give infertility treatment, or cause, suffer or permit infertility treatment to be given, to a married couple unless the licensee is satisfied -

(a) that the couple has received adequate counselling from a medical practitioner or a counsellor regarding -

- the paramount importance of the welfare of any child that may be born in consequence of infertility treatment; and
- the stress factors involved in the treatment.

Welfare of the child requires that people seeking treatment for infertility make informed decisions and are as prepared as possible. The South Australian Council on Reproductive Technology (SACRT) has

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made a number of recommendations to assist the process towards a systematic approach to matters that impact upon the welfare of the child. These are set out below.

1. In order to give paramount consideration to the issue of the welfare of the child to be born, units be required to schedule a pretreatment appointment between a medical practitioner or a counsellor and the individual or couple seeking treatment which specifically addresses this issue.

2. Couples be provided with the option of having sessions as individuals with the person providing the counselling.

3. A note of the conduct of this interview be entered in the person’s file.

4. After pregnancy is established all expectant parents be offered further counselling support to help address issues related to the welfare of the child to be born.

5. After 12 months the process be evaluated to determine the perceived usefulness and the number of patients availing themselves to the services. A summary report of this evaluation should be made available to the South Australian Council on Reproductive Technology.

6. Given the absence of an appropriate and available referral agency, a private assessment from a psychologist, social worker or psychiatrist be sought whenever problems are identified indicating the possibility of treatment being denied.

7. Ongoing counselling be encouraged and counsellors be retained with regard to child focused counselling.

### 3.2.3 Victoria

The Infertility Treatment Act 1995 includes the following provision that -

> it is Parliament’s intention that the following principles be given effect in administering this Act, carrying out functions under this Act, and in the carrying out of activities regulated by this Act -

(a) the welfare and interests of any person born or to be born as a result of a treatment procedure are paramount.

### 3.2.4 New South Wales

The NSW Law Reform Commission (LRC) recommended that the welfare of the child should be paramount and should prevail over the interest of adults involved in surrogate motherhood.

### 3.2.5 United Kingdom

Section 13(5) of the Human Fertilisation and Embryology Act 1990, states that a treatment centre licensed under the Act must not provide treatment for a woman unless -

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64 South Australian Council on Reproductive Technology. Memorandum 6 to Reproductive Medicine Units. *Counselling for clients on the paramount importance of the welfare of the child.* July 1998.

account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for a father), and of any other child who may be affected by the birth.

However, Mr Eric Blyth, Principal Lecturer in Social Work, University of Huddersfield, identified problems with the Act’s view of children’s welfare. “It does not afford any priority to the welfare of the child in the face of any competing interests (i.e. the welfare of involuntary childless couples or the welfare of donors of genetic material)”.

The Select Committee noted the emphasis placed upon the welfare of the child by different jurisdictions and Members believed that the HRT Act should be amended to ensure that the welfare of the child is paramount and superior to the interests of other participants in ART procedures.

**Recommendation 3b**

That the welfare of the child be paramount in all human reproductive technology procedures and in recognition of that paramountcy, that the Human Reproductive Technology Act 1991 be amended where required to reflect and give priority to that.

### 3.3 IMPACT OF ASSISTED REPRODUCTIVE TECHNOLOGY UPON CHILDREN

The Select Committee received a number of submissions and correspondence that raised concerns about the impact of the current legislation upon children’s welfare and further concerns that may arise if changes are made to the legislation.

The Select Committee obtained information about the impact of reproductive technology upon children during its investigative visits and by inviting a number of individuals and organisations to respond to the following issues -

- What areas of the Human Reproductive Technology Act 1991 impact on resulting children and how could these be clearly set out in the Act?
- What level of access to information should any child born as a result of human reproductive technology be given?
- What are the possible psychological and social effects on the offspring of surrogacy and human reproductive technology in general?
- Are there other child welfare issues that the Committee should consider that are not adequately covered by WA procedure and law?

Information received with reference to the welfare of the child has been incorporated into the relevant parts of the report.

### 3.3.1 Child advocacy

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66 Submission 70 - Mr Eric Blyth, University of Huddersfield.

67 Correspondence from the Hon. Barbara Scott, MLC, Member for the South Metropolitan Region. 30 April 1998.
During the Select Committee’s visit to Melbourne in March 1998, Members met with Ms Moira Rayner, a Melbourne lawyer and writer. She expressed concern that children born of surrogacy arrangements should have as much protection as adopted children. Ms Rayner told Members that in 1994, she was a Deputy Director of the Australian Institute of Family Studies. In a report to the then Minister for Family Services on the Commonwealth’s role in preventing child abuse, she recommended the establishment of an Office of the Child to be responsible for such issues as ensuring that children have appropriately qualified and experienced representatives as well as co-ordinating children’s policy. Ms Rayner believed that children need expert legal representation in any case, especially when there are strong views on both sides and where agencies are involved and children’s interests are clearly at risk.

3.3.2 Rights and status of the child

One submission pointed out that:

a particular difficulty in linking welfare of the child issues to ART legislation is the unavoidable fact that the child whose welfare needs to be considered does not exist - and will not exist save for the provision of ART. This means that the type of criteria that may be applied in respect of existing children ... are rarely transferable to ART.

A further limiting factor ... is the lack of acknowledgement that individuals born as a result of ART will have an existence beyond childhood.

Ms Moira Rayner agreed that the law does not recognise a child until it is born or capable of being born alive, and has a legal personality. Therefore, its interests can not be protected if it is not acknowledged by the law. Ms Rayner added that the only acknowledgement of a child’s status prior to birth comes in the UN Convention on the Rights of the Child.

Legislation dealing with the status of children born as a result of artificial insemination and IVF was enacted in New South Wales, South Australia and Victoria in 1984 and in Tasmania, WA, the Northern Territory and the Australian Capital Territory in 1985. Three Commonwealth Acts also refer to the status of IVF children -

- **Marriage Act 1961** (section 92(3) (Marriage Amendment Act 1983 - section 26)
- **Family Law Act 1975** (section 5A) (Family Law Amendment Act 1983 - section 4)
- **Australian Citizenship Act 1948** (section 5(6) - (8)) - inserted in 1984.

3.3.3 Research

Professor Susan Golombok believed that research into the consequences for children growing up in families created by ART is still in its infancy. However, “existing findings appear to suggest ... that aspects of family structure such as a genetic relatedness, number of parents and the mother’s sexual

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69 Submission 70 - Mr Eric Blyth.

70 Ms Moira Rayner. Meeting with Select Committee, Melbourne, 24 March 1998.
orientation, may matter less for children’s psychological adjustment than warm and supportive relationships with parents, and a positive family environment”.

The Select Committee acknowledged that many of the social and psychological implications of human reproductive technology are still unknown and recommended that long-term studies should be conducted or monitored to ensure that the best interests of the child are respected.

**Recommendation 3c**

That the newly established Family and Children’s Policy Office, within the department for Family and Children’s Services in conjunction with the Health Department of Western Australia and the Australian Institute of Family Studies, conduct research to monitor the impact upon, development of and welfare of the child resulting from assisted reproductive technology.

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## CHAPTER THREE - RECOMMENDATIONS

### Recommendation 3a
That the Reproductive Technology Council in conjunction with the newly established Family and Children’s Policy Office within the department for Family and Children’s Services determine guidelines for defining the “best interests of the child”.

### Recommendation 3b
That the welfare of the child be paramount in all human reproductive technology procedures and in recognition of that paramountcy, that the *Human Reproductive Technology Act 1991* be amended where required to reflect and give priority to that.

### Recommendation 3c
That the newly established Family and Children’s Policy Office, within the department for Family and Children’s Services in conjunction with the Health Department of Western Australia and the Australian Institute of Family Studies, conduct research to monitor the impact upon, development of and welfare of the child resulting from assisted reproductive technology.
CHAPTER FOUR

OPERATIONS AND FUNCTIONS OF THE REPRODUCTIVE TECHNOLOGY COUNCIL

4.1 INTRODUCTION

The Select Committee was asked to examine the matters specified for review under section 61 of the HRT Act, namely the effectiveness of the operation of the Reproductive Technology Council (RTC) and its committees and the need for the continuation of the functions conferred on the RTC and on the Commissioner of Health respectively by the HRT Act.

4.1.1 Establishment of the Reproductive Technology Council

In 1986, the In vitro Fertilization Ethics Committee of Western Australia presented its report to the Minister for Health. It recommended that a Licensing and Supervisory Authority and Bioethics Committee should be established. In 1988, the Minister for Health announced the formation of a Reproductive Technology Working Party. It was responsible for making specific legislative recommendations based on the reports of the IVF Ethics Committee and the independent scientific evaluation of IVF, and the South Australian Reproductive Technology Act 1988. The Working Party recommended the creation of the HRT Act and the establishment of the Western Australian Council on Reproductive Technology under the Act. This was supported by the Select Committee appointed to inquire into the Reproductive Technology Working Party’s Report.

The Interim Reproductive Technology Council was appointed in August 1989. The inaugural meeting of the RTC was convened by the Minister for Health on 28 April 1992.

4.2 OPERATION OF THE REPRODUCTIVE TECHNOLOGY COUNCIL

The functions of the RTC (the Council) are covered briefly in section 5(2) and in section 14 of the HRT Act.

Section 14(1) states that subject to section 13(2), the functions of the Council are -

(a) to advise the Minister -

(i) on reproductive technology and any matter that is connected with, or incidental to, reproductive technology; and

(ii) generally, as to the administration and enforcement of this Act;

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72 Health Department of Western Australia. Report of the Committee appointed by the Western Australian Government to enquire into the social, legal and ethical issues relating to in vitro fertilisation and its supervision. Perth 1986.

73 WA Legislative Assembly. 1988.
(b) to advise the Commissioner of Health -

(i) on matters relating to licensing under this Act, including but not limited to the suitability of any applicant for a licence or of any licensee to carry out particular procedures or approved research and as to the conditions that should be imposed on any licence; and

(ii) generally as to the administration and enforcement of this Act and particularly on disciplinary matters, having regard to any findings made by, or report received from, a committee of inquiry appointed under section 38;

(c) after consultation with bodies representing persons having relevant expertise or sections of the public having appropriate interests, to compile and to cause to be published, to review, and to amend, a Code of Practice which -

(i) sets out Rules, guidelines and relevant information;

(ii) establishes the ethical standards required of licensees, and gives effect to the principles specified in, and the requirement of, this Act; and

(iii) provides for such other matters as may be instructed by the Minister, or as the Council may determine,

regulating the proper conduct of any reproductive technology practice, and of any procedure, required to be licensed and the proper discharge of the functions of the person responsible and the other persons to whom a licence applies, having due regard to this Act;

(d) subject to paragraph (e), to encourage and facilitate, research -

(i) into the cause, prevention and treatment of all types of human infertility, adequate attention being given both to female and to male infertility; and

(ii) as to the social and public health implications of reproductive technology;

(e) to ensure that no project of research is carried out by or on behalf of a licensee upon or with -

(i) any egg collected in the course of an *in vitro* fertilisation procedure;

(ii) gametes intended for subsequent use in an artificial fertilisation procedure;

(iii) any egg in the process of fertilisation;

(iv) any embryo; or

(v) any participant,

otherwise than in accordance with this Act and pursuant to a general or specific prior approval given by the Council;

(f) to consider applications for, and where proper grant, approval to carry out research to which paragraph (e) applies;

(g) to promote informed public debate, and to consult with bodies representing the public or sections of the public, on the ethical, social, economic and public health issues that arise from reproductive technology;

(h) to communicate and collaborate with other bodies having similar functions, in Australia and elsewhere,

and generally, to give effect or to cause effect to be given to the objects of this Act.

The Select Committee acknowledged the functions of the RTC. Members noted section 14(1)(c) of the HRT Act and felt that the RTC should produce a Code of Practice. They were impressed with the apparent success of the model developed in the United Kingdom although they acknowledged that in
the UK, the Code of Practice has to be approved by the Secretary of State and laid before the Parliament in accordance with section 26 of the Human Fertilisation and Embryology Act 1990.

The Select Committee did recognise that despite the absence of a Code of Practice, WA clinics have been working under enforceable directions and have been subject to disciplinary proceedings as required.

The Select Committee wished to see the establishment of a Code of Practice that will not be required to be laid before Parliament. The form that the Code should take is outlined in Chapter Ten.

**Recommendation 4a**

That the Reproductive Technology Council produce a Code of Practice modelled on the UK Human Fertilisation and Embryology Authority’s Code of Practice.

4.3 ROLE OF THE REPRODUCTIVE TECHNOLOGY COUNCIL

Overall, the Select Committee did not receive many submissions that addressed the role of the RTC. Many of the comments below were from the RTC or from organisations or individuals closely associated with the RTC.

The Select Committee was told that “the role of the Western Australian Reproductive Technology Council in overseeing the provisions of the Act is very important and needs to be strengthened and better resourced”.74 The Western Australian Reproductive Technology Council’s Counselling Committee believed that the RTC has provided “a very essential information and education role in the community”.75 According to Dr Jennifer Kurinczuk it “operates at a very high level” and the “current constitution of Council provides for a balanced and informed debate”.76 Ms Suzanne Midford saw the RTC “as incredibly important in managing the Act. It has tried hard to listen to people in the community, primarily through the counselling committee”.77 However, Mrs Stephanie Knox felt that the RTC should change its perspective “to a more proactive outlook”78 and it was criticised by Dr Robert Mazzuchelli and Dr Bruce Bellinge for its inability to understand proposals, especially relating to innovative procedures.79 One submission expressed the view that the RTC should not act as an

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74 Submission 33 - Ms Suzanne Midford, Ms Jill Bain, Ms Maxine Chapman, Ms Antonia Clissa, Ms Deborah Foster-Gaitskell, Ms Prue Reynolds, Western Australian Human Reproductive Technology Clinic and Community Counsellors Group.

75 Submission 29 - Western Australian Reproductive Technology Council Counselling Committee (RTCCC).

76 Submission 30 - Dr Jennifer Kurinczuk.

77 Ms Sue Midford. Evidence to the Select Committee, 9 March 1998.

78 Submission 17 - Mrs Stephanie Knox, Genesis Infertility Group.

79 Submission 15 - Dr Robert Mazzuchelli and Dr Bruce Bellinge, Concept Fertility Clinic.
institutional ethics committee, but rather should formally acknowledge research projects following their approval by “relevant and properly constituted Institutional Ethics Committees”.

Dr Bronwyn Stuckey, Director, Keogh Institute for Medical Research, indicated that the RTC was very useful for interpreting the HRT Act and Rules with regard to stored sperm but there were sometimes delays in the approval of new protocols or in obtaining permission to export sperm interstate.

Authorities overseeing reproductive technology have been established in other Australian jurisdictions where reproductive technology legislation exists - the South Australian Council on Reproductive Technology (SACRT) and the Victorian Infertility Treatment Authority (ITA).

In the UK, the Human Fertilisation and Embryology Authority (HFEA) was established in response to public concern about the implications that new techniques might have on the perception and value of human life and family relationships.

The Canadian Royal Commission recognised the importance of a regulatory structure “possibly in the form of an agency separate from Health Canada ... [to] report to the Minister of Health ... [to] facilitate the multidisciplinary approach that is essential to managing NRGTs [new reproductive and genetic technologies]”.

It recognised that no single department contains the specialized expertise that these technologies require while an external body “can draw on such expertise ... with greater flexibility”.

The Select Committee felt that the RTC provides an important role overseeing reproductive technology in WA and has been effective in fulfilling its requirements.

**Recommendation 4b**

That the Reproductive Technology Council continue to function in Western Australia.

### 4.4 COMPOSITION OF THE REPRODUCTIVE TECHNOLOGY COUNCIL

Under the HRT Act, the RTC consists of 10 nominated members to be appointed by the Governor on the recommendation of the Minister for Health. Seven individuals must be selected by each of the following - Royal Australian College of Obstetricians and Gynaecologists (RACOG); Australian Medical Association (AMA); Law Society of WA; three other bodies, being bodies having interests relevant to this Act; and the Minister charged with the administration of the Community Services Act 1972. The three remaining individuals are selected by the Minister for Health having regard to section 80, Submission 22 - Dr Pia Broderick and Dr Iain Walker.

81 Dr Bronwyn Stuckey. Meeting with the Select Committee, 9 February 1998.


83 Health Canada. 1996.
9(2) of the HRT Act. In addition, there is an *ex officio* member appointed by the Minister, as the Executive Officer.

Under section 9(2), the RTC must have equal numbers of men and women and adequate representation of the interests of women, parents, children born of reproductive technology and participants in reproductive technology. The RTC should have available to it from its own membership, expertise in reproductive technology, experience in public health matters and relevant ethical guidance. No one person should be the sole representative of disparate interests.

Professor Con Michael, Chairman of the RTC, told the Select Committee that the structure of the RTC was “good and appropriate, as is its representation which gives balance”. Dr Sandra Webb, Executive Officer to the RTC, said that “the breadth [of the RTC] is very important, as is the fact that the majority of members are nominated by different bodies”.

Dr Webb told the Select Committee that members are appointed for a three year period with new members being appointed every 18 months. She felt that this serves to reduce the potential influence of an individual Minister for Health because membership changes on a rolling basis.

In a submission to the New South Wales (NSW) Review of the *Human Tissue Act 1983*, Mr Eric Blyth, recommended “the model adopted for the Western Australian Reproductive Technology Council specifying certain organisations that may nominate members” as an appropriate model.

Section 9(2)(d) of the HRT Act states that no more than one member of the Council at any time is a licensee; or is a person who has a pecuniary or other beneficial interest, other than an interest of a prescribed kind, in the practice of a licensee.

Professor Michael told the Select Committee that he did not wish to see industry representation extended “by having more than one person from the industry or practising in one of the three clinics that we [the RTC] must oversee”. However, Dr Anne Jequier said that most RTC members are “not medically qualified nor are they specialist trained ... as a consequence there have been some ill thought out decisions”.

The Select Committee received a number of submissions and verbal evidence that suggested changes to the composition of the RTC.

The WA Reproductive Technology Clinic and Community Counsellors’ group suggested the creation of two additional posts on the RTC - one being specifically for a counsellor from the RTC’s list of

84 Professor Con Michael. Evidence to the Select Committee, 9 March 1998.
85 Dr Sandra Webb. Evidence to the Select Committee, 9 March 1998.
86 Dr Sandra Webb. Personal communication to the Select Committee.
87 Submission 70 - Mr Eric Blyth.
88 Professor Con Michael. Evidence to the Select Committee, 9 March 1998.
89 Submission 10 - Dr Anne Jequier.
approved counsellors and secondly for a person to represent the interests of adult offspring. The group acknowledged the current difficulty because IVF offspring are still only children and very few donor offspring adults know that they were conceived by DI. Ms Sue Midford strongly supported “an interim measure that recognises the offspring by someone who has some sort of parallel or similar experience ... an adult adoptee or an adult who has been raised in a step-parent situation where that person has not known his or her biological father or mother”. 

Ms Midford also felt that the RTC had an over-representation of medical people on it. She felt a lawyer, ethicists and epidemiologists were important people to have on the RTC. A number of submissions requested consumer representation while another felt that “the lack of representation by a scientist with an active knowledge of ART is compromising the ability of the Council to be able to address issues, related to ART procedures”.

The Select Committee believed that the overall structure of the RTC was adequate but Members felt that since the HRT Act was originally drafted there has been a change in community attitude towards ART legislation to emphasise protection of the rights of the offspring resulting from an ART procedure. The Select Committee was informed that there had always been a consumer member on the RTC. However, the Members believed that the Minister for Health should ensure that a consumer member or a person representing consumer interests, must be required to be appointed to the RTC. The Select Committee also felt that an approved infertility counsellor and a scientist with expert knowledge of the area of ART should be appointed to the RTC.

The Select Committee noted that having a scientist with expert knowledge of ART and a clinician might create a problem with respect to only having one member who has a pecuniary interest and that section 9(2)(a)(ii) of the HRT Act might clash with section 9(2)(d)(ii). One possible way around the problem of having a scientist as well as a clinician could be to have a shared position with a clinician and scientist as member and deputy. Both could attend RTC meetings but only the member could vote. The Select Committee felt that Parliamentary Counsel should take this into consideration when the HRT Act is amended.

The Select Committee noted and supported the recommendation of the Auditor General’s Report *Public Sector Boards - Boards Covering Statutory Authorities in Western Australia* that “legislation establishing a new board or reconstituting an existing one should ensure that membership is on the basis of relevant expertise and experience rather than on representational status”.

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90 Submission 33 - Ms Sue Midford, *et al.*

91 Ms Sue Midford. Evidence to the Select Committee, 9 March 1998.

92 *ibid.*

93 Submission 32 - Ms Caroline Lorbach, DCGS.

94 Submission 34 - Mrs Natalie Peters, DCGS(WA).

95 Submission 15 - Dr Robert Mazzucchelli and Dr Bruce Bellinge.

In making its recommendations, the Select Committee recognised that one RTC member can fulfil more than one role within the RTC. Therefore, it should be possible to ensure that particular experts are appointed to the RTC without increasing the overall membership size.

**Recommendation 4c**

That section 8 of the *Human Reproductive Technology Act 1991* be amended to ensure that the Reproductive Technology Council comprise a consumer or a person representing consumer interests, an infertility counsellor and a scientist with expert knowledge in reproductive technology.

**Recommendation 4d**

That the size of the Reproductive Technology Council remain at its present size.

### 4.5 REPRODUCTIVE TECHNOLOGY COUNCIL COMMITTEES

The RTC has established a number of committees - Counselling Committee, Embryo Storage Committee, Scientific Advisory Committee, and Licensing and Administration Advisory Committee. Under section 11 of the HRT Act, the RTC is able to delegate certain of its powers and functions to specific bodies. To date these powers have been delegated solely to the Embryo Storage Committee, to facilitate urgent consideration of applications for extension to embryo storage.97

#### 4.5.1 Reproductive Technology Council Counselling Committee

The terms of reference of the Counselling Committee include -

- establishing standards for approval of counsellors;
- recommending counsellors deemed suitable for RTC approval;
- monitoring and reviewing the work of approved counsellors;
- convening training programs for counsellors;
- establishing a process whereby counsellors may have approval withdrawn or may appeal a Council decision;
- reporting annually to the Commissioner of Health.

The Counselling Committee also advises the RTC on matters relating to -

- consultation with community bodies;
- promotion of informed debate in the community;
- access to information held on IVF and donor registers;
- psychosocial issues.

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4.5.2 Embryo Storage Committee

Under section 11(1) of the HRT Act, the RTC may delegate the Embryo Storage Committee to “make decisions on applications for extension of the periods of storage of embryos on a case-by-case basis, based on the criteria agreed to by the Reproductive Technology Council”. It also advises upon or carries out other functions relating to embryo storage. In 1997-98, 26 applications for extension were considered urgent and required special meetings of the Embryo Storage Committee.98

The RTC felt that it is important for it to retain the power under section 11, to delegate the granting of extensions of embryo storage to the Embryo Storage Committee.99 The Select Committee concurred with the RTC’s view.

4.5.3 Scientific Advisory Committee

The Scientific Advisory Committee provides the RTC with scientific advice in relation to research projects, embryo diagnostic procedures or innovative practices. The RTC may appoint suitably qualified persons who are not Council members to the Scientific Advisory Committee to ensure that the RTC is provided with appropriate expert input.

4.5.4 Licensing and Administration Advisory Committee

The Licensing and Administration Advisory Committee may advise the RTC on the following -

- matters relating to licensing under the HRT Act, including suitability of any applicant and conditions imposed;
- administration and enforcement of the Act, particularly disciplinary matters;
- suitable standards to be set under the Act, including clinical standards;
- matters relating to licensing, administration and enforcement of the Act.

The RTC was of the view that the constitutions of the Committees must continue to allow appointment of relevant expert advisers within the confidentiality provisions of the HRT Act.100

The Select Committee recognised the roles of the RTC’s Committees and felt that they should continue.

**Recommendation 4e**

That the Reproductive Technology Council’s Committees continue to function at the discretion of the Minister for Health and the Reproductive Technology Council.

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99 Submission 27 - Western Australian Reproductive Technology Council (RTC).
100 *ibid.*
4.6 FUNCTIONS CONFERRED ON THE REPRODUCTIVE TECHNOLOGY COUNCIL AND ON THE COMMISSIONER OF HEALTH

Generally the relationship between the RTC, the Commissioner of Health and the Minister for Health is determined by Part 2 of the HRT Act. According to the RTC, the power relationship between the Council, the Minister for Health and the Commissioner of Health, as set out by the HRT Act, appear to be reasonable.101

4.6.1 Relationship of the Minister for Health to the Reproductive Technology Council102

The Minister for Health is involved with the establishment and membership of the RTC, and certain RTC activities. The Minister must resolve any conflict that may arise between the Commissioner of Health and the RTC, approve where and how registers are kept. It is also the Minister’s responsibility to carry out and report on a review of the HRT Act.

4.6.2 Relationship of the Commissioner of Health to the Reproductive Technology Council

Under section 5(1) of the HRT Act, the Commissioner of Health is charged with the overall administration of the Act, subject to the Minister. The Commissioner -

(a) shall be responsible for the implementation of the licensing system set out in Part 4 (of the Act); and
(b) may give directions to licensees.

The RTC has a major advisory role to the Commissioner of Health regarding reproductive technology matters especially regarding licensing, discipline and enforcement (section 14(1)(b)).

The HRT Act includes a safeguard provision (section 13(2)) which, in an emergency situation, allows the Commissioner of Health to carry out any function of the RTC as though he/she were the RTC’s delegate in the situation where that function had not been carried out properly by the RTC. Thus, the Commissioner of Health is able to enforce all requirements under the HRT Act, even where the RTC is named as the responsible authority. To date the power has not been exercised. The RTC felt that it is important to retain the Commissioner of Health’s power to take over from the RTC in an emergency where the RTC cannot reach a decision.103

Under section 11(1)(c) of the HRT Act, the RTC can also resolve to delegate certain of its functions other than its advisory role on disciplinary matters, to the Commissioner of Health.

Under section 13 of the HRT Act, the Commissioner of Health may delegate all his powers and functions under the Act to an officer of the Health Department except -

- the power to take a decision required under subsection (2)(c) [of section 13];
- the power to license;
- any disciplinary function referred to in section 37 or 38;

101 ibid.
102 Western Australian Reproductive Technology Council. The duties and powers of the Minister and Commissioner of Health under the Human Reproductive Technology Act.
103 Submission 27 - RTC.
The Select Committee heard from the Commissioner of Health that his power to delegate requires clarification.\textsuperscript{104} Under the HRT Act, the Commissioner of Health is given extensive powers to issue Directions on a range of matters relating to reproductive technology and administration of the Act.

Pursuant to the Commissioner’s delegated powers, the Senior Policy Officer, Reproductive Technology has issued Directions ... as the Commissioner’s delegate. The difficulty arises as section 13(5)(b) of the Act provides that the Commissioner cannot delegate his power to license. The exemption does not limit itself to the power to grant, issue or approve licences, but is stated generally.

Further, section 31(4) provides that “anything done by a person pursuant to directions is to be treated for the purposes of this Act as done pursuant to a licence”. As a result\textsuperscript{105} -

it becomes arguable that the power to give directions relating to the Import, Export and Storage of Gametes and Embryos, Annual Reporting for Practice and Storage Licensees, and the Expiry of Storage of Embryos relate to the Commissioner’s power to licence, and cannot be delegated by him. Therefore, the Commissioner of Health requested clarification between\textsuperscript{106} -

- the power to actually grant a licence, and powers to issue directions about standards and practice requirements under a licence.

Clarification is also required between -

- statutory responsibility for assessment of the suitability of applicants to be licensed, and the responsibility for setting terms and conditions necessary for practice under that licence to required standards. (The former responsibility clearly rests with the Commissioner of Health while the latter, currently being exercised by the Commissioner’s delegate, requires direct and extensive technical expertise and a mechanism that is responsive and flexible to changing technologies).

The Select Committee felt that the Commissioner of Health should retain the statutory authority to grant a licence but should be able to delegate the power to set standards and conditions for licences. However, the Members recognised the need for an avenue of appeal to the Minister for Health in circumstances where disagreements arise between the Commissioner of Health, the RTC and the clinics.
**Recommendation 4f**

That the Commissioner of Health retain the statutory authority to grant licenses but that the *Human Reproductive Technology Act 1991* be clarified to enable the Commissioner of Health to delegate powers including the power to set standards and conditions for licences.

That the Commissioner of Health not delegate the power to delegate.

### 4.7 OTHER RELATED COMMITTEES

There are a number of national committees and working parties whose recommendations impact upon assisted reproductive technology (ART) in WA.

#### 4.7.1 Reproductive Technology Accreditation Committee (RTAC)

In 1986, the Fertility Society of Australia (FSA) prepared standards as a guide to the Code of Practice of IVF and related technologies. In 1987, the Reproductive Technology Accreditation Committee (RTAC) was established under the umbrella of the FSA. It is a national committee that comprises eminent clinicians, a scientist, a nominee of the Royal Australian College of Obstetricians and Gynaecologists (RACOG), a patient counsellor and a patient representative.

The RTAC has added a series of explanatory notes to many of the original FSA standards and its code of practice is to be observed in clinics and centres involved with ART. The Code was revised in 1992 and 1997.\(^{107}\)

The RTAC’s functions include the inspection and accreditation of units conducting assisted conception in Australia. Clinics are usually accredited for three years. However, if there are problems, accreditation is made conditional on immediate change, followed by a one year accreditation. During its visit to Melbourne, the Select Committee heard from Dr Gordon Baker, Chairman of the RTAC, that units need to be accredited in order to receive free drugs for the stimulation and production of eggs.\(^{108}\) In addition, in States where legislation exists, units need to have RTAC accreditation in order to obtain their licence or authority to practice.

**Relationship between the RTC and the RTAC**

In WA, the RTC works closely with the RTAC with regard to licensing. Under section 1.1 of the Directions -

\[\text{the Licensee and person responsible in relation to a Practice Licence that authorises IVF procedures must ensure that the minimum standards maintained for practice, personnel and premises are those set}\]

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\(^{108}\) Dr Gordon Baker. Meeting with the Select Committee, Melbourne, 24 March 1998.
by the Reproductive Technology Accreditation Committee (RTAC) and the National Association of Testing Authorities (NATA).

Similarly, section 1.3 of the Directions states that the Licensee and person responsible in relation to a storage licence authorising collection and storage of sperm for artificial procedures involving donation, and/or the storage of eggs or embryos, must comply with RTAC/NATA standards.

Under section 14(3)(b) of the HRT Act -

where a person contravenes any direction given by the Commissioner, being a direction which is consistent with the Code or is not inconsistent with -

(i) ethical guidelines laid down by the National Health and Medical Research Council, as for the time being prescribed;
(ii) criteria established by the Reproductive Technology Accreditation Committee for the Fertility Society of Australia, as for the time being prescribed; or
(iii) a provision of, or any principal set out in, or requirement under, this Act, as from time to time amended, and

the Council shall endeavour to ensure, if necessary by disciplinary action under section 38, that effect is given to that provision, requirement or direction.

However, it was pointed out to the Select Committee that even if a licensee loses RTAC accreditation, “the license under the (HRT) Act is not automatically lost and the summary determination process must be carried out in order to achieve this”.

The RTAC is funded by a contribution from all clinics. In addition, a site visiting fee is to be introduced, to cover costs, that may act as a deterrent to a clinic from being found wanting. If a clinic is only accredited for one year, the RTAC has to return after 12 months, thus incurring unnecessary extra cost.

The Select Committee heard concerns that data collection was a serious problem because clinics are “forced” to collect data for two sources - the RTC and the National Perinatal Statistics Unit (NPSU), as recommended by the RTAC guidelines. Data collection is addressed further in Chapter Fourteen.

4.7.2 Australian Health Ethics Committee (AHEC)

The Australian Health Ethics Committee (AHEC) is a Principal Committee of the National Health and Medical Research Council (NHMRC) (“the Council”). Its functions are:

(i) to advise the Council on ethical issues relating to health; and
(ii) to develop and give the Council guidelines for the conduct of medical research involving humans; and
(iii) such other functions as the Minister from time to time determines -

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109 Submission 19 - Confidential.
110 Submission 10 - Dr Anne Jequier.
To develop and give the Council guidelines for ethical conduct in the health field, additional to those required for function 2 above, and for the purposes of the Privacy Act 1988;

To promote community debate, and consult with individuals, community organisations, health professionals and governments, on health and ethical issues;

To monitor, and advise on the workings of institutional ethics committees;

To monitor international developments in relation to health ethical issues and liaise with relevant international organisations and individuals.

The AHEC has prepared “Ethical Guidelines on Assisted Reproductive Technology” which apply to all clinical and research activities in the area of ART.112 “In particular, the guidelines require that any innovations in clinical practice be notified to an Institutional Ethics Committee (IEC) ... [which] must approve any major changes to existing practice, based on the same standards as research”.

The RTAC states that “ART, whether therapeutic or experimental must only be practised within the guidelines published by the NHMRC”.113 Therefore, in WA, clinics comply with AHEC guidelines as part of their compliance with RTAC’s guidelines. The ethical guidelines are referred to in section 14(3)(b)(i). However, according to the ethical guidelines, in States “where there is specific legislation ... compliance with provisions of the statutes must be observed. Where both the State law and the guidelines apply, the State law prevails”.114

4.7.3 Australian Health Technology Advisory Committee (AHTAC)

The Australian Health Technology Advisory Committee (AHTAC) reported to the Australian Health Ministers Advisory Committee (AHMAC) and the Federal Minister for Health. AHTAC ceased to function on 30 June 1998 and was replaced by the Medicare Services Advisory Committee (MSAC). AHTAC’s mission was to evaluate health technologies and highly specialised services looking at safety, efficacy, effectiveness, cost, equity, access and social impact. One of AHTAC’s working parties - the Assisted Reproductive Technology Working Party - conducted a review of ART to examine its current status, the current arrangements for the provision of services, future developments and to make recommendations regarding the appropriate and cost-effective application of ART in Australia. The working party’s report has not been released and has been referred to the MSAC.

The Select Committee was concerned that despite national ethical guidelines and standards of practice, there were inconsistencies across State borders and conflict for clinics responding to demands from a number of different authorities.

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114 NHMRC. 1996: 2.
Recommendation 4g

That the Western Australian Minister for Health approach all States and the Commonwealth to produce nationally consistent legislation under one authority.
CHAPTER FOUR - RECOMMENDATIONS

Recommendation 4a

That the Reproductive Technology Council produce a Code of Practice modelled on the UK Human Fertilisation and Embryology Authority’s Code of Practice.

Recommendation 4b

That the Reproductive Technology Council continue to function in Western Australia.

Recommendation 4c

That section 8 of the Human Reproductive Technology Act 1991 be amended to ensure that the Reproductive Technology Council comprise a consumer or a person representing consumer interests, an infertility counsellor and a scientist with expert knowledge in reproductive technology.

Recommendation 4d

That the size of the Reproductive Technology Council remain at its present size.

Recommendation 4e

That the Reproductive Technology Council’s Committees continue to function at the discretion of the Minister for Health and the Reproductive Technology Council.
Recommendation 4f

That the Commissioner of Health retain the statutory authority to grant licenses but that the *Human Reproductive Technology Act 1991* be clarified to enable the Commissioner of Health to delegate powers including the power to set standards and conditions for licences.

That the Commissioner of Health not delegate the power to delegate.

Recommendation 4g

That the Western Australian Minister for Health approach all States and the Commonwealth to produce nationally consistent legislation under one authority.
CHAPTER FIVE

RIGHTS OF ACCESS TO PROCEDURES

5.1 INTRODUCTION

The Select Committee reviewed the rights of access to procedures, with particular regard to conflict between eligibility criteria in the HRT Act and the Sex Discrimination Act 1984 (Cwlth) (SDA). Submissions received expressed various opinions that ranged from a call for removal of all eligibility criteria to endorsement of the existing access requirements and amendment of the SDA to exclude its application to reproductive technology and adoption.\textsuperscript{115} 116 117

5.1.1. Human Reproductive Technology Act 1991

Rights of access to procedures are provided for generally by Division 2 of Part 3 of the HRT Act and sections 3 and 7 of the Directions.

Under section 23, an \textit{in vitro} fertilisation procedure may be carried out where -

(a) it would be likely to benefit -

(i) persons who, as a couple, are infertile; or
(ii) a couple whose child would otherwise be likely to be affected by a genetic abnormality or disease;

(b) each of the participants required to do so has given an effective consent;

(c) the persons seeking to be treated as members of a couple are -

(i) married to each other; or
(ii) are co-habiting in a heterosexual relationship as husband and wife and have done so for periods aggregating at least 5 years, during the immediately preceding 6 years;

(d) the reason for infertility is not age or some other cause prescribed for the purpose of this paragraph; and

(e) consideration has been given to the welfare and interests of -

(i) the participants; and
(ii) any child likely to be born as a result of the procedure.

\textsuperscript{115} Submission 2 - Assoc. Professor Jim Cummins, Submission 4 - Ms Laural Guymer and Ms Renate Klein, FINNRAGE (Australia); Submission 7 - Dr Phillip Matson, Concept Fertility Clinic; Submission 19 - Confidential; Submission 20 - Ms Astrid Norgard; Submission 24 - S Tarrant, Law School, University of Western Australia.

\textsuperscript{116} Submission 8 - Dr ED Watt.

\textsuperscript{117} Submission 12 - Mr John Barich.
and in the opinion of the licensee that consideration does not show any cause why the procedure should not be carried out, but not otherwise.

The Select Committee received advice from Ms Leigh Newman about specific issues in section 23.\textsuperscript{118} She suggested that section 23 needs to be set out on its own to avoid confusion. Section 23 comes under the consent division (Division 2) of the HRT Act.

Ms Newman also indicated that section 23(a) requires that IVF must be “likely” to benefit persons whereas in the Victorian \textit{Infertility Treatment Act 1995}, the lower standard of “may” benefit applies. This is felt to be less stringent. She also was of the view that the reference to the best interests of the child in section 23(e)(ii), needs to be interpreted and clarified as to how it will be met.

The Select Committee considered the points above. With regard to the best interests of the child, the Select Committee has already canvassed the issue in Chapter Three.

5.1.2 Directions

Under Direction 7.2, the licensee must ensure that the medical practitioner treating the patient makes the final decision as to the eligibility of any participant on both legal and medical grounds, and that the reasons for the decision are recorded.

Under Direction 7.3, the licensee must ensure that the role of the clinic-based counsellor is separated from the assessment process. However, situations may arise where duty of care to a future child may override this requirement and a counsellor should advise the medical practitioner of concerns and suggest that a second opinion be sought about matters that may affect eligibility.

The Select Committee supported Directions 7.2 and 7.3.

5.1.3 Welfare of the Child

According to the RTC Counselling Committee (RTCCC), “while treatment should not be ruled out for any particular group of persons, access to it is not considered ... to be a right and the welfare of the potential child should always be of paramount importance”.\textsuperscript{119} Consideration should be given to how the welfare of the potential child should be determined.

In its submission, the RTC said that whether or not eligibility criteria are to be retained “the likely welfare of the potential child must always be considered by the treating medical practitioner prior to any decision to proceed with treatment”.\textsuperscript{120}

The Select Committee agreed with both the RTC and the RTCCC about the need to consider the welfare of the future child prior to treatment.

The welfare of the child is discussed in Chapter Three and is referred to throughout this report.

\textsuperscript{118} Submission 86 - Ms Leigh Newman.

\textsuperscript{119} Submission 29 - RTCCC.

\textsuperscript{120} Submission 27 - RTC.
5.2 LEGISLATION AND LEGAL CASES FROM OTHER JURISDICTIONS

5.2.1 South Australia

Until recently, couples in South Australia had to be married or in a *de facto* relationship for five years in order to access treatment. However, the situation in South Australia changed following a challenge that was accepted by the Supreme Court. Single people in South Australia are now eligible to receive treatment if they are medically infertile. Current eligibility criteria for ART have been provided to reproductive medicine units by the South Australian Council on Reproductive Technology (SACRT).

5.2.2 Victoria

The Human Rights and Equal Opportunity Commission found that in Victoria, unmarried people were discriminated against when they were denied access to reproductive technology programs. The respondent hospitals refused treatment because the *Infertility (Medical Procedures) Act 1984* (Victoria) required participants to be married. This refusal was contrary to provisions under the *Sex Discrimination Act 1984* (Cwlth) (SDA). A recent amendment to the *Infertility Treatment Act 1995* (Victoria) lifted the ban on the access of *de facto* couples to treatment. It does not specify a minimum time period for the relationship. The amendment does not address single women or same sex couples.

Other eligibility criteria include:

- prior to the commencement of a treatment, a woman and her husband must give informed consent to the kind of treatment to be performed;
- for a woman to undergo a treatment, it must be established by a doctor that the woman is unlikely to become pregnant from an oocyte produced by her and sperm produced by her husband, other than by a treatment procedure; or
- for a woman to undergo treatment, it must be established by a specialist qualified in human genetics that the couple might transmit a genetic abnormality or a disease if the woman became pregnant with her oocyte and her husband’s sperm.

5.2.3 Queensland

There is no reproductive technology legislation in Queensland. A recent case (*JM v QFG and GK, State of Queensland*) was brought before the Queensland Anti-Discrimination Tribunal. JM had been in a stable lesbian relationship for four years. She sought donor insemination (DI) at an infertility

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121 Pearce *v South Australian Health Commission & Ors* (unreported, Supreme Court of South Australia, 10 September 1996).


123 MW & Ors *v Royal Women’s Hospital & Ors* (H96/26, 96/33 and 96/48, A Kohl, 12 March 1997).


clinic but was refused treatment. On 31 January 1997, the Tribunal found that JM had been directly and indirectly discriminated against under sections 11 and 8 of the Queensland Anti-Discrimination Act. JM was refused service on the basis of her lawful sexual activity of being engaged in an exclusive lesbian relationship.

According to Bunney (1997)\textsuperscript{126} -

\begin{quote}
the decision in JM should have been unproblematic. If a lesbian couple in a stable relationship decide to have children, then their ability to do so should in no way be different to those persons in stable heterosexual relationships. The focus should be on the capacity of the individuals to be parents, not on their sexual preferences.
\end{quote}

Subsequently, the Supreme Court of Queensland overturned the Tribunal’s decision after the clinic appealed, saying it had a right to refuse treatment because the woman was not infertile.\textsuperscript{127} On 18 August 1998, that decision was upheld by the Queensland Court of Appeal.\textsuperscript{128}

\subsection*{5.2.4 RTAC}

The RTAC has no guidelines to address access to treatment because restrictions are discriminatory. Dr Gordon Baker, Chairman of the RTAC, told the Select Committee that it is unfair that infertile people are expected to have a standard of living and family care that is not required of the rest of the community, i.e. that the proposition of the ideal nuclear family is forced upon infertile couples.\textsuperscript{129}

\subsection*{5.3 ATTITUDES TOWARDS ACCESS TO TECHNOLOGY}

The Select Committee received a number of submissions which addressed access to ART. Some supported a complete removal of the restrictions to access and some supported the retention of all restrictions. Other submissions indicated that restrictions based upon marital status and/or gender should continue.

The Select Committee was told that the majority of RTC members considered discrimination in the provision of infertility treatment on the basis of marital status, sexual orientation or advanced age to be inappropriate.\textsuperscript{130}

\begin{flushleft}
\vspace{1cm}
\textsuperscript{127} QFG \& GK v JM. OA No. 1877 of 1997. BW Ambrose J. Supreme Court of Queensland, 24 October 1997.
\textsuperscript{129} Dr Gordon Baker. Meeting with the Select Committee, Melbourne, 24 March 1998.
\textsuperscript{130} Submission 27 - RTC.
\end{flushleft}
In 1997, a Health Omnibus Survey was conducted in South Australia. At that time, access to ART was restricted to married couples and people in a long-term relationship of five years or more. Respondents were asked to examine a list of people who might want access to IVF and to select those who should have a right to access IVF (Table 3). Overall, 60.9% of respondents were in favour of widening access. Just under one third of respondents (32.6%) thought none of the suggested groups should have access.

<table>
<thead>
<tr>
<th>Possible groups requiring right of access</th>
<th>Percentage of total respondents in favour of widening access (Total n=3,019) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled people</td>
<td>34.0</td>
</tr>
<tr>
<td>Unmarried couples living together for less than 5 years</td>
<td>32.5</td>
</tr>
<tr>
<td>Single women</td>
<td>23.5</td>
</tr>
<tr>
<td>People with a past conviction for a minor assault</td>
<td>21.0</td>
</tr>
<tr>
<td>Lesbian women</td>
<td>19.1</td>
</tr>
<tr>
<td>Post menopausal women</td>
<td>13.1</td>
</tr>
<tr>
<td>People with a past conviction for a major assault</td>
<td>6.4</td>
</tr>
<tr>
<td>People with a conviction for a sexual offence involving a child</td>
<td>1.4</td>
</tr>
<tr>
<td><strong>Total in favour of widening access</strong></td>
<td><strong>60.9</strong></td>
</tr>
<tr>
<td>Don’t know</td>
<td>6.5</td>
</tr>
<tr>
<td>Don’t think any of the above should have access</td>
<td>32.6</td>
</tr>
</tbody>
</table>


### 5.4 INFERTILITY

As stated in section 23(a) of the HRT Act, two of the main reasons for seeking ART are infertility and the risk of conceiving a child who suffers from a genetic disease or abnormality. The Select Committee agreed that infertility should remain as a threshold for access to treatment. Members felt that no definition of infertility was required within the HRT Act and agreed that Direction 7.2 should be referred to when considering eligibility for treatment. The Select Committee wished to re-emphasise that when considering eligibility for treatment, the welfare of the child and the best interests of the offspring should remain paramount.

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According to the NSW Review of the Human Tissue Act 1983, “prescription of a criteria of infertility may have an effect on access to the program by women who are not in a heterosexual relationship. If a definition of fertility relates to an inability to conceive as a result of intercourse, this would prevent women who are not engaging in intercourse from being considered infertile”.

In New Zealand, access to treatment is refused if there are situations that compromise the safety of the couple or a child. However, no exclusion factor may be used that is unlawful and that might breach the Human Rights Act or the Bill of Rights Act.

5.4.1 Fertile women

The Select Committee was of the view that infertility should be one of the main reasons for accessing ART procedures and did not feel that a normally fertile single woman or couple should have access to ART procedures (excluding DI) for several reasons - that the technology was developed to address infertility problems; that Members did not want people to access the technology in order to have “designer babies”; and on the grounds that the technology is still extremely expensive and not a reasonable use of public funds.

The Select Committee was aware that under section 23(a)(ii) women who may be fertile can access an IVF procedure if their future child would otherwise be likely to be affected by a genetic abnormality. However, the Select Committee was made aware of circumstances where women were technically fertile but for other medical reasons they were unable to bear a child. The problem may also arise for fertile women seeking to use embryos posthumously. In order to address these situations, the Select Committee favoured an appeal provision to the Minister for Health.

**Recommendation 5a**

That Section 23(a) of the Human Reproductive Technology Act 1991 be retained.

That there be an avenue of appeal to the Minister for Health to approve an exemption if he feels there is good and sufficient reason.

The majority of the Select Committee recognised that section 23(a) will need to be amended if the Select Committee’s recommendations with regard to surrogacy (Chapter Eighteen) are accepted by the Parliament. The Member for Joondalup dissented on this recommendation.

5.4.2 Women undergoing medical treatment

Restriction of access to IVF to “infertile women” bars access to those women whose fertility is at risk because of disease and medical treatment which may prevent them from having children later, e.g. cancer and undergoing irradiation or chemotherapy. A legal opinion indicated that these women are

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not banned from egg collection by the HRT Act. The Select Committee was told that there are still problems with egg freezing technology. Therefore, Members had to consider whether these women should have access to IVF in order to store embryos rather than eggs. If this was allowed it would mean that single women would have to have their eggs fertilised with donor sperm. The Select Committee felt that all women whose fertility is at risk because of disease or who are undergoing medical treatment which may prevent them from having children later, should be eligible for IVF treatment.

**Recommendation 5b**

That all women be eligible for IVF treatment if there is any likelihood of them becoming infertile as a result of disease or a medical procedure.

The Member for Joondalup dissented and requested that the word “any” be substituted with the words “strong and demonstrable”.

### 5.5 AGE LIMITATIONS

The chance of pregnancy per month falls as a woman becomes older, particularly as she reaches her late 30s and early 40s. This applies to both fertile women and women undergoing ART.

The HRT Act states that the cause of a couple’s infertility cannot be age. According to Ms Leigh Newman, WA is the only jurisdiction that cites age as an exclusion ground of infertility.

Joyce and Hildebrand (1994) felt that older women are discriminated against if they wish to conceive or adopt children. Selecting older couples has two advantages from the point of view of stability - if they married later in life they are less likely to divorce and if they married early they have passed the time of highest risk for divorce. The authors suggested that the upper limit for IVF should be increased to 45 years and the lower limit raised to 26 years.

In 1994, the RTC convened a workshop on “Age, Assisted Reproduction and the Family”. Dr Anne Jequier stated that one of the most common arguments against late pregnancy is that “it may leave the child motherless at an early age”. However, she pointed out that women are living much longer.

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135 Professor Con Michael. Evidence to the Select Committee, 9 March 1999.


137 Submission 86 - Ms Leigh Newman.


139 Western Australian Reproductive Technology Council *Age and Assisted Reproduction - Contributions to the ethical debate*. Perth, Western Australia. 1994.
longer and she felt, from a social point of view, that there are few arguments against pregnancy for older women. She also cited an Australian study where over half of those interviewed (54.6%) felt happy with a woman of 50 having her own embryos replaced and around one third (37.9%) were happy for a woman of 50 to have a pregnancy using donated eggs.\textsuperscript{140}

Dr Jennifer Kurinczuk could not see “how it is possible to argue that it is in the interests of the child not to exist rather than to be born to an older mother and father.”\textsuperscript{141}

Dr Stephen Zubrick said that the age of onset of parenting can be harmful for children if the parents are young.\textsuperscript{142} His research has associated highest biological, social and physical risks with infants born of teenage parents. He felt that “age provides growth, maturity, and experience”.

Dr Jocelyne Scutt pointed out that “not only women are affected if age limitations are set. Men generally become less fertile with age”.\textsuperscript{143} She concluded that -

not having any age limit would hardly affect the programmes materially in terms of how many people (including older women) are on them. It is hardly likely that many women who are post-menopausal will seek to participate in an IVF programme. And it is even less likely that they will be encouraged to do so.

5.5.1 Post-menopausal women

The American Society of Reproductive Medicine (ASRM) considered the issue of post-menopausal pregnancy.\textsuperscript{144} The ASRM indicated that women of post-reproductive age may give birth by using donated oocytes fertilised \textit{in vitro} and transferred to their uteri.\textsuperscript{145} Arguments in favour of oocyte donation to post-menopausal women are based upon “societal practices, gender equality, and reproductive freedom”. However, one major argument against the procedure is “that there is a ‘natural’ limit to reproductive capacity that is intrinsic to being human, and to transcend this limit is ‘unnatural’ ”. The ASRM concluded that post-menopausal pregnancy should be discouraged.


\textsuperscript{141} Submission 30 - Dr Jennifer Kurinczuk.

\textsuperscript{142} Zubrick SR. \textit{Age, assisted reproduction and the structure and function of families}. In: RTC. \textit{Age and Assisted Reproduction - Contributions to the ethical debate}. Perth, Western Australia. 1994.

\textsuperscript{143} Scutt JA. \textit{Using women, using sexism - age, sex and the failure of reproductive technology}. In: RTC. \textit{Age and Assisted Reproduction - Contributions to the ethical debate}. Perth, Western Australia. 1994.

\textsuperscript{144} American Society of Reproductive Medicine. \textit{Oocyte donation to post menopausal women}. http://www.asrm.org/current/press/postmenp.html

\textsuperscript{145} \textit{ibid}. 
The UK Code of Practice does not specify age limitations for people who seek licensed treatment. However, centres providing treatment are asked to consider “their (participants) ages and likely future ability to look after or provide for a child’s needs”.

The Select Committee considered that there should be an age limit for access to treatment. The members felt that when people over 50 years of age seek treatment, careful consideration must be given by the clinics to the welfare of the future offspring and their right to adequate parenting. The Select Committee acknowledged that a number of men over the age of 50 do undergo treatment in IVF clinics in WA although most of them are under 55 years of age (Table 4). In 1997, these men represented three per cent of the total number of men undergoing IVF treatment in WA (Table 5).

**Table 4: Men aged 50 years and over undergoing treatment in Western Australian IVF clinics, 1993 - 1997.**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>50-54</td>
<td>10</td>
<td>16</td>
<td>16</td>
<td>27</td>
<td>27</td>
</tr>
<tr>
<td>55-59</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>60+</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>11</td>
<td>21</td>
<td>22</td>
<td>38</td>
<td>33</td>
</tr>
</tbody>
</table>

Source: WA IVF Register. Supplied by Dr Sandra Webb, 2 February 1999.

**Notes:**
1. Data from 1993 only includes treatments from 8 April 1993.
3. Since there is no male code on the retrieval form, males could only be identified through the fertilisation and transfer forms. This means that the partners of women who experience a failed collection, or who donate eggs to another couple, may not be included.
4. As couples may undertake treatment over a number of years, the same men may appear in more than one year category. For example, eight of the men treated in 1995 were also treated in 1996 and three of these were still being treated in 1997. Eight men treated in 1996 were also treated in 1997.
5. A 50 year old woman was treated in 1994.

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Table 5: Proportion of all men undergoing treatment in Western Australian IVF clinics aged 50 years and over, 1993 - 1997.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Number of Men Undergoing Treatment</th>
<th>Number of Men Undergoing Treatment aged 50 Years and Over</th>
<th>% of Total Number of Men Undergoing Treatment aged 50 Years and Over</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993*</td>
<td>500</td>
<td>11</td>
<td>2.20</td>
</tr>
<tr>
<td>1994</td>
<td>747</td>
<td>21</td>
<td>2.81</td>
</tr>
<tr>
<td>1995</td>
<td>915</td>
<td>22</td>
<td>2.40</td>
</tr>
<tr>
<td>1996</td>
<td>999</td>
<td>38</td>
<td>3.80</td>
</tr>
<tr>
<td>1997</td>
<td>1086</td>
<td>33</td>
<td>3.04</td>
</tr>
</tbody>
</table>

* 1993 relates to only 9 months of data from 8 April 1993 - 31 December 1993.

Dr Sandra Webb told the Select Committee that although only one 50 year old woman was treated during the period 1993 - 1997, this may not be representative of the demand by older women if the eligibility criteria are relaxed.147

The majority of the Select Committee believed that access to treatment should not be available where either of the parties exceed 55 years of age, except in exceptional circumstances as decided on by the RTC.

Recommendation 5c

That treatment not be available where either of the parties exceed 55 years of age, except in exceptional circumstances as decided on by the Reproductive Technology Council (RTC) and taking as the paramount consideration the welfare of the potential offspring.

That for clients between the ages of 50 and 55 years, clinics assess their suitability for treatment and that the RTC monitor the process.

The Member for Joondalup dissented and requested that “55” be substituted with “45”.

5.6 ACCESS BASED UPON MARITAL STATUS AND GENDER

Section 23(c) of the HRT Act limits access to treatment to married couples or couples who have been in a de facto relationship for five of the last six years.

147 Dr Sandra Webb. Personal communication to the Select Committee.
The NHMRC’s Australian Health Ethics Committee acknowledges that restrictions to access to ART programs may conflict with provisions in the SDA. “ART programs which may be in breach of the SDA may seek exemption from this act by application to the Human Rights and Equal Opportunity Commission”.

A number of submissions highlighted the contradictions between the HRT Act and the SDA and called for changes to the HRT Act. However, others argued that the State Government should ask the Federal Government to amend the SDA to exempt adoption and human reproductive technology from its requirements.

5.6.1 Relevant Legislation

Sex Discrimination Act 1984 (Cwlth)

Section 6 of the Sex Discrimination Act 1984 (SDA) addresses discrimination on the ground of marital status. It states that -

a person ... (the “discriminator”) discriminates against another person ... (the “aggrieved person”) on the ground of the marital status of the aggrieved person if, by reason of -

(a) the marital status of the aggrieved person; ...

the discriminator treats the aggrieved person less favourably than, in circumstances that are the same or are not materially different, the discriminator treats or would treat a person of a different marital status.

According to the Report of the Standing Committee on Legislation in relation to the Acts Amendment (Sexuality Discrimination) Bill 1997, “because Commonwealth law over-rides State law where there is an inconsistency, a State eligibility test for IVF which discriminates on the ground of marital status is potentially invalid”.

WA Equal Opportunity Act 1984

Section 9 of the Act addresses discrimination on the ground of marital status.

A person ... discriminates against another person ... on the ground of the marital status of the aggrieved person if, on the ground of the marital status of the aggrieved person the discriminator treats the aggrieved person less favourably than, in circumstances that are the same or are not materially different, the discriminator treats or would treat a person of a different marital status.
Ms Leigh Newman informed the Select Committee that the current eligibility criteria in WA may be void because they breach both the SDA and the WA Equal Opportunity legislation. She felt that if the criteria remain there needs to be liaison at both State and Commonwealth level to address policy decisions about clinic guidance.

The Standing Committee on Legislation reported that:

on examination it is clear that section 23 of the HRT Act operates unaffected by the EO Act ... for two reasons. First, section 69 of the EO Act makes it clear that an act is not unlawful for the purposes of the EO Act if it was done in order to comply with a requirement of another Act. This allows IVF providers a clear exemption from the operation of the EO Act when they refuse to allow a same sex couple access to IVF procedures. Secondly, to resolve inconsistencies between laws, a general maxim applied by a court is that general provisions do not derogate from specific provisions. That is, provisions in an Act dealing specifically with the matter in hand (in this case, IVF under the HRT Act) will over-ride provisions in a more general Act (in this case, the EO Act).

Acts Amendment (Sexuality Discrimination) Bill 1997

At the time of writing the report, the Acts Amendment (Sexuality Discrimination) Bill 1997 was currently before Parliament.

The Standing Committee on Legislation reported that the proposed Bill is:

not inconsistent with any Commonwealth law relating to IVF technology and is not relevant to the question of whether the Human Reproductive Technology Act 1991 is inconsistent with any Commonwealth law.

Other jurisdictions

According to NSW Health, as a result of decisions in South Australia and Victoria, it would appear that provisions that seek to restrict access to ART on the grounds of marital status “are likely to be vulnerable to a challenge to their validity, pending any amendment of the Commonwealth Sex Discrimination Act, or any granting of an exception under that Act in relation to ART”. NSW Health added that it was likely that -

this would apply to other relationship criteria apart from marriage, that is, any requirement that the woman be in a relationship of any sort (be it a heterosexual or homosexual de facto relationship).
The Standing Committee on Legislation stated that the South Australian and Victorian laws prohibited not only single women but also heterosexual de facto couples from using IVF, and were therefore more clearly in conflict with the Commonwealth Sexual (sic) Discrimination Act 1984 than section 23 of the HRT Act. The risk that section 23 of the HRT Act is invalid is lower than in those cases.

5.6.2 De facto relationships

The Select Committee received submissions which called for the reduction or removal of the five year period of co-habitation for de facto couples.

The majority of the Select Committee felt that specifying the period of time for co-habitation in section 23(c)(ii) should be dropped. Members agreed with one submission that the time limit was arbitrary and that in the light of the high incidence of marriage breakdowns a time should not be specified. Members also believed that it was impossible to police the length of time for a de facto relationship.

**Recommendation 5d**

That section 23(c)(ii) of the Human Reproductive Technology Act 1991 be amended to read “are living in a stable, heterosexual relationship”.

5.6.3 Access to posthumous reproductive material

Under section 26(1)(b) of the HRT Act, if a couple has stored embryos and the male partner subsequently dies, the rights to the embryos vest solely in the surviving partner. However, the woman cannot use the embryos herself because under the HRT Act she is no longer married. This is addressed further in Chapter Eight. The majority of the Select Committee felt that women in this situation should be able to access and use their own embryos provided written consent to use of the embryos was obtained prior to their partner’s death and other conditions outlined in Chapter Eight (Recommendation 8j) are met.

**Recommendation 5e**

That women be able to access and use their own embryos provided written consent to the use of the embryos was obtained prior to their partner’s death and other conditions outlined in Recommendation 8j are met.

The Member for Joondalup dissented opposing the posthumous use of embryos.

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160 Submissions 17 - Mrs Stephanie Knox; Submission 30 - Dr Jennifer Kurinczuk.
161 Submission 30 - Dr Jennifer Kurinczuk.
5.6.4 Single women

The Select Committee was aware that there is debate regarding the impact upon children of being raised in a single parent family in comparison with a two parent family.

The Select Committee was told that single women should be able to save eggs that are collected and stored prior to ovarian failure. Dr Sandra Webb told the Select Committee that under the HRT Act the collection of eggs from single women is allowed. The Select Committee agreed that single women should be allowed to store eggs and to be able to access ART procedures in order to collect reproductive material prior to medical procedures that may affect their fertility.

However, the majority of the Select Committee members did not want to amend section 23(c) to allow single women to access IVF procedures other than in exceptional circumstances.

The minority of the Select Committee felt that there were no evidence-based or research-based reasons to prevent access by single infertile women and noted that many children currently reside with a sole parent. It was also persuaded by the potential for legal challenge that exists and noted the recent change to South Australian legislation following successful litigation brought by a single woman (see section 5.2.1 of this Report).

According to Ms Sue Midford:

research shows that single women’s mothering skills are okay, although they are financially worse off than their counterparts in a couple relationship ... It is an acceptable form of parenting in the community.

While researchers have shown that an association does appear to exist between single parenthood, poverty and childhood problems, Golombok, et al. (1997) felt that the circumstances of single mother families can be just as diverse as those of the traditional nuclear family. Professor Golombok and her colleagues showed that children raised in fatherless families from birth or early infancy are not disadvantaged in terms of either the quality of their relationship with their mother or their emotional wellbeing. This appears to be contrary to what is known about children in father-absent families resulting from divorce. Burghes (1994) indicated that the nature of family disruption may be more important than either the disruption itself or the type of family structure that results - “children who

162 Submission 29 - RTCCC.
163 Dr Sandra Webb. Evidence to the Select Committee, 9 March 1998.
164 Ms Sue Midford. Evidence to the Select Committee, 9 March 1998.
have experienced separation or divorce of their parents often have poorer average outcomes than those who have not”.

5.6.5 Lesbian women

Many children are raised in homosexual relationships. It has been reported that 1.5 million homosexual couples are bringing up children in the United States.

In a review article, Stuhmcke (1997) indicated that “there are many normative social structures which prevent lesbians from accessing IVF ... psychology, medicine, educational institutions and the media”.

Englert (1994) stated that his fertility unit has decided to welcome requests from single and lesbian women for AI following the application of a thorough interview process to determine suitability. Englert added that the demands of single women are more complex than those of homosexual couples and that this is “an observation that contradicts all prejudice surrounding this topic”.

Safety issues

Legal restrictions on access to safe semen and reproductive technology can lead to an increase in dangerous practices. As a result, single women and lesbians may incur risks for themselves and their potential offspring. One of the major issues for lesbian and single women is using semen that may not have been tested for STDs. Participants at the South Australian Council on Reproductive Technology (SACRT)’s Forum on Donor Issues “were keen to see a source of ‘safe’ sperm provided for single women who were not infertile but needed to be sure that their donor was not carrying infections or genetic abnormalities”. Stuhmcke (1997) reported that clinics are becoming more popular amongst members of the lesbian community due to perceived health risks and the availability of technology.

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171 Submission 20 - Ms Astrid Norgard.


Responsibilities of partner in a same sex relationship

A judge in a 1996 Supreme Court of NSW case held that\textsuperscript{174} -

it is not contrary to public policy for a court to find that a person who is living in a lesbian relationship with the mother of a child, conceived by artificial insemination, and who also participates in the act of conception and acts as a parent to the child or children thereby conceived, is liable to provide material support for that child.

Impact upon the offspring

The Select Committee was particularly concerned to ensure the welfare of the potential offspring and found that there was a wide range of opinions about the impact upon children of being raised in a same sex relationship, although much of the recent research suggested that children raised by lesbian couples did not differ from their peers in two parent, heterosexual families.

Basile (1974) stated that “the best interests of the child lay with a loving parent not with a heterosexual parent or a homosexual parent”.\textsuperscript{175} Bates quoted from an adoption case that\textsuperscript{176} -

where a child has two adults dedicated to his welfare secure in their loving partnership, and determined to nurse him to the best of their considerable abilities, there is no reason in law, logic or social philosophy to obstruct such a favourable situation.

According to Kirkpatrick (1996), early studies of children of lesbian mothers dispelled the myths that the children would demonstrate gender development or sexual orientation problems.\textsuperscript{177} Patterson (1994) examined 37 children born to or adopted by single or coupled lesbians.\textsuperscript{178} The results were compared to norms for children of the same age and no significant differences were found except that the children of lesbian mothers reported both more stress and a greater sense of well-being. Research conducted by Professor Susan Golombok and her colleagues suggested that “the use of donor insemination by lesbian or single heterosexual women would not, in itself, lead to difficulties for the


children”. Professor Golombok and her colleagues also conducted longitudinal studies of adults raised as children in lesbian families. They found that the offspring continued to function well in adult life and to maintain positive relationships with both their mother and her partner and contrary to popular assumptions, the large majority identified as heterosexual.

Stuhmcke (1997) found that “given the empirical evidence ... lesbian couples are more than capable of fulfilling all of the necessary functions of a family, providing a stable family life for their children and being adequate and suitable parents”.

However, there are also studies that claim that children would not be better off if they were brought up by homosexual parents. Cameron and Cameron (1998) examined cases of custody disputes and believed that if the present survey of cases is representative of custody disputes, it appears that children are considerably more apt to be harmed in the custody of a homosexual than of a heterosexual parent.

A review of data-based studies which addressed the effect of homosexual parenting upon children found that many of the studies lacked external validity. The authors concluded that the statement that there are no significant differences in children reared by homosexual parents versus heterosexual parents is not supported by the published research base. The converse also remains unproven.


Legal situation

Western Australia
According to the Standing Committee on Legislation184 -

the limitation in section 23 of the HRT Act that prevents persons who are not in a heterosexual relationship from obtaining access to IVF is not inconsistent with any law, either State or Commonwealth.

Queensland
As discussed previously (see page 44), the Supreme Court of Queensland overturned a decision by the Queensland Anti-Discrimination Tribunal and found that an infertility clinic had a right to refuse to treat a woman in a stable lesbian relationship because she was not infertile.185

International situation
An international comparative study found that a number of countries made “medically assisted procreation (MAP)” available to women who were not in a heterosexual relationship - Estonia, Latvia, the Netherlands, Russia, Spain, the United Kingdom, Canada and the United States.186

In Spain, the law states that any woman who has reached the age of 18, is in possession of full legal capacity and has given free and informed consent expressly in writing may receive or use these techniques. In Canada, in the case of Anderson v Luoma, the British Colombian Supreme Court held that the Family Relations Act RSBC 1979, c 121, “does not purport to affect the legal responsibilities which homosexuals have to each other or to children born to one of them as a result of artificial insemination”.187

The majority of the Select Committee (the Hon. Member for Greenough, and the Members for Carine and Joondalup) did not favour relaxing the eligibility criteria to allow access to IVF for lesbian couples.

The minority view, held by the Members for Kalgoorlie and Thornlie, was persuaded by the body of research which concluded that children of lesbian couples functioned well in terms of socio-emotional development and do not differ in terms of gender development. The minority view also held that in determining the “best interests of the child” the focus should be on the stability and capacity of the potential parent(s) rather than the sexual preference or marriage.

The inconsistency between the SDA and the HRT Act was also a persuasive factor in the minority position to remove or relax the exclusion provisions contained in section 23.

5.7 THE SELECT COMMITTEE’S VIEW OF THE NEED FOR LEGISLATIVE CHANGE.

Notwithstanding evidence heard by the Select Committee that section 23(c) should be removed in its entirety, the majority view was that it should remain at least until court decisions clarified the situation and truly definitive longitudinal studies indicated that its removal was consistent with the minimum risk philosophy and can truly be said to be in the best interests of the potential offspring resulting from the use of the technology. However, the majority of the Select Committee felt that in the following special circumstances, access to technology contrary to section 23(c) can be allowed by the RTC - posthumous use of embryos where one partner has died and the deceased party’s written consent for use is available, the use of technology by people who might become infertile as a result of disease or medical procedures and surrogacy arrangements recommended in Chapter Eighteen.

Recommendation 5f

That section 23(c) of the Human Reproductive Technology Act 1991 remain with the amendment proposed in Recommendation 5d.

That access contrary to section 23(c) be allowed for -

(i) posthumous use of embryos where one partner has died and the deceased party’s written consent for use is available;

(ii) the use of technology by people who might become infertile as a result of disease or medical procedures; and

(iii) surrogacy arrangements.

The Member for Joondalup dissented and opposed the posthumous use of embryos and any change to the existing law regarding surrogacy.

Minority Recommendation 5f (Members for Kalgoorlie and Thornlie)

That section 23(c) of the Human Reproductive Technology Act 1991 be amended to allow access to women regardless of sexual preference or marital status.

5.8 CLINICAL OBLIGATIONS

Professor Con Michael told the Select Committee that

I would like to see ... that if a practitioner does not wish to undertake this sort of treatment, for whatever reason ... he should be permitted to be free from any sort of litigation because he did not undertake it.
The Standing Committee on Legislation indicated that\(^ {189}\) -

an IVF practitioner in WA can (and in fact under State law is required to) refuse IVF treatment to a woman on the ground that she is a lesbian, without fear of breaching either State or Commonwealth law.

Englert (1994) indicated that “it is very clear that in all medical activities and particularly in the field of reproductive medicine, every practitioner must have the right of non-participation should their moral conscience tell them so”.\(^ {190}\)

Under the Victorian Infertility Treatment Act 1995 (section 152), a person who has a conscientious objection to research involving gametes, zygotes and embryos or a treatment procedure does not have to participate unless it is likely that the person who is or was a participant in the research or procedure will otherwise die. The burden of proving a conscientious objection is on the person who relies on it.

In a number of international jurisdictions including Austria, Denmark, Germany, Spain and the United Kingdom, a person working in an establishment that practises ART can refuse to take part for reasons of conscience.\(^ {191}\) The UK Human Fertilisation and Embryology Act 1990 (section 38) indicates that anyone who can show a conscientious objection to any of the activities governed by the Act is not obliged to participate in them.

A spokesperson for the Western Australian Branch of the Australian Medical Association (AMA WA) said that technically no doctor is obliged to treat anyone unless it is an emergency situation (i.e. life threatening).\(^ {192}\) The Medical Act 1894 is silent on this issue. The spokesperson said that it would be potentially beneficial to enshrine a conscientious objection clause in the legislation.

The Select Committee acknowledged that clinicians have the right to refuse to provide a service. These is clearly some doubt amongst clinicians about the potential for a legal challenge to their refusal of treatment. The Select Committee felt that it was clear that clinicians were already protected but that in order to remove doubt, Members felt that this should be enshrined within the legislation.

### Recommendation 5g

That no clinic or practitioner be under any obligation to provide a service.

### 5.9 DONOR PREFERENCES

In WA, under Direction 4.2, prior to consent being given to donation or use of donated human reproductive material, the “person responsible” must ensure that all donors and recipients are given oral

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\(^ {190}\) Englert Y. 1994.

\(^ {191}\) Council of Europe. 1998.

\(^ {192}\) Australian Medical Association (WA Branch). Personal communication to the Select Committee.
explanations supported by relevant written information in a form approved by the RTC, including information -

- drawing attention to the *Artificial Conception Act 1985*, in particular to the effect of sections 6 and 7 of that Act in relation to semen donation and section 60B of the *Family Law Act*;

- where a donor consents to use by a woman who does not have the consent of a husband or *de facto* partner, information about uncertainty in the application of the *Artificial Conception Act 1985* or *Family Law Act*;

- about the Donor Register and inclusion of information about biological parentage, and access to non-identifying information under the *Human Reproductive Technology Act 1991* to children born or to donors;

- about the possibility of developments in policy and legislation making identifying information about their biological parentage available to children of donors;

- about the medical, social (rearing) and secrecy implications in relation to donation and the rearing of donor children.

The Select Committee heard from a former donor that he felt “strongly that the donor should have some preference to whom their gametes are donated to”.[193] In Victoria, donors are asked if they agree to have their gametes used for single women, same sex couples and couples of different racial groups.

Following the Pearce decision in South Australia, single persons can now apply to undergo ART procedures if they are infertile.[194] Fertility clinics are bound by the SDA and cannot place restrictions on the use of donated gametes without contravening the SDA. However, this does not bind donors of gametes. In theory, a donor who attached conditions to the use of his or her gametes could be liable for bringing a clinic into contravention of the SDA. The SACRT has accepted that[195] -

- provided there are always donor gametes available for single persons and treatment is not totally refused, donors of gametes should be able to place conditions on their donation if they choose to do so;

and recommended that -

- clinics contact donors, advise them of the Pearce decision, provide counselling and ask them whether they are prepared to extend the use of their gametes for the benefit of single persons as well as married couples. Clinics could also ask whether the donor wishes to place any other conditions on the donation of gametes.

In WA, the current consent form “Consent to donate gametes (eggs or semen) for treatment” asks donors if they have any conditions of donation. In addition, semen donors are asked if they consent to

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193 Submission 56 - Mr Kevin Coleman.

194 *Pearce v South Australian Health Commission & Ors* (unreported, Supreme Court of South Australia, 10 September 1996).

the use of semen in any artificial fertilisation procedure to which section 6 of the *Artificial Conception Act 1985* does no apply.

The Select Committee agreed that donors must give informed consent prior to donation and believed that they must receive counselling in view of the possibility that future children may have access to identifiable information about donors. The Select Committee also felt that recipients of donated reproductive material should receive mandatory counselling. Counselling is discussed further in Chapter Sixteen.

**Recommendation 5h**

That counselling be mandatory for gamete donors and recipients of donated reproductive material.

### 5.10 ACCESS TO ARTIFICIAL INSEMINATION

WA, South Australia and Victoria have treated artificial insemination (AI) differently in their respective legislation.

#### 5.10.1 Western Australia

The HRT Act is silent about eligibility for artificial insemination. A licence is not required if the procedure is carried out by a medical practitioner who has applied for exemption from the licensing requirement. The practitioner must notify the Commissioner of Health of the procedures to be carried out. According to the WA Legislative Council’s Standing Committee on Legislation, section 20 of the *Equal Opportunity Act 1984* prevents a practitioner refusing to offer an AI procedure to a woman because she is single, but it does not prevent a practitioner refusing because she is a lesbian.196

*Acts Amendment (Sexuality Discrimination) Bill 1997*

According to the WA Legislative Council’s Standing Committee on Legislation, there are two ways in which the *Acts Amendment (Sexuality Discrimination) Bill 1997* may affect the availability of AI197 -

- ... section 20 of the EO Act prohibits discrimination in the provision of services on the ground of marital status. ... The Bill will broaden the effect of section 20 by including a lesbian relationship as a type of marital status. A practitioner will therefore also be prohibited from refusing to provide artificial insemination services to a woman on the ground that she is in a same sex relationship.

- ... #35Z of the Bill prohibits discrimination in provision of services on the ground of sexuality. A practitioner will not be allowed to refuse to provide artificial insemination to a woman on the ground that she is a lesbian.

The Standing Committee reported in its findings that -

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197 *ibid*: 43.
if Parliament wishes to amend the law applying to human reproductive technology, so as to prohibit a practitioner refusing to provide artificial insemination services to a woman who is a lesbian or is in a same sex relationship, this should be done by way of amendment to the Human Reproductive Technology Act 1991 itself.

5.10.2 South Australia

In South Australia, a licence is required to carry out AI except where -

- it is carried out by a registered medical practitioner who has submitted his or her name for registration to the Health Commission and has made an undertaking to the Health Commission to observe the Code of Ethical Practice under the Act; or
- it is carried out gratuitously.

5.10.3 Victoria

In Victoria, section 7(1) of the Infertility Treatment Act 1995 permits DI of a married woman or a woman living in a de facto relationship in non-licensed centres, but only if the doctor is approved to carry out DI under the Act and other requirements are met.\(^ {198} \)

5.10.4 Opinions about artificial insemination

The RTC was of the view that DI of women who have no male partner should not be ruled out as there are significant health risks to the woman and the potential child if access to medical treatment is denied and the woman makes private arrangements for treatment with semen that has not undergone adequate screening.\(^ {199} \) The RTC was also concerned about the lack of access by children to registered information if access to DI was not allowed.\(^ {200} \)

The Select Committee was told that for same sex couples and single women requesting DI “there is no alternative but ... to use infertility clinics ... it would be more appropriate for essentially normal women ... to use an alternative system” overseen by the Health Department of WA.\(^ {201} \)

The majority of the Select Committee felt that AI is such a simple procedure and that as long as screening safeguards are maintained, access to AI should not be altered from the current situation. Members were aware of the safety benefits for the women undergoing AI and their potential children through the use of screened semen, and the opportunity for potential offspring to access donor information.

\(^ {198} \) Infertility Treatment Authority (ITA). Conditions of licence. Applications for licences by hospitals and day procedures centres. 6 November 1997: 20.

\(^ {199} \) Submission 27 - RTC.

\(^ {200} \) Dr Sandra Webb. Evidence to the Select Committee. 9 March 1998.

\(^ {201} \) Submission 42 - Dr Roger Perkins.
Recommendation 5i

That current access to artificial insemination be retained.
CHAPTER FIVE - RECOMMENDATIONS

Recommendation 5a

That section 23(a) of the Human Reproductive Technology Act 1991 be retained.

That there be an avenue of appeal to the Minister for Health to approve an exemption if he feels there is good and sufficient reason.

Recommendation 5b

That all women be eligible for IVF treatment if there is any likelihood of them becoming infertile as a result of disease or a medical procedure.

Recommendation 5c

That treatment not be available where either of the parties exceed 55 years of age, except in exceptional circumstances as decided on by the Reproductive Technology Council (RTC) and taking as the paramount consideration the welfare of the potential offspring.

That for clients between the ages of 50 and 55 years, clinics assess their suitability for treatment and that the RTC monitor the process.

Recommendation 5d

That section 23(c)(ii) of the Human Reproductive Technology Act 1991 be amended to read “are living in a stable, heterosexual relationship”.

Recommendation 5e

That women be able to access and use their own embryos provided written consent to the use of the embryos was obtained prior to their partner’s death and other conditions outlined in Recommendation 8j are met.
Recommendation 5f

That section 23(c) of the Human Reproductive Technology Act 1991 remain with the amendment proposed in Recommendation 5d.

That access contrary to section 23(c) be allowed for -

(i) posthumous use of embryos where one partner has died and the deceased party’s written consent for use is available;

(ii) the use of technology by people who might become infertile as a result of disease or medical procedures; and

(iii) surrogacy arrangements.

Minority Recommendation 5f (Members for Kalgoorlie and Thornlie)

That section 23(c) of the Human Reproductive Technology Act 1991 be amended to allow access to women regardless of sexual preference or marital status.

Recommendation 5g

That no clinic or practitioner be under any obligation to provide a service.

Recommendation 5h

That counselling be mandatory for gamete donors and recipients of donated reproductive material.

Recommendation 5i

That current access to artificial insemination be retained.
CHAPTER SIX

RESEARCH AND EXPERIMENTATION

6.1 INTRODUCTION

The Select Committee was asked to address research and experimentation on gametes, eggs in the process of fertilisation and embryos. Members were aware that a degree of conflict and hypocrisy surrounds the issue of research. Without past research, current ART practices would not exist. This is recognised in the preamble to the HRT Act -

Parliament recognises that research has enabled the development of current procedures and that certain non-harmful research and diagnostic procedures upon an egg in the process of fertilisation or an embryo may be licit.

The Select Committee considered the current WA legislation and legislation and guidelines from other jurisdictions.

6.1.1 Human Reproductive Technology Act 1991

Division 1 of Part 3 of the HRT Act and section 9 of the Directions provide for research and experimentation.

According to briefing notes from the Commissioner of Health, “the Act does not signal all significant research provisions clearly”. Provisions governing research are contained in section 14, relating to the functions of the Council; section 20, in relation to compilation of the Code of Practice, and in section 7, relating to offences.

Part of section 14 addresses research and states that subject to section 13(2) the functions of the Council are -

(1) subject to paragraph (e), to encourage and facilitate, research -

(d) into the cause, prevention and treatment of all types of human infertility, adequate attention being given both to female and to male infertility; and

(ii) as to the social and public health implications of reproductive technology;

(e) to ensure that no project of research is carried out by or on behalf of a licensee upon or with -

(i) any egg collected in the course of an in vitro fertilisation procedure;

(ii) gametes intended for subsequent use in an artificial fertilisation procedure;

(iii) any egg in the process of fertilisation;

(iv) any embryo; or

(v) any participant,

otherwise than in accordance with this Act and pursuant to a general or specific prior approval given by the Council;

(f) to consider applications for, and where proper grant, approval to carry out research to which paragraph (e) applies;

and, generally, to give effect or to cause effect to be given to the objects of this Act.

(2) The Council shall not grant approval to any research being conducted, or any diagnostic procedure to be carried out, upon or with an egg in the process of fertilisation, or any embryo, unless the Council is satisfied -

(a) that the proposed research or procedure is intended to be therapeutic for that egg or embryo; and

(b) that existing scientific and medical knowledge indicates that no detrimental effect on the well-being of any egg in the process of fertilisation or any embryo is likely thereby to occur.

Ms Leigh Newman told the Select Committee that, in her view, section 14(2) of the HRT Act “means that all research must be reasonably expected to result in embryos that are competent for implantation only, and not damaged in any way, so that there is more likelihood of successful implantation”. In other words, there is very little scope for research.

6.2 DEFINITIONS

6.2.1 Research

“Research” is defined in section 3 of the HRT Act as “systematic investigations carried out for the primary purpose of adding to general knowledge but includes the carrying out of an experiment”. The Commissioner of Health felt that the adequacy of the definition of research should be considered to ensure it is flexible enough to enable beneficial advances in relation to human fertility, clear enough to distinguish between research and procedures carried out for therapeutic purposes and defined adequately to prohibit practices that conflict with the principles of the Act.

6.2.2 In vitro fertilisation

Under the HRT Act (section 3(1)), an IVF procedure is a procedure which -

(a) is consequent upon the removal of an egg from the body of a woman, and carried out for one or more of the following purposes -

(i) the fertilisation of that egg, within or outside her body;
(ii) the keeping or use of that egg with intent to derive from it an egg in the process of fertilisation or an embryo; or

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204 Commissioner of Health. Briefing notes to the Select Committee. 14 July 1997; and Submission 36 - Commissioner of Health, Health Department of Western Australia.
(iii) the keeping or use of that egg in the process of fertilisation or embryo so derived;

(b) is directed at the introduction into the body of a woman of -

(i) an egg, whether produced by that woman or by another woman; or
(ii) an egg in the process of fertilisation or an embryo, whether produced by that woman or by another woman and whether or not fertilisation began outside the body into which it is introduced; or

(c) is a procedure in relation to artificially assisted human conception which is prescribed for the purposes of this definition.

According to Dr Sandra Webb, this is a broad definition that was deliberately worded to provide the potential to regulate under the HRT Act, as yet unforeseen techniques. Dr Webb felt that there is scope under the HRT Act, via Directions or the Code of Practice, to regulate innovative procedures that are not research.

6.3 RESEARCH AND LIMITATIONS

6.3.1 Gametes

Western Australia

Under section 20(2)(a)(i) of the HRT Act -

no licensee shall carry out, or authorize or facilitate or become involved in the carrying out of, any project of research upon or with gametes obtained in the course of an in vitro fertilisation procedure or intended for use in an artificial fertilisation procedure ... unless general or specific approval relevant to that project has already been granted by the Council, or unless specific prior approval from the Council for that particular project of research is sought for in such manner as may be required by the Code or directions, and if the Council so requires is also sought from a specific Institutional Ethics Committee recognized by the Council, and is obtained.

The RTC expressed the view that its current power to regulate all research on gametes that are to be used in assisted fertilisation procedures should be retained.

Victoria

Under the Infertility Treatment Act 1995, no notification or approval is required for research on gametes, provided that they are not used to form a zygote, and that consent has been given by the gamete provider, as required under section 36.

The Select Committee felt that the RTC should retain its power to regulate all research on gametes.
Recommendation 6a

That the power to regulate all research on gametes as provided for in section 20(2)(a)(i) of the Human Reproductive Technology Act 1991 be retained.

6.3.2 Eggs in the process of fertilisation

The HRT Act defines “fertilisation” as -

the process that commences at the moment of inclusion of a sperm head within the plasma membrane of an egg, and is completed with the appearance of a two cell zygote.

and in so doing, defines for the HRT Act an egg in the process of fertilisation. This is a pragmatic definition as detecting syngamy, as in Victoria, (which occurs a few hours prior to the two cell stage) puts embryos at risk of damage or destruction.

Section 20(2)(a)(ii) of the HRT Act states that -

no licensee shall carry out, or authorize or facilitate or become involved in the carrying out of, any project of research upon or with an egg in the process of fertilisation, or any embryo whether or not live ... unless general or specific approval relevant to that project has already been granted by the Council, or unless specific prior approval from the Council for that particular project of research is sought for in such manner as may be required by the Code or directions, and if the Council so requires is also sought from a specific Institutional Ethics Committee recognized by the Council, and is obtained.

In Victoria, the Infertility Treatment Act 1995 does not refer to “eggs in the process of fertilisation” but to a zygote which is defined as “the stages of human development from the commencement of penetration of an oocyte by the sperm up to but not including syngamy”. Under section 26 of the Infertility Treatment Act 1995, research on zygotes may be undertaken if:

- it is approved by the Authority;
- appropriate consent is given by the person/s providing the gametes;
- if the zygote does not continue to develop to syngamy.

The Select Committee received submissions that suggested that “eggs in the process of fertilisation” should be excluded from bans or other limitations on embryo research and that the terminology should be changed. One submission suggested that if the term “eggs in the process of fertilisation”
remains in the bans, there should be “some change to the definition of fertilisation so that the commencement of the process of fertilisation is given a more pragmatic and useful definition”.

It is generally agreed that an “egg in the process of fertilisation” is not regarded as an embryo but that difficulty exists as to rights to and storage of what is referred to in the HRT Act as an egg in the process of fertilisation.

Consequently, the majority of the Select Committee believed that reference to the term “egg in the process of fertilisation” should be removed from the HRT Act except for the purposes of rights to an egg in the process of fertilisation and its storage and that in those circumstances it should be regarded as though it were an embryo from the period commencing with the mixing of the sperm and egg.

**Recommendation 6b**

That references to an “egg in the process of fertilisation” be removed from the *Human Reproductive Technology Act 1991* except where reference to rights to an egg in the process of fertilisation and storage of an egg in the process of fertilisation exist, in which case an egg in the process of fertilisation will be regarded as though it were an embryo.

That in all other circumstances an egg in the process of fertilisation not be regarded as though it were an embryo.

The Member for Joondalup dissented.

**6.3.3 Creation of eggs in the process of fertilisation for research**

Under section 17(b) of the HRT Act, the RTC prohibits “the development of any egg in the process of fertilisation ... other than with a view to its future implantation into a particular woman”.

Under section 49(2) on the *Victorian Infertility Treatment Act 1995* -

- a person must not knowingly or recklessly form or attempt to form a zygote outside the body of a woman except for the purposes of -
  - (a) a treatment procedure to be carried out in accordance with this Act; or
  - (b) approved research to be carried out in accordance with this Act.

The majority of the Select Committee supported retention of section 17(b) of the HRT Act but that reference to an “egg in the process of fertilisation” should be removed as recommended in Recommendation 6b.
Recommendation 6c

That reference to an egg in the process of fertilisation in section 17(b) of the Human Reproductive Technology Act 1991 be removed.

The Member for Joondalup dissented.

6.3.4 Embryos

One of the difficulties in the area of reproductive research is defining an “embryo”. Under the HRT Act, an embryo is defined as -

a live human embryo, in the stage of development which occurs from the completion of the fertilisation of the egg or the initiation of parthenogenesis to the time when, excluding any period of storage, 7 completed weeks of the development have occurred.

The Victorian Infertility Treatment Act 1995 defines an embryo as “any stage of embryonic development at or from syngamy - (that stage of development of a fertilised oocyte [ovum] where the chromosomes derived from the male and female pronuclei align on the mitotic spindle)”.

The NSW review document defines “embryo” as “the stages of human development from the commencement of penetration of an ovum by a sperm up to and including the ensuing stages of embryonic development”.\textsuperscript{212}

The South Australian legislation does not define the term “embryo”.

Under the UK legislation, “embryo” means a live human embryo where fertilisation is complete, and references to an embryo include an egg in the process of fertilisation, and for this purpose, fertilisation is not complete until the appearance of a two cell zygote.\textsuperscript{213}

6.3.5 Embryo research

NHMRC’s Ethical Guidelines

According to the NHMRC’s “Ethical Guidelines on Assisted Reproductive Technology”, research involving early human embryos raises profound moral and ethical concerns. There are differences of opinion amongst Australians regarding the moral status of the human embryo, particularly in its early stages of development. The differences were understood and reflected in the development of the guidelines, but “at the present time the differences cannot be resolved”. The guidelines state that\textsuperscript{214} -

6.1 Research on human embryos must take place within the limits prescribed by law. In those States and Territories where there is no relevant legislation such research may only take place according to these guidelines.

\textsuperscript{212} NSW Health. 1997.

\textsuperscript{213} Human Fertilisation and Embryology Act 1990, Section 1(1).

\textsuperscript{214} NHMRC. 1996.
6.2 Embryo experimentation should normally be limited to therapeutic procedures which leave the embryo or embryos with the expectation of implantation and development.

6.3 Non-therapeutic research which does not harm the embryo may be approved by an IEC.

6.4 Non-therapeutic research which involves the destruction of the embryo, or which may otherwise not leave it in an implantable condition, should only be approved by an IEC in exceptional circumstances. Approval requires -

- a likelihood of a significant advance in knowledge or improvement in technologies for treatment as a result of the proposed research;
- that the research involves a restricted number of embryos; and
- the gamete providers, and their spouses or partners, to have consented to the specific form of research.

6.5 Protocols for ART in any clinic should take account of the success rates of fertilisation typically achieved in that clinic and, on that basis, seek to avoid the likelihood of production of embryos in excess of the needs of the couple. Techniques and procedures which create embryos surplus to the needs of the infertility treatment should be discouraged.

Western Australia

Under the HRT Act, section 7(1)(a) provides that it is an offence to conduct research on an egg in the process of fertilisation or an embryo without the permission of the RTC. Section 14(2) outlines conditions for RTC approval and prevents research or procedures that are not therapeutic to the specific egg or embryo. As referred to previously, section 20(2)(a)(ii) also addresses embryo research and the approval process.

Other jurisdictions

No Australian jurisdiction prohibits all research on embryos. A major issue is whether destructive research or “non-therapeutic” research should be permitted. The NSW review defines “destructive research” as 215 -

that which harms an embryo, renders it unfit for implantation into the body of a woman or renders it less likely that a pregnancy will result from the transfer of the embryo.

Victoria

Under sections 22 - 25 of the Infertility Treatment Act 1995, research on human embryos may only be undertaken if 216 -

- it is approved by the Authority;
- appropriate consent is given by the couple providing the embryo;
- the embryo remains fit for transfer to the body of a woman;
- there is no harm done to the embryo, which would either make it unfit for transfer or reduce the likelihood of pregnancy;


216 ITA. Conditions for licence. Applications by research scientists. 6 November 1997.
it is undertaken at a place licensed for approved research.

Destructive research is only prohibited after syngamy - “that stage of development of a fertilised oocyte [egg] where the chromosomes derived from the male and female pronuclei align on the mitotic spindle”.

South Australia
In South Australia, standard conditions of research licences prevent research that is detrimental to an embryo.

Attitudes towards embryo research

The Select Committee received differing views about embryo research.

FINNRAGE (Australia) believed that 217 -

there will never be justification for experimenting on embryos ... there is a potential to put reproduction in the hands of the medical scientists and remove women’s control.

There was support for the current ban on non-therapeutic research on eggs in the process of fertilisation and embryos 218 and “no change to current research practice”. 219 According to Mr Richard Egan, Secretary of the Coalition for the Defence of Human Life 220 -

the comprehensive ban under the HRT Act of all research involving human embryos that is not therapeutic for each embryo was a decisive and welcome achievement. Such a ban is the only way of taking seriously the ethical status of the human embryo and the respect due to the human being in the first stage of existence.

On the other hand, the RTC recommended that 221 -

the current inclusion of eggs in the process of fertilisation in the bans and other limitations on embryo research is inappropriate and should be re-dressed to allow some good research and diagnostic testing at this early stage of development to be considered.

Some RTC members also believed that section 14(2) of the HRT Act should be reconsidered. The Select Committee was told that while the effects of these provisions on research are obvious, of greatest concern is the effect of section 14(2)(b) on approvals to embryo observations and diagnostic procedures that are considered by many to be valuable and appropriate. 222

217 Submission 4 - FINNRAGE.
218 Submission 8 - Dr ED Watt.
219 Submission 17 - Mrs Stephanie Knox.
220 Submission 1 - Mr Richard Egan, Secretary, Coalition for the Defence of Human Life.
221 Submission 27 - RTC.
222 *ibid.*,
One submission indicated that the HRT Act has “virtually totally stifled research” and there needed to be a “considerable relaxation of the restrictions on research”. Assoc. Professor Jim Cummins said that it “effectively prevents ‘double-blind’ trials that are essential for evidence-based medicine ... reproductive research has almost completely stagnated in Western Australia. We have to rely on research conducted out of state and overseas to improve procedures”. Dr Robert Mazzuchelli and Dr Bruce Bellinge felt that to prevent the introduction of new technology and procedures because of a lack of understanding or a philosophical bias is compromising the opportunities for Western Australian couples to achieve their dreams of a health

Professor Con Michael told the Select Committee that it was unfair to say that “we have hampered research. If workers in the field were prepared to put up sound research, it would never be turned down provided it met the conditions of the Act”. However, the latest opinion from the Crown Solicitor’s Office appears to indicate that no embryo research can be approved under the current legislation. “There is no provision which provides scope for circumvention of the limitations in section 14(2).”

Researchers and clinicians also called for control of research “within the framework of existing constraints and the Code of Practice of Council” and agreed that “strict limitations need to be in place as a protection mechanism which may otherwise exploit the life of the early embryo”.

The Select Committee believed that the original intention of the HRT Act was not to “stifle” research in Western Australia. The Select Committee felt that experimentation that was clearly designed to be of benefit to an embryo or to improve efficacy of treatment procedures should be allowed. Members thought that practitioners should be able to indicate if the research would be beneficial or would improve the overall success rate of treatment.

The NHMRC’s ethical guidelines acknowledge that there are different opinions with regard to embryo research. These differences were understood and reflected in the development of the ethical guidelines. The NHMRC added that “at the present time these differences cannot be resolved”.

The Select Committee examined closely the NHMRC’s ethical guidelines on research and experimentation and recommended that they be incorporated into the HRT Act with the following amendments to Guideline 6.4 -

- Replacement of “destruction of the embryo, or which may otherwise not leave it in an implantable condition” by “some risk of harm to the embryo, or to its ability to implant”.

223 Submission 10 - Dr Anne Jequier.
224 Submission 2 - Assoc. Professor Jim Cummins.
225 Submission 15 - Dr Robert Mazzuchelli and Dr Bruce Bellinge.
226 Professor Con Michael. Evidence to the Select Committee, 9 March 1998.
227 Correspondence from Mr John Lyon, Deputy Crown Solicitor. 16 November 1998.
228 Submission 2 - Assoc. Professor Jim Cummins.
229 Submission 18 - Dr John Yovich.
230 NHMRC. 1996.
• Replacement of “an IEC” by “the Reproductive Technology Council” as the approving body in the amended guideline because the HRT Act does not regulate IECs although it could possibly do so indirectly through a Code of Practice.

• Replacement of “the gamete providers, and their spouses and partners” with “the people with the right and responsibility to make decisions about an embryo”.

The majority of the Select Committee recognised that prior to seeking RTC approval, approval shall already have been sought from an IEC and that this provides a further safeguard for approval.

The amended section should read as follows -

Non-therapeutic research which involves some risk of harm to the embryo, or to its ability to implant should only be approved by the Reproductive Technology Council in exceptional circumstances. Approval requires -

• a likelihood of a significant advance in knowledge or improvement in technologies for treatment as a result of the proposed research;

• that the research involves a restricted number of embryos; and

• the people with the right and responsibility to make decisions about an embryo, to have consented to the specific form of research.

Recommendation 6d

That the National Health and Medical Research Council’s ethical guidelines on research and experimentation, as for the time being prescribed, with the exception of Guideline 6.1, be incorporated into the Human Reproductive Technology Act 1991 with the following amendments to Guideline 6.4 -

Non-therapeutic research which involves some risk of harm to the embryo, or to its ability to implant should only be approved by the Reproductive Technology Council in exceptional circumstances. Approval requires -

• a likelihood of a significant advance in knowledge or improvement in technologies for treatment as a result of the proposed research;

• that the research involves a restricted number of embryos; and

• the people with the right and responsibility to make decisions about an embryo, to have consented to the specific form of research.
The Member for Joondalup dissented and opposed any research or experimentation which would involve some risk of harm to the embryo.

**Recommendation 6e**

That the relevant sections on embryo research within the *Human Reproductive Technology Act 1991* (HRT Act) be redrafted to reflect the intent of the 1996 National Health and Medical Research Council (NHMRC)’s ethical guidelines as amended by the Select Committee in Recommendation 6d.

That in particular, section 14(2)(a) and (b) of the HRT Act be removed and replaced with the amended NHMRC’s guidelines.

That the Reproductive Technology Council be authorised to grant final approval for research.

The Member for Joondalup dissented.

6.3.6 Creation of embryos and spare embryos

**Creation of embryos**

The creation of embryos for research is prohibited in WA. Under section 17(b) of the HRT Act, the RTC prohibits “the development of ... any embryo other than with a view to its future implantation into a particular woman”. The RTC believed that the prohibition should be retained. Professor Con Michael told the Select Committee that “the generation of embryos for the purposes of research ... is not something we should entertain”. The current ban received support from other submissions.

South Australia does not prevent the creation of embryos for research. The NHMRC’s ethical guidelines state that “protocols for ART in any clinic should ... seek to avoid the likelihood of production of embryos in excess of the needs of the couple.” The Victorian *Infertility Treatment Act 1995* does prevent the development of a “zygote past syngamy” (an embryo under the legislation) for the purposes of research.

The majority view of the NSW Law Reform Commission (LRC) was that “there should be no prohibition upon the creation of embryos solely for the purpose of research” while Dr Jennifer

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231 Submission 27 - RTC.
232 Professor Con Michael. Evidence to the Select Committee, 9 March 1998.
233 Submission 17 - Mrs Stephanie Knox; Submission 19 - Confidential; Submission 30 - Dr Jennifer Kurinczuk; Submission 37 - Mr Ray Shaw, President, Baptist Union of Western Australia, Inc.
235 *ibid*; 29.
236 *ibid*; 29.
Kurinczuk felt that practitioners should not be allowed to create embryos for research and there should be no means by which this could happen.\footnote{Submission 30 - Dr Jennifer Kurinczuk.}

The Select Committee did not support the creation of embryos for research and wished to retain the current prohibition found in section 17(b) of the HRT Act.

\begin{quote}
**Recommendation 6f**

That the ban on creating embryos for research continue.
\end{quote}

**Spare embryos**

If embryos cannot be created specifically for research, research would be limited to embryos created in the course of treating a woman but not implanted into her body or donated to another couple.

Some members of the RTC felt that current restrictions on research using “spare” embryos are too restrictive and that the RTC should be allowed to approve good research using these embryos “whose existence is ethically ‘futile’, where couples consent to this and where any in vitro culture is limited to 14 days”.\footnote{Submission 27 - RTC.} The Select Committee was told that\footnote{Submission 19 - Confidential.} -

\begin{quote}
for some couples it would provide an option where they could feel some value from their donation when they do not wish to donate their embryos to another couple or simply allow them to succumb.
\end{quote}

The RTC added that “if any non-therapeutic research is to be allowed on “spare embryos”, the HRT Act should make clear that allowing an embryo to succumb (passively) is not the exclusive mode of disposal of an embryo”.\footnote{Submission 27 - RTC.}

Article 18 of the Convention on Human Rights and Biomedicine states that “where the law [in a member state] allows research on embryos in vitro, it shall ensure adequate protection of the embryo”.\footnote{Council of Europe. *Convention on human rights and biomedicine.* Oviedo, Spain, 4 April 1997.} It also states that “the creation of human embryos for research purposes is prohibited” - only spare embryos can be used. However, countries are able to “opt out” of articles that do not comply with their existing legislation.\footnote{Progress Educational Trust Annual Review. 1997: 3.}
The LRC felt that arguments limiting research to spare embryos was “unconvincing”. “The majority of the LRC were not persuaded that the intention with which a normal embryo is created should be the crucial factor in whether it can be used as a subject for research”.

The preference of the Baptist Union of WA was that no research be carried out on spare embryos. However, according to the submission, it realises that spare embryos will exist where earlier attempts at IVF have been successful or where one or both partners have opted out of a contract to continue. Bearing in mind, especially, that the rate of attrition of natural pregnancies in their early stages remains high for causes unknown, we recognise that some research may be permitted in the context of testing and improving the efficiency of IVF procedures, provided certain conditions are met.

Dr Jennifer Kurinczuk drew the Select Committee’s attention to the fact that if research is to be allowed on “spare” embryos, the definition of what constitutes a “spare” embryo must be spelt out.

The majority of the Select Committee accepted that embryos exist that are no longer required for implantation and that many couples may prefer to donate their embryos to research in the hope of improving procedures in the long-term rather than allowing them to succumb or donating them to another couple.

**Recommendation 6g**

*That embryos created for the purpose of implantation but subsequently not required, be allowed to be used for research with the Reproductive Technology Council’s approval and the written consent of the people with the rights and responsibilities to make decisions about the embryos, in accordance with the 1996 National Health and Medical Research Council’s ethical guidelines which have been amended to reflect the Select Committee’s point of view.*

*That a 14 day limit to embryo development *in vitro* be retained in Western Australia as provided for in section 7(1)(c) of the Human Reproductive Technology Act 1991.*

The Member for Joondalup dissented and opposed research and experimentation being conducted on embryos.

**6.3.7 Prohibition on development of embryos**

Implantation of an embryo normally occurs at 14 days. Keeping or using an embryo after the appearance of the primitive streak or after 14 days (whichever is earlier) is not approved by the RTAC Guidelines, the South Australian Reproductive Technology (Code of Ethical Clinical Practice)

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244 Submission 37 - Baptist Union of WA, Inc.

245 Submission 30 - Dr Jennifer Kurinczuk.
Regulations 1995 (Part 2(4)(a)) or by the Human Fertilisation and Embryology Act 1990 (section 3(3)(a)). The NHMRC’s ethical guidelines state that culturing of an embryo in vitro for more than 14 days is a prohibited, unacceptable practice.

Under the HRT Act, section 7(1)(c) states that it is an offence for a person, whether a licensee or not, to cause or permit:

- an embryo, being produced by an in vitro fertilisation procedure or collected by embryo flushing, to be:
  1. maintained; or
  2. kept outside the body of a woman,

after 14 completed days, excluding any period of storage, from the time the gametes were mixed have occurred.

The Select Committee recommended above (Recommendation 6g) that a 14 day limit to embryo development be retained in WA as provided for in section 7(1)(c).

### 6.4 APPROVAL OF RESEARCH

Under section 14 of the HRT Act, the RTC must consider applications for, and grant approval to carry out research.

Section 20(4) of the HRT Act states that the RTC, subject to subsection (5), may under the Code grant general approval to the carrying on by any licensee of a project of research of any kind or in relation to matters specified in the Code, but may impose conditions as to the manner in which the research is to be carried on. Under section 20(6) -

in considering whether to grant approval to a project of research, the Council shall have regard to any decision or report which may have been made by an Institutional Ethics Committee and may adopt a decision or report so made as sufficient grounds for the grant of approval by the Council.

Dr Sandra Webb told the Select Committee that the RTC may consider taking up the power under section 18(h) of the HRT Act to recognise some ethics committees and not others. Dr Webb suggested that committees containing a scientific review panel may get approval while proposals coming from “those which do not have a ... subcommittee looking at scientific design proposals may be put out to independent scientific peer review”.

### 6.4.1 Approval of routine laboratory and clinical procedures

Approval of routine laboratory and clinical procedures is addressed in sections 9.1 and 9.2 of the Directions. At the time of licensing, the person responsible must ensure that all routine procedures which are to be followed are in accordance with criteria outlined in the guidelines, and documented in a detailed manual for which the approval of the RTC is obtained.

9.2  For any change or addition to approved routine clinical or laboratory procedures -

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246 Dr Sandra Webb. Evidence to the Select Committee, 9 March 1998.
(i) Council may -
  • grant its general approval; or
  • request further information to assist consideration of its approval for the change, and in the meantime it may or may not require the new practice to be withdrawn; or
  • refuse to grant general approval, require the new practice to be withdrawn, and suggest that an application be made for specific approval of the proposed change.

Approval of research, innovative procedures and embryo diagnostic tests are also addressed in sections 9.3 and 9.4 of the Directions.

9.3 For any proposed research, any clinical or laboratory procedure that may be considered as innovative according to the criteria set out in the guidelines, or any diagnostic procedure involving an embryo, the person responsible must ensure that the specific approval of Council is sought, in accordance with the guidelines, and the research, innovative laboratory or clinical procedure, or embryo diagnostic procedure must not be implemented without this approval.

9.4 Where approval is sought from Council for any embryo research or diagnostic procedure to be carried out upon or with an embryo, the person responsible must ensure that the application for approval gives evidence, as outlined in the guidelines, that this is intended to be therapeutic for that embryo, and unlikely to have any detrimental effect upon it.

Mr Haydn Lowe of the Disability Services Commission felt that -

all research should be closely monitored on a case-by-case basis by a Research and Ethics Committee which has both the scientific knowledge and legal and ethical understanding of the issues of human reproductive experimentation. Projects should be scrutinised prior to approval being given, monitored throughout and results reviewed to ensure that appropriate legal and ethical codes of conduct are properly adhered to throughout.

The Country Women’s Association indicated that research or experimentation on gametes or eggs in the process of fertilisation and embryos “must never take place without the natural parents’ permission” and should include a “mandatory cooling off period”.

Victoria

In Victoria, section 122(h) of the Infertility Treatment Act 1995 states that one of the functions of the ITA is to promote research into the causes of infertility.

Approval of the ITA is required for any research that -

• involves a living embryo;
• involves the formation of a zygote for the purposes of research, or the use for research of a zygote originally formed for a treatment procedure;
• uses a parthenogenic oocyte.

247 Submission 16 - Mr Haydn Lowe, Disability Services Commission.
248 Submission 21 - Mrs Rosa Tognela, Country Women’s Association.
No notification or approval is required for research on gametes, provided that they are not used to form a zygote, and that consent has been given by the gamete provider, as required under section 36 of the Act. In addition, no notification or approval is required for research undertaken on embryos after they have succumbed.

In the case of research, experimental procedures or clinical trials, where embryos or zygotes are utilised, a researcher will not be required to seek approval if that researcher is reasonably certain that a procedure will not substantially disadvantage the patient and/or embryo, e.g. introduction of an embryo culture medium that has been extensively tested using human embryos elsewhere. However, the Authority will require notification of the proposed changes, with a view to monitoring the impact of such changes through the licensing process.\(^{249}\)

ITA approval is required for procedures that are at the research stage, or for a procedure that has passed the research stage but requires human application, e.g. testing a novel culture medium.

**United Kingdom**

Under section 3(1) of the *Human Fertilisation and Embryology Act 1990*, all research which involves the creation, keeping and using of human embryos outside the body must be licensed by the HFEA. Centres must apply for separate licenses for each research project. Each project is referred to a properly constituted ethics committee for approval before applying to the HFEA.\(^{250}\)

### 6.4.2 Applications for approval

From 1 July 1997 to 30 June 1998, the RTC received seven complete applications for research and five preliminary or general queries/incomplete applications (Table 6).

**Table 6:** Applications for project approval sought from the Reproductive Technology Council, 1997-1998.

<table>
<thead>
<tr>
<th>Application Number</th>
<th>Clinic</th>
<th>Title of Project</th>
<th>Nature of Project</th>
<th>Result of Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>003</td>
<td>Assisted hatching</td>
<td>Research</td>
<td>Returned because of concerns with study design and patient information</td>
</tr>
<tr>
<td>2</td>
<td>005</td>
<td>Storage of primordial follicles for women with malignant disease</td>
<td>Research</td>
<td>Conditional approval granted to March 24 1998: for storage only</td>
</tr>
<tr>
<td>3</td>
<td>005</td>
<td>Use of immature sperm in ICSI</td>
<td>Research</td>
<td>Application withdrawn by clinic</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Application Number</th>
<th>Clinic</th>
<th>Title of Project</th>
<th>Nature of Project</th>
<th>Result of Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>003</td>
<td>Use of semen from an HIV+ve man in treatment</td>
<td>Innovative procedure</td>
<td>The RTC considered this decision subject only to clinical judgement re eligibility and welfare of the child etc, as the procedure itself is not innovative</td>
</tr>
<tr>
<td>5</td>
<td>005</td>
<td>Storage of primordial follicles for women with malignant disease</td>
<td>Research</td>
<td>Approval granted: for storage and QA testing only</td>
</tr>
<tr>
<td>6</td>
<td>003</td>
<td>Extended culture of blastocysts</td>
<td>Research</td>
<td>Awaiting advice from the CSO on research involving embryos</td>
</tr>
<tr>
<td>7</td>
<td>003</td>
<td>Cryopreservation of blastocysts</td>
<td>Innovative procedure</td>
<td>Approvable, pending CSO advice on #6</td>
</tr>
</tbody>
</table>

Preliminary or General Queries/Incomplete Applications

<table>
<thead>
<tr>
<th>Application Number</th>
<th>Clinic</th>
<th>Title of Project</th>
<th>Nature of Project</th>
<th>Result of Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>005</td>
<td>Application for use of ICSI to reinseminate failed IVF fertilisations</td>
<td>Research</td>
<td>Incomplete application: returned for completion</td>
</tr>
<tr>
<td>9</td>
<td>003</td>
<td>Pre-implantation embryo diagnosis</td>
<td>Diagnostic test</td>
<td>Sent for CSO opinion: advised not allowed under the Act</td>
</tr>
<tr>
<td>10</td>
<td>003</td>
<td>Seeking RTC approval to treat single woman by IVF</td>
<td>General advice sought re Act</td>
<td>Clinic advised the RTC has no role in this and to seek own legal advice</td>
</tr>
<tr>
<td>11</td>
<td>003</td>
<td>Relevance of the Act to collection of testicular tissue for research</td>
<td>General advice sought re Act</td>
<td>Clinic informed that the Act is not applicable</td>
</tr>
<tr>
<td>12</td>
<td>003</td>
<td>Permission to export semen for posthumous use</td>
<td>Advice sought re a special case</td>
<td>CSO opinion sought: advised export not ruled out under the Act for this case at present</td>
</tr>
</tbody>
</table>

CHAPTER SIX - RECOMMENDATIONS

**Recommendation 6a**

That the power to regulate all research on gametes as provided for in section 20(2)(a)(i) of the *Human Reproductive Technology Act 1991* be retained.

**Recommendation 6b**

That references to an “egg in the process of fertilisation” be removed from the *Human Reproductive Technology Act 1991* except where reference to rights to an egg in the process of fertilisation and storage of an egg in the process of fertilisation exist, in which case an egg in the process of fertilisation be regarded as though it were an embryo.

That in all other circumstances an egg in the process of fertilisation not be regarded as though it were an embryo.

**Recommendation 6c**

That reference to an egg in the process of fertilisation in section 17(b) of the *Human Reproductive Technology Act 1991* be removed.
**Recommendation 6d**

That the National Health and Medical Research Council’s ethical guidelines on research and experimentation, as for the time being prescribed, with the exception of Guideline 6.1, be incorporated into the *Human Reproductive Technology Act 1991* with the following amendments to Guideline 6.4 -

Non-therapeutic research which involves some risk of harm to the embryo, or to its ability to implant should only be approved by the Reproductive Technology Council in exceptional circumstances. Approval requires -

- a likelihood of a significant advance in knowledge or improvement in technologies for treatment as a result of the proposed research;
- that the research involves a restricted number of embryos; and
- the people with the right and responsibility to make decisions about the embryo, to have consented to the specific form of research.

**Recommendation 6e**

That the relevant sections on embryo research within the *Human Reproductive Technology Act 1991* (HRT Act) be redrafted to reflect the intent of the 1996 National Health and Medical Research Council (NHMRC)’s ethical guidelines as amended by the Select Committee in Recommendation 6d.

That in particular, section 14(2)(a) and (b) of the HRT Act be removed and replaced with the amended NHMRC’s guidelines.

That the Reproductive Technology Council be authorised to grant final approval for research.

**Recommendation 6f**

That the ban on creating embryos for research continue.
**Recommendation 6g**

That embryos created for the purpose of implantation but subsequently not required, be allowed to be used for research with the Reproductive Technology Council’s approval and the written consent of the people with the rights and responsibilities to make decisions about the embryos, in accordance with the 1996 National Health and Medical Research Council’s ethical guidelines which have been amended to reflect the Select Committee’s point of view.

That a 14 day limit to embryo development *in vitro* be retained in Western Australia as provided for in section 7(1)(c) of the *Human Reproductive Technology Act 1991*. 
CHAPTER SEVEN

PRE-IMPLANTATION DIAGNOSIS AND GENETIC TESTING OF EMBRYOS

7.1 INTRODUCTION

The Select Committee examined the issues of pre-implantation genetic diagnosis of embryos (PGD). This area overlaps with issues addressed in Chapter Six, in that determination as to whether a procedure is for research or for therapy becomes unclear in relation to new technologies. According to the RTC, on examination of the HRT Act and Parliamentary debate during the passage of the Bill, there appear to be inconsistencies relating to the acceptability or otherwise of genetic testing and the use of embryo diagnostic procedures.

7.1.1 Diagnostic procedures

PGD uses the techniques of superovulation and IVF to produce a number of normally fertilised embryos in a single cycle accessible for genetic screening. Early research showed that it was possible at three days after fertilisation to remove one or two cells from an 8-10 celled embryo without detriment to its further development. The sex of the embryo can be determined on the basis of the presence or absence of a DNA fragment specific for the Y chromosome.

Sexing the embryo to avoid X-linked diseases such as Duchenne Muscular Dystrophy, Fragile X and Haemophilia is the commonest reason for PGD. However, the technique is becoming increasingly available for specific genetic disorders such as Tay-Sachs Disease, Down’s Syndrome, Huntington’s Disease and achondroplasia. PGD is also indicated for the detection of aneuploidy in older women having IVF and following ICSI and in translocation carriers.

Article 12 of the Council of Europe’s Convention on Human Rights and Biomedicine states that -

254 tests which are predictive of genetic diseases or which serve either to identify the subject as a carrier of a gene responsible for a disease or to detect a genetic predisposition or susceptibility to a disease may be performed only for health purposes or for scientific research linked to health purposes, and subject to appropriate genetic counselling.

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252 Submission 27 - RTC.


In 1996, about 10 clinics around the world were practising PGD. One problem is the high cost of combining IVF or ICSI with PGD. By 1997, only 55 couples had been treated in the UK but PGD had been limited to a single licensed centre. Dr Leeanda Wilton, Research Embryologist, Melbourne IVF Clinic, told the Select Committee that less than 100 children have been born worldwide after PGD.

According to Snowden and Green (1997), PGD allows parents the chance of an unaffected genetically related child without the need to consider abortion. However, they also acknowledged that there are both physical and emotional problems associated with the procedure. Following a study of the attitudes of 245 carriers of recessive disorders towards PGD, there was positive support for the technique. Almost the entire sample viewed early reassurance and the opportunity to avoid a termination of pregnancy as important advantages of PGD. However, the study concluded that PGD did not displace pre-natal diagnosis as the most useful option.

7.1.2 Limitations

The reliability of PGD is still questionable and the RTC believed that more research was required to justify the benefits. Dr Athel Hockey, Medical Research Coordinator, Disability Services Commission, indicated that there still needs to be monitoring of the long-term outcome before advocating such procedures come into general practice and pointed out both the advantages and limitations of PGD in her submission. Limitations include -

- the possibility that there may be no surviving cells for testing;
- the problem of contamination;
- as with other indications for IVF procedures, the “take-home baby” rate may be 15-20%.

Dr Jack Goldblatt, Director, Genetic Services of WA, felt that “in view of the complications and limited indications of this testing, its availability should be restricted to a single laboratory in Western Australia, possibly by decision of the Council”. Dr Goldblatt told the Select Committee that “considering the numbers wanting the procedure in Western Australia, there would not be enough work for more than one laboratory to be doing it regularly to develop expertise”.

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257 Dr Leeanda Wilton. Meeting with Select Committee, Melbourne, 23 March 1998.


259 ibid.

260 Submission 27 - RTC.

261 Submission 14 - Dr Athel Hockey, Medical Research Coordinator, Disability Services Commission.

262 Submission 5 - Dr Jack Goldblatt, Director, Genetic Services of WA.

263 Dr Jack Goldblatt. Evidence to the Select Committee, 16 March 1998.
The Select Committee received a number of submissions that addressed PGD. The submissions expressed a range of views from prohibition of any diagnostic procedures to a desire to allow PGD to occur. Dr Anne Jequier, Medical Director, Perth Andrology, felt that “many patients find the need to replace the embryos, prior to genetic testing, as a very unethical situation”. According to Assoc. Professor Jim Cummins, School of Veterinary Studies, Murdoch University, “if embryos have to be allowed to succumb it is far better that this is done at the preimplantation stage”. The RTC indicated that if implantation proceeds, “later pre-natal diagnosis and termination of an affected pregnancy may be the result. This can also lead to enormous distress for the couple concerned”. In 1996, Assoc. Professor Cummins said that one of the side-effects of the reproductive technology laws in Western Australia is that we are not allowed to carry out pre-implantation embryo diagnosis, so that even though you may be knowingly transmitting or knowingly inseminating eggs that have a risk of genetic disease, you are in fact compelling women to go through implantation, pregnancy and later diagnosis and possible termination of pregnancy. This is a very real problem. It is certainly a major quandary for infertility units.

Dr Jack Goldblatt said that PGD was an important adjunct to other antenatal testing procedures. He added that services must be able to offer appropriate counselling and support to couples considering testing. Mr Haydn Lowe said PGD should be undertaken at the request/consent of the parties involved.

Professor Con Michael told the Select Committee that “embryo biopsy ... is certainly diagnostic. It is of value in genetic testing. If we do not have something in place for embryo biopsy, we will be falling behind not only the rest of the country but also the rest of the world in what we can offer these couples”.

A number of submissions raised concerns about permitting PGD and the possible destruction of embryos found to carry “undesirable traits”. One submission described PGD as “another technological fix for a technological problem which devalues anyone not perfect”. Some submissions

264 Submission 10 - Dr Anne Jequier.
265 Submission 2 - Assoc. Professor Jim Cummins.
266 Submission 27 - RTC.
267 RTC. ICSI. The proceedings of the seminar. June 1996: 49.
268 Submission 5 - Dr Jack Goldblatt.
269 Submission 16 - Mr Haydn Lowe.
270 Professor Con Michael. Evidence to Select Committee, 9 March 1998.
271 Submission 1 - Mr Richard Egan.
272 Submission 4 - FINNRAGE.
recommended that the HRT Act should not be amended.\textsuperscript{273} \textsuperscript{274} In his submission, Mr Richard Egan stated that these diagnostic procedures\textsuperscript{275} -

- reduce the status of the human embryo to that of a product;
- ignore the social impact of attitudes to persons with disabilities
- provide no rational basis for limiting the trend towards “designer babies”;
- ignore the difficulties of attributing freedom of choice to parents.

The Select Committee received the findings of a community consultation on perceptions of human gene therapy conducted by Murdoch University.\textsuperscript{276} The workshop discussion stated that -

the use of testing for the elimination of people was proposed as discriminatory; however, the legal issues about discrimination about living people and the moral issue about the status of the foetus were seen as different. It was also suggested that the practice of pre-implantation diagnosis is required by the Hippocratic principle of “doing-less-harm” to which medical doctors are morally bound, (i.e. transferring a defective embryo causes harm).

\subsection*{7.1.3 Human Reproductive Technology Act 1991}

A number of sections of the HRT Act and Directions refer to diagnostic procedures. The preamble of the HRT Act states that “in enacting this legislation Parliament is seeking to give help and encouragement to those eligible couples ... whose children may be affected by a genetic disease”. Section 9 of the Directions provides for diagnostic procedures. Section 23(a)(ii) says that an IVF procedure may be carried out where it would be likely to benefit a couple whose child would otherwise be likely to be affected by a genetic abnormality or disease. These appear to suggest that persons at risk of transmission of a genetic disease who are not infertile may be treated.

Parts of section 21 imply that PGD procedures may be carried out and that embryos may be selected on the basis of them.\textsuperscript{277} Section 21 states that -

without limiting the generality of section 14(1)(c), the Code, or directions, may make provision as to -

(b) the means of determining and evaluating the considerations which should or may be taken into account before an artificial fertilisation procedure is commenced, including the diagnostic procedures involved;

(d) the practice and procedures to be carried out in relation to the collection, keeping, use and disposal of gametes, eggs in the process of fertilisation or embryos, or for securing that such eggs or embryos are in a suitable condition for implantation;

\textsuperscript{273} Submission 3 - Mrs Monique Bertino-Clarke and Mr Adrian Bertino-Clarke, Disabled Advocacy.

\textsuperscript{274} Submission 8 - Dr ED Watt.

\textsuperscript{275} Submission 1 - Mr Richard Egan.

\textsuperscript{276} Submission 46 - Dr RA Schibeci, School of Education, Murdoch University.

\textsuperscript{277} Submission 27 - RTC.
(k) what, for the purposes of this Act, may constitute an authorized diagnostic procedure in relation to any egg in the process of fertilisation or an embryo or an approved project of research, or may be carried out or performed in any particular kind of research, and what shall not.

Counselling and consent

Section 22(e)(i) of the HRT Act requires that an embryo brought about by IVF “shall not be used for any purpose ... unless there is an effective consent, by each person from whose gametes the ... embryo was derived, to the use for that purpose” and this would include diagnostic testing. One submission stated that “we feel that the main complication with the tests are not the technical aspects of the laboratory, but the support counselling and understanding of the results and how they are used”.

Offences under the HRT Act

Under section 7(1)(b) -

a person, whether or not a licensee, who causes or permits ... a diagnostic procedure to be carried out upon or with an egg in the process of fertilisation, or any embryo, not being a procedure which is -

(i) authorized by the Code; or
(ii) specifically approved by the Council

... commits an offence.

In a submission to the Select Committee, Assoc. Professor Cummins argued that it is clear from the Hansard transcript that, while the Minister (Hon. Keith Wilson) desired to ban non-therapeutic research on human embryos, he wished to leave open the possibility of genetic diagnosis of the embryo by cell biopsy when this could be done without harm to the embryo concerned.

Assoc. Professor Cummins felt that “Mr Wilson moved an amendment ... that was evidently intended to permit non-harmful genetic diagnosis”. He continued that “subsequent interpretation of the Act has revealed that this was not the case and that permission to allow pre-implantation genetic diagnosis of human embryos could not in practice be granted by the Reproductive Technology Council”.

The inconsistencies appear to result from section 14. Section 14(2) states that -

the Council shall not grant approval to any research being conducted, or any diagnostic procedure to be carried out, upon or with an egg in the process of fertilisation, or any embryo, unless the Council is satisfied -

(a) that the proposed research or procedure is intended to be therapeutic for that egg or embryo; and
(b) that existing scientific and medical knowledge indicates that no detrimental effect on the well-being of any egg in the process of fertilisation or any embryo is likely thereby to occur.

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278 Dr Jack Goldblatt. Evidence to the Select Committee, 16 March 1998.
279 Submission 2 - Assoc. Professor Jim Cummins.
According to Draft Guideline 9.4(i), “the interpretation of whether the procedure is likely to fulfil these criteria is to be based on the scientific documentation given with the request for approval, with a similar interpretation of ‘therapeutic’ and ‘detrimental’ to that outlined in Draft Guideline 9.2(iv) referred to below.

The Select Committee heard that a recent Crown Solicitor’s Office opinion confirmed that “the effect of section 14(2)(a) is to rule out the application of any diagnostic procedures including one that would not directly harm the embryo, if it was not ‘intended to be therapeutic for that egg or embryo’”. Therefore, PGD would be prohibited where the result would be to terminate an embryo with a genetic or other defect.

**Definition of diagnostic**

According to a legal opinion “diagnostic has a primary meaning relating to the identification of disease”. The opinion suggested that “simple observation of embryo quality may not in fact be diagnostic if it is not directed towards the identification of disease. Procedures directed towards the identification of a disease or defect would readily be defined as diagnostic”.

**Definition of therapeutic**

Under the HRT Act’s draft guidelines (section 9.2(iv)) -

therapeutic research refers to research likely to benefit the embryo. This must relate to the individual embryo and is of course tied in with the corollary that any experiment will also not be detrimental to the embryo.

In the context of embryo experimentation, the NHMRC’s definition of therapeutic is “interventions directed towards the wellbeing of the individual embryo involved”.

Under section 3 of the Health Act 1911, the term “therapeutic use” is defined as -

a use for the purpose of -

- (a) preventing, diagnosing, curing or alleviating of a disease, ailment, defect or injury in persons;
- (b) influencing, inhibiting or modifying of a physiological process in persons;
- (c) testing of susceptibility to disease or ailment in persons.

An opinion from the Crown Solicitor’s Office indicated that the definition of “therapeutic use” in the Health Act 1911 was not suitable because “testing of embryos to ascertain their sex with a view to allowing any female embryos to succumb could not be said to be a curative or healing procedure”.

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280 Submission 27 - RTC.

281 Correspondence from Mr J Allanson, Senior Assistant Crown Solicitor, 5 November 1992.

282 NHMRC. 1996.

283 Correspondence from Mr John Lyon, Deputy Crown Solicitor, 9 March 1998.
Ms Leigh Newman suggested that “a different definition of ‘therapeutic’ could be used - such as the one in our (WA’s) Human Tissue and Transplant Act which is wide enough to include procedures which are diagnostic only”.  

7.2 OTHER JURISDICTIONS

Many countries have no legislation to address PGD. However, Finland and the United States (State differences not specified) allow it to occur without there being conditions attached. In Denmark, genetic examination of a fertilised ovum shall be made only in instances where there is a known and considerably increased risk that the child will have a serious hereditary disease. In addition, genetic examination may be made in connection with artificial procreation outside the woman’s body because of infertility where such an examination can demonstrate or exclude a considerable chromosome abnormality. Estonia, France, Norway, Slovakia, Slovenia, Spain, Sweden, the United Kingdom and some Australian States allow PGD to occur with special authorisation. Only Germany and Austria state that PGD, even with special authorisation, is not allowed. In Germany, an exception is made for diagnostic activities aimed at excluding serious sex-linked diseases in the unborn child.

7.2.1 Victoria

During its visit to Victoria, the Select Committee was told that PGD is allowed for medical reasons. The Infertility Treatment Act 1995 allows embryos not to be transferred. The ITA has accepted that embryo biopsy is not destructive and is no longer regarded as research.

A number of sections of the Infertility Treatment Act 1995 are related to PGD. Section 8(b) states that before a woman undergoes a treatment procedure a doctor, who has specialist qualifications in human genetics, must be satisfied, from an examination he or she has carried out, that if the woman became pregnant from an oocyte produced by her and sperm produced by her husband a genetic abnormality or a disease might be transmitted to a person born as a result of the pregnancy.

Section 24 (ban on destructive research on embryos) does not preclude PGD because the procedure would not harm the embryo or make the embryo unfit for transfer and section 50(2) (ban on sex selection) indicates that it is possible to choose an embryo of a particular sex in order to avoid the risk of transmission of a genetic abnormality.

Very few cases of PGD are carried out. In 1998, Dr Leeanda Wilton told the Select Committee that there had been two cases of sex determination for genetic disorders in the previous 18 months at Melbourne IVF Clinic. Dr Wilton felt that PGD has a broader application for IVF rather than for genetic diagnosis. One in three embryos they examine have chromosomal abnormalities. PGD would allow these to be detected and unaffected embryos to be transferred.

7.2.2 United Kingdom

286 Infertility Treatment Authority. Meeting with the Select Committee, Melbourne, 23 March 1998.
287 Dr Leeanda Wilton. Meeting with Select Committee, Melbourne, 23 March 1998.
PGD does occur in the UK. Schedule 2(3)(2)(e) of the Human Fertilisation and Embryology Act 1990 and section 10(2)(e) of the Code of Practice address preimplantation genetic diagnosis. The HFEA may grant licenses “for research projects ... to develop methods for detecting the presence of gene or chromosome abnormalities in embryos before implantation”\(^{288}\).

7.2.3 France

The French National Assembly ruled that PGD should be authorised in exceptional cases concerning families at high risk of transmitting severe genetic diseases. This amended an earlier vote by the Senate for a total ban on the technique.\(^ {289}\)

7.3 THE SELECT COMMITTEE’S VIEW OF THE NEED FOR LEGISLATIVE CHANGE

Ms Leigh Newman told the Select Committee that section 14(2) of the HRT Act needed to be amended to allow procedures intended to identify serious genetic diseases as well as those intended to be therapeutic to the embryo.\(^ {290}\) There needs to be a mechanism to separate the ability to test/screen for genetic conditions and then based on the results, the ability to make the decision not to implant.

All members of the RTC agreed that the HRT Act should be amended (by the deletion of section 14(2)(a) in particular) to allow the RTC the option of approving PGD when appropriate.\(^ {291}\) Assoc. Professor Jim Cummins suggested that “or any diagnostic procedure to be carried out” could be deleted from section 14(2) and “or procedure” should be deleted from section 14(2)(a).\(^ {292}\)

The Select Committee believes that PGD with restrictions should be allowed in WA. The Members acknowledged recent changes to WA’s abortion laws. In light of these changes they felt it was preferable to be able to implant embryos that had been tested and found to be free of a genetic disease rather than a woman becoming pregnant, undergoing prenatal testing and subsequently choosing to have an abortion.

**Recommendation 7a**

That the Human Reproductive Technology Act 1991 be amended to allow pre-implantation genetic diagnosis to occur under restrictions determined by the Reproductive Technology Council.


\(^{290}\) Submission 86 - Ms Leigh Newman.

\(^{291}\) Submission 27 - RTC.

\(^{292}\) Submission 2 - Assoc. Professor Jim Cummins.
The Select Committee noted the RTC’s concern that caution is required in the drafting of any amendments, in particular to definitions of cloning and of an embryo, to ensure that the option of PGD is not inadvertently ruled out.  

7.3.1 Gene Therapy

There are two types of gene therapy -

- somatic cell therapy involves inserting healthy genes into the body so that they will be incorporated into a particular tissue and make a desired protein;
- germ line gene therapy involves the incorporation of needed genes into the embryo itself.

The Select Committee was aware that with the advances in technology, gene therapy might become available to correct genetic abnormalities at the preimplantation stage. Such a procedure would be of benefit to an embryo. However, the Select Committee would strongly oppose the use of gene therapy for purposes other than those of treating severe genetic disease, and strongly rejected the use of gene therapy to produce so called “designer babies”.

7.3.2 Restrictions of use

Article 14 of the Council of Europe’s Convention on Human Rights and Biomedicine states that “the use of techniques of medically-assisted procreation shall not be allowed for the purpose of choosing a future child’s sex, except where serious hereditary sex-related disease is to be avoided”.  

The RTC would wish to limit the types of factors that can be tested for under the HRT Act. No Council members would support the use of genetic testing for sex determination other than where the information is necessary to avoid transmission of a serious sex-linked genetic disorder. Others agreed with this limitation although Mr Maxim Keyt, Manager of PIVET said there was a big demand by WA couples to be able to select the sex of their child. Dr Sandy Webb told the Select Committee that the British Medical Association (BMA) in the UK had banned sex selection. The RTC was aware of the sensitivity surrounding genetic testing and suggested that use of PGD should be subject to approval by a body like the RTC.
One issue is whether there should be a list of diseases for which PGD can be used to detect. A forum conducted by the UK Progress Educational Trust indicated that there should not be a list. Many who attended the forum thought that decisions about testing should be left to the families “since they are the ones who often have experience of the disease in question and who will ultimately be left to deal with the consequences”.

Dr Sandra Webb told the Select Committee that restrictions to the use of PGD could be included in section 21(b) of the HRT Act.

Recommendation 7b

That pre-implantation genetic diagnosis (PGD) technology not be used for sex selection alone or for the determination of physical characteristics (“designer babies”).

That use of PGD be restricted to clients whose future child would otherwise be likely to be affected by a genetic abnormality or disease as determined by the Reproductive Technology Council.


303 Dr Sandra Webb. Personal communication to the Select Committee.
CHAPTER SEVEN - RECOMMENDATIONS

**Recommendation 7a**

That the *Human Reproductive Technology Act 1991* be amended to allow pre-implantation genetic diagnosis to occur under restrictions determined by the Reproductive Technology Council.

**Recommendation 7b**

That pre-implantation genetic diagnosis (PGD) technology not be used for sex selection alone or for the determination of physical characteristics (“designer babies”).

That use of PGD be restricted to clients whose future child would otherwise be likely to be affected by a genetic abnormality or disease as determined by the Reproductive Technology Council.
CHAPTER EIGHT

RIGHTS TO STORED EMBRYOS AND GAMETES

8.1 INTRODUCTION

The Select Committee was required to address the rights to stored gametes and embryos, including -

- rights upon the separation or divorce of donors, the death of one or both donors or the physical or mental incapacity of one or both donors; and
- rights of third parties such as subsequent spouses, both heterosexual and of the same sex, and the rights of other relatives.

8.1.1 Human Reproductive Technology Act 1991

Rights in relation to gametes and embryos are covered by Division 3 of Part 3 of the HRT Act (sections 25 and 26) and Directions 3.3 and 8.5 in relation to posthumous use of gametes. Section 22 deals with “consents, generally”.

Section 22

22(1) Where by or under this Act consent is required to be given in relation to the use or keeping of any gametes, egg in the process of fertilisation or embryo -

(a) the gametes of a person shall not be used, or for such a use be received by the licensee or participant, unless -

(i) there is an effective consent, by that person, to the gametes being so used; and
(ii) the gametes are used in accordance with that consent;

(b) the gametes of a person shall not be kept in storage unless -

(i) there is an effective consent, by that person, to the storage; and
(ii) the gametes are stored in accordance with that consent;

(c) the gametes of a person shall not be used in an in vitro fertilisation procedure unless there is an effective consent, by that person, to any egg in the process of fertilisation or embryo thereby derived being used for a consequential purpose authorized by this Act;

(d) where the development of an egg in the process of fertilisation or an embryo was brought about by an in vitro fertilisation procedure it shall not be kept in storage unless -

(i) there is an effective consent, by each person from whose gametes the egg or embryo was derived, to the storage; and
(ii) the egg or embryo is stored in accordance with that consent;
(e) where the development of an egg in the process of fertilisation or an embryo was brought about by an in vitro fertilisation procedure, it shall not be used for any purpose, or for such a purpose be received by a licensee or participant, unless -

(i) there is an effective consent, by each person from whose gametes the egg or embryo was derived, to the use for that purpose;
(ii) the purpose is authorized by this Act; and
(iii) that egg or embryo is used in accordance with that consent,

and the Code may make further provision in relation to such, or related matters.

(2) Where a consent is given in general terms to the use and storage of gametes separately, whether eggs or sperm, that consent shall be taken to relate to the use or storage of any of those eggs or sperm, and also to any egg in the process of fertilisation or embryo derived from the use of the gametes, for the purpose, save that -

(a) any such consent may be given subject to specific conditions in its terms; and
(b) notwithstanding subsection (4) or that an egg in the process of fertilisation, or an embryo, may have developed which is derived from the use of gametes the subject of any particular consent, in so far as it relates to any egg or sperm that has not been used that consent may be varied or withdrawn,

but where an egg in the process of fertilisation, or an embryo, has been developed from any gametes the consent thereafter to be required is not a consent to the use of the gametes but a specific consent relating to that particular egg in the process of fertilisation or embryo only.

(3) The terms of any effective consent may from time to time be varied or the consent withdrawn, unless subsection (4) applies, by notice given by the person who gave the consent to the person keeping the gametes, egg in the process of fertilisation or embryo to which the consent is relevant.

(4) The terms of any effective consent to the use of any gametes, egg in the process of fertilisation or embryo can not be varied, and such a consent can not be withdrawn, once the gametes have, or that egg or embryo has, been used.

(5) A consent to the use of an egg in the process of fertilisation or an embryo must specify one or more of the following purposes -

(a) use in providing treatment to the person giving consent, or that person and another named person together; or
(b) use in providing treatment to persons, other than the person giving consent, who are -

(i) named in the consent; or
(ii) to be selected in accordance with circumstances specified in the consent,

and may specify conditions subject to which the egg or embryo shall or shall not be so used.

(6) A consent to the keeping of any gametes, egg in the process of fertilisation or embryo must -

(a) specify the maximum period of storage, if that is to be less than such limit as may be prescribed or may be determined in accordance with section 24(1)(b); and
(b) give instructions as to what is, subject to this Act, to be done with the gametes, the egg or the embryo if the person who gave the consent is unable by reason of incapacity or otherwise to vary the terms of consent or to withdraw it, and may specify conditions subject to which the gametes, or the egg or embryo, shall or shall not remain in storage.

(7) Before a licensee gives effect to a consent given for the purposes of this Act the licensee shall ensure that each participant has been provided with a suitable opportunity to receive -

(a) proper counselling about the implications of the proposed procedures; and

(b) such other relevant and suitable information as is proper or as may be specifically required by the Code or directions,

including an explanation of the effect of subsection (3) and subsection (4).

(8) For the purposes of this Act a consent to the use or keeping of any gametes, egg in the process of fertilisation or embryo shall not be taken to be effective unless -

(a) it is given in writing;
(b) any condition to which it is subject is met;
(c) it has not been withdrawn; and
(d) those gametes are, or that egg or embryo is, kept and used in accordance with the consent.

(9) Where a consent required by or under this Act is not given, or is not effective, or is not complied with that matter may be a cause for disciplinary action or proceedings for an offence but does not necessarily affect the rights of any person.

Section 26 addresses “control, dealing and disposal in relation to an egg in the process of fertilisation or an embryo”.

Section 26(1)(c) states that -

where from any gametes an egg in the process of fertilisation or embryo is developed, whether or not with effective consent, the individual rights of a gamete provider or person to whom the gametes were provided and of a licensee cease at the moment fertilisation begins and the rights thereafter vest jointly in the couple on whose behalf that egg or embryo was developed.

Section 26(1)(e) states that -

on the commencement of an implantation procedure the rights in an egg in the process of fertilisation or in an embryo vest in the woman receiving it, whether or not -

(i) that recipient was eligible to undergo the procedure; or
(ii) any consent required was given or, if given, was effective.

8.2 RIGHTS TO GAMETES

Rights in relation to gametes are addressed under section 25 of the HRT Act. Gamete providers have rights of control over their own gametes, and must consent to any storage or use of the gametes they
provided, until they are used to create an egg in the process of fertilisation or embryo. At this point the rights transfer to the couple for whom the process is carried out. Section 26(1)(c) of the HRT Act seeks to transfer rights to gametes used in a fertilisation procedure to those for whom the embryo is being developed “from the moment fertilisation begins”. The RTC suggested amending the phrase to read “when the gametes are mixed” or “when the oocyte is exposed to sperm” because to apply the current instruction would require destroying the embryo to detect whether or not fertilisation had begun.

The Select Committee agreed that it was necessary to amend section 26(1)(c) to redefine the time at which gamete donors rights are extinguished.

**Recommendation 8a**

That section 26(1)(c) of the *Human Reproductive Technology Act 1991* be amended by deleting “at the moment fertilisation begins” and substituting “when the oocyte is exposed to the sperm”.

8.2.1 Gamete donation

Under section 25(b) of the HRT Act, if the gametes are donated, with effective consent, the rights vest in the licensee, subject to the limitation that, in accordance with that consent, the gametes may be used as set out in the Act -

(i) for the purpose of initiating an *in vitro* fertilisation procedure intended to develop an egg in the process of fertilisation or an embryo for implantation into a recipient named in, or to be selected in accordance with circumstances specified, in that consent;

(ii) for artificial insemination purposes;

(iii) in, or in connection with, an approved project of research; or

(iv) for the purposes of diagnostic procedures,

and not otherwise, but if the gametes are not so used they shall, subject to section 26(1)(c) and (d), be allowed to succumb.

Under section 25(c) -

in respect to gametes donated subject to a consent which is conditional and which are not used, if a condition to which the consent was made subject is not observed, the rights, subject to section 22(6) and any instructions to which effect can then be given, revert to the donor and in default vest in the Commissioner of Health.

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304 Submission 27 - RTC.
8.2.2 Posthumous use of gametes

The HRT Act does not make special provision for the use of gametes where the donor has died.

Section 24(2) of the HRT Act states that -

where the persons on behalf of whom the storage of any gametes, egg in the process of fertilisation or embryo was undertaken have died, or the licensee otherwise does not have and can not obtain any instructions or consent required for the purposes of this Act in relation to the storage, the control and the power of disposal are deemed to vest in the Commissioner of Health who shall, subject to section 22 (6) and any instructions or conditions to which effect may then be given, direct that any such egg or embryo be made available for the purpose of providing treatment for a specific recipient, unless a court of competent jurisdiction otherwise requires.

The RTC discussed two situations where gametes (including precursors to gametes such as primordial ovarian follicles or immature testicular tissue) are already stored.

- The majority of RTC members recommended that where clear written consent existed, gametes could be used in posthumous treatment of a named person but would require a cooling off period and counselling to explore fully issues for themselves and the potential offspring;

- the majority of RTC members recommended that where no written consent for use in treatment by a named person existed, gametes could not be used.

In Victoria, section 43 of the Infertility Treatment Act 1995 bans procedures involving gametes of people known to be dead.

The issue of posthumous use of gametes has been debated in the United Kingdom (UK) since the case of R v Human Fertilisation and Embryology Authority ex parte Blood. The UK Court of Appeal held that the decision of the HFEA disallowing the export of Mrs Diane Blood’s deceased husband’s semen could not stand. Since the case, Professor Sheila McLean of the University of Glasgow prepared a document for UK Health Ministers entitled “Consent and the law. Review of the current provisions in the Human Fertilisation and Embryology Act 1990”. The remit of the review was -

1. to review whether - and in which circumstances - explicit consent under the common law to the removal of gametes might be waived;

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305 Recommendations from the RTC on posthumous use of embryos and gametes in assisted fertilisation procedures. Correspondence to the Select Committee, 30 September 1998.


307 Correspondence from Ms Alicia Campos, Professional Assistant, Crown Solicitor’s Office to Mr John Lyon, Deputy Crown Solicitor. 22 April 1998. Provided to the Select Committee by the Health Department of WA.

(2) to consider in the light of (1) whether changes are required to the Human Fertilisation and Embryology Act whereby effective consent to storage and use of gametes must always be given in writing;

(3) to consider the implications of any changes to the present consent regime in the Human Fertilisation and Embryology Act 1990 for the remainder of that Act, including for the operation of the Human Fertilisation and Embryology Authority;

(4) to consider the implications for 1-3 above of the judgement given by the Court of Appeal in the case of R v Human Fertilisation and Embryology Authority ex parte Diane Blood.

In July 1998, Professor McLean presented her findings. These are referred to in this Chapter.

Many countries do not permit either artificial insemination or IVF with the sperm of a deceased husband. However, both are permitted in Spain, where the husband must “validly consent to the use of his ‘reproductive material’ during a period of 6 months before death”.\(^{309}\)

Ms Alicia Campos noted the decisions of the Californian Court of Appeal in *Hecht v Superior Court of the State of California for the County of Los Angeles* (1993) 16 Cal. App. 4th 836, *Hecht v Kane et al* (1996) Cal. App. 7th “where custody of 15 vials of frozen semen of a deceased man was awarded to his partner on the basis of his wishes in various documents that she have his child posthumously”. Further on 15 January 1997, the Supreme Court of California denied the petition for review and “deauthorised the Court of Appeal judgement for use as a precedent”.\(^{310}\)

In September 1998, the RTC informed the Select Committee that the majority of Council members believed that posthumous use of stored gametes, could be used, if there was clear written consent for use in treatment of a named person, and after a cooling off period and counselling to explore fully issues for the named person and the potential offspring.\(^{311}\)

**Posthumous use of donor gametes**

Section 8.5 of WA’s Directions states that “any person to whom the license applies must not knowingly use or authorise the use of gametes in an artificial procedure after the death of the gamete provider”.

The Select Committee received submissions stating that there should be no posthumous use of gametes.\(^{312}\) Some indicated that if either partner dies, all gametes should be destroyed.\(^{313}\) It was felt that it was not fair on a child for a dead person to become a parent. The RTCCC felt that the intention

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309 Council of Europe. 1998.
310 Correspondence from Ms Alicia Campos, Professional Assistant, Crown Solicitor’s Office to Mr John Lyon, Deputy Crown Solicitor. 22 April 1998. Provided to the Select Committee by the Health Department of WA.
311 Professor Con Michael, Chairman, RTC. Correspondence to the Select Committee, 30 September 1998.
312 Submission 29 - RTCCC; Submission 33 - Ms Sue Midford, *et al*.
313 Submission 13 - Ms Judith Armstrong.
to create life after the death of the gamete provider is ethically distinct from the accidental death of the father after conception. However, it was suggested that each case should be considered on its merits.

The Select Committee considered that posthumous use of gametes should not be allowed in Western Australia. In reaching its decision, Members tried to reflect the situation that would arise naturally if one partner died - they would either no longer be able to impregnate another person or be impregnated themselves. The Members also believed that future offspring should have the right to know their parents if possible and that no-one has an absolute right to pass on their genetic material.

**Recommendation 8b**

That posthumous use of gametes not be allowed in Western Australia.

**Collection of gametes from a person who is dead or incapacitated**

According to Professor Sheila McLean -

there may be some situations where there is reason to be unclear about whether or nor recovery is likely. Or there may be certainty about the likelihood of recovery, but uncertainty about post-recovery fertility. In these circumstances, it may be appropriate that the ‘best interests’ test is used to judge the lawfulness or otherwise of gamete removal. Since this judgement depends on legal not medical criteria, although medical information will be crucial to the evidence before a court, the decision as to whether or not the ‘best interests’ test is met is one which should be reached by a court of law.

The Select Committee felt that harvesting gametes after a person is dead or is no longer capable of giving consent should be prohibited. This view was supported by the RTC which stated that the collection and use of gametes in this situation should “not be allowable for an assisted fertilisation procedure”.

**Recommendation 8c**

That collection of gametes after a person is dead or is no longer capable of giving consent be prohibited.

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314 Submission 29 - RTCCC.
315 Submission 21 - Mrs Rosa Tognela.
317 Recommendations from the RTC on posthumous use of embryos and gametes in assisted fertilisation procedures. Correspondence to the Select Committee, 30 September 1998.
Transfer of ownership of gametes

The Select Committee was told that if posthumous use of gametes is to be prohibited, it should not be possible to inherit gametes as property. Section 7(1)(j) of the HRT Act already prevents commercial trading of gametes -

A person, whether or not a licensee, who causes or permits ... gametes, an egg in the process of fertilisation or an embryo to be supplied for valuable consideration, commits an offence.

**Recommendation 8d**

That under the *Human Reproductive Technology Act 1991*, gametes not be considered to be property for inheritance purposes.

8.2.3 Import and export of gametes and embryos

**Western Australia**

Directions 6.1 - 6.4 address the import and export of donated material. Importation of donated gametes and embryos from outside the State is not allowed unless all the information required under the Act for the Donor Register is available. An exemption may be granted on compassionate grounds.

Gametes and embryos may be accepted from outside the State if no donation is involved and the material is to be used by the gamete/embryo provider or if the material is to be used in an RTC-approved research project.

Donated gametes and embryos cannot be exported, where the export is to a person not approved by the RTC and where there is no written undertaking by that person to provide the “person responsible” with information that would be required for the WA Donor Register, if the donated material had been used in WA. In addition, embryos cannot be exported for a purpose other than would be allowed under WA legislation.

In 1995, section 4(4) of the *Human Reproductive Technology (Licences and Registers) Regulations 1993* was amended to state that the Commissioner of Health shall cause to be kept registers containing information relating to export from the State of gametes, eggs in the process of fertilisation and embryos, and their subsequent use, other dealing in, or disposal.

The Health Department of WA recently sought advice on the export of semen after the death of the semen provider. The RTC has the power to advise the Commissioner of Health to issue a direction regulating export. For example, a direction could be issued either requiring persons who wish to export gametes from WA to apply to the Council or prohibiting such export altogether.318

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318 Correspondence from Alicia Campos, Crown Solicitor’s Office to John Lyon. Provided to the Select Committee by the Health Department of WA. 4 April 1998.
Victoria

In Victoria, import and export of gametes and embryos requires the approval of the Infertility Treatment Authority.

United Kingdom

Under section 5.21 of the UK Code of Practice, export of gametes or embryos produced using them requires the specific consent of the people providing the gametes. Section 7.23 states that centres must not export gametes from donors who have produced 10 live children in the UK.

The Select Committee recommended that licensees must keep accurate records of use of gametes that are imported and exported for either the gamete provider’s own use or as donated material. Members felt that it was important that the standard of recording was the same as if the gametes were to be used in WA.

**Recommendation 8e**

That licensees keep accurate records of use of gametes imported or exported for the gamete provider’s own use or as donated material.

That the standard of the records be the same as if the gametes were to be used in Western Australia.

The Member for Joondalup dissented in so far as he was opposed to the importation or exportation of donor gametes.

Export of gametes or embryos for posthumous use

The RTC was of the view that export of gametes or embryos, for posthumous use that would not be allowed in this State, should be “explicitly ruled out in the Act”. 319

In this Chapter, the Select Committee recommends a ban on posthumous use of gametes, but not of embryos, if prior written consent has been given by the deceased partner. The majority of the Select Committee felt that the HRT Act must be consistent with regard to the export of gametes and embryos for posthumous use.

**Recommendation 8f**

That export of gametes for posthumous use be banned but that export of embryos for posthumous use be permitted, if prior written consent by the deceased partner is available.

319 Professor Con Michael. Correspondence to the Select Committee, 30 September 1998.
The Member for Joondalup dissented and opposed the posthumous use of embryos.

8.3 RIGHTS TO EGGS IN THE PROCESS OF FERTILISATION AND EMBRYOS

Eggs in the process of fertilisation or embryos may only be created for implantation into a particular woman. Both the woman and her partner must consent to any storage or use of an egg in the process of fertilisation or embryo. As discussed in Chapter Six (Recommendation 6b), the Select Committee felt that the term “egg in the process of fertilisation” should be removed from the HRT Act except with reference to rights to an egg in the process of fertilisation and its storage.

8.3.1 Disagreement over use

Under section 26(2) of the HRT Act -

Where rights to an egg in the process of fertilisation or an embryo are vested in a couple and the couple disagree over its use or continued storage, the Commissioner of Health shall, on application by a member of that couple, direct the licensee storing the egg or embryo to ensure storage is maintained subject to -

(a) payment of the proper charges of the licensee for the storage;
(b) any limitation as to the time of storage prescribed or determined in accordance with section 24(1)(b); and
(c) any order made by a court of competent jurisdiction which otherwise requires.

The NHMRC’s ethical guideline 3.2.8 states that “where disputes arise between couples about storage of embryos, those embryos shall be kept and not allowed to succumb until the dispute has been resolved and a decision taken about the embryos”.

The Select Committee felt that in the event of a dispute, the embryo should be kept until the dispute was resolved or a statutory time had elapsed when it would be allowed to succumb. In the event of the relationship breaking down, it is unlikely to be in the best interests of the child to be born into conflict. The embryos should be allowed to succumb unless all parties agree to donate.

The Select Committee felt that the NHMRC’s ethical guideline 3.2.8 should be incorporated into the HRT Act to include eggs in the process of fertilisation as well as embryos and with the addition “until a statutory time has elapsed when the embryo would be allowed to succumb”. The relevant section of the HRT Act must be clarified to reflect the guideline.
Recommendation 8g

That the National Health and Medical Research Council’s ethical guideline 3.2.8, as for the time being prescribed, that states “where disputes arise between couples about storage of embryos, those embryos shall be kept and not allowed to succumb until the dispute has been resolved and a decision taken about the embryos” be incorporated into the Human Reproductive Technology Act 1991 to include eggs in the process of fertilisation as well as embryos with the addition of “until a statutory time has elapsed when the embryo would be allowed to succumb”.

8.3.2 Donation of eggs in the process of fertilisation and embryos

Section 26(1)(d) of the HRT Act states that -

where an egg in the process of fertilisation or an embryo has been developed on behalf of a couple and is no longer required for that purpose, if all the participants in a proposed procedure give an effective consent it may be donated for the purpose of providing treatment for a specific recipient.

Some submissions indicated that people should only provide sperm and eggs for their own use. As stated above, under the HRT Act, the egg in process of fertilisation or embryo can only be donated by the couple to another couple for the purpose of being implanted into the other woman, thus excluding donation for research purposes.

The Select Committee was told that the rights to embryos are never in limbo and they never lie with the licensee, unlike the rights to gametes.

8.3.3 Posthumous use of embryos

Under section 26(1)(b) of the HRT Act, if one member of the couple dies, rights vest solely in the surviving member. Under section 23 of the HRT Act, the surviving female partner cannot use the embryos personally because she would be regarded as a single woman (unless she remarries) and would therefore not be eligible for treatment. The remaining choices are to allow the embryos to succumb or to donate them to another couple.

The RTC proposed the following two options -

(i) the survivor should either be able to use the embryos for their own treatment but would require a cooling off period and counselling to explore fully issues for themselves and the potential offspring; or

(ii) the survivor could donate the embryos for the treatment of others but would require a cooling off period and counselling of the donor and recipients to explore fully all issues, especially for the potential offspring.

321 Submission 13 - Ms Judith Armstrong.
322 Dr Sandra Webb. Personal communication to the Select Committee.
If both members die, under section 24(2) -

control and the power of disposal are deemed to vest in the Commissioner of Health who shall, subject to section 22(6) and any instructions or conditions to which effect may then be given, direct that any such ... embryo be made available for the purpose of providing treatment for a specific recipient, unless a court of competent jurisdiction otherwise requires.

The RTC examined two situations where both members of a couple die.

(i) Where a couple with the right to make a decision about the embryo, when consenting to storage or making variation to that consent later, leave written consent for donation to another couple if both members die or become incapacitated.

The majority of RTC members felt that premeditated posthumous donation should not be allowed and that if the people responsible for the embryos do not wish to use them for their own treatment, they should be encouraged to either donate the embryos immediately or to remove them from storage.

(ii) Where both members of a couple die without leaving instructions, a third party, (e.g. Commissioner of Health (s24(2))) could be required to donate them to an infertile couple, or to remove them from storage.

The majority of RTC members were of the view that donation by a third party without the consent of the couple was not allowable. If there were no instructions, embryos should be removed from storage and allowed to succumb. The RTC suggested that section 24(2) of the HRT Act should be amended to reflect this.

The Select Committee was of the opinion that where no consent has been given by the parties with rights to and responsibilities for the embryos, embryos should be allowed to succumb. It further felt that the Commissioner of Health may only permit third party use of embryos if explicit written consent has been received from the parties with rights to and responsibilities for the embryos. Consent forms must allow the parties to state clearly their intentions.

<table>
<thead>
<tr>
<th>Recommendation 8h</th>
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<tbody>
<tr>
<td>That where no consent has been given by the parties with rights to and responsibilities for the embryos, embryos be allowed to succumb.</td>
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<td>That the Commissioner of Health only permit third party use of embryos if explicit written consent has been given by the couple.</td>
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<table>
<thead>
<tr>
<th>Recommendation 8i</th>
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<tbody>
<tr>
<td>That consent forms be altered to ensure that prior written consent be obtained before embryos are created.</td>
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</table>
The NHMRC’s ethical guidelines state that\(^{323}\) -

should one member of a couple with the responsibility to make decisions about an embryo die, the surviving member has the responsibility to make the relevant decisions about the keeping or use of the embryo, taking into consideration any advance directive from the deceased partner.

Should both members of the couple die, where possible any advance directive from the couple should be complied with or, if there is no such directive or it cannot be complied with, the embryo should be allowed to succumb.

**Victoria**

In Victoria, the *Infertility Treatment Act 1995* provides that embryos, where one or both gamete providers have died, where the parties consent to removal and on expiry of the permitted storage time, are allowed to succumb.

**Overseas**

Posthumous use of embryos is permitted in a number of countries - Germany, Spain, Switzerland, and the United Kingdom.\(^{324}\) In Germany and Switzerland, transfer of the embryo is permitted based on the principle of saving the life of the embryo.

Mrs Josephine Quintavalle from CORE told the Select Committee that “posthumous use of embryos is morally different from posthumous use of gametes. The living human embryo has a right to life and therefore should be donated to willing couples whenever possible”.\(^{325}\)

**Inheritance**

The Select Committee was aware that there is legal precedence for children born from stored embryos to make claims against the estates of their parents.

In Australia, a Tasmanian judge found “that a child, being the product of his father’s semen and mother’s ovum, implanted in the mother’s womb subsequent to the death of his father is, upon birth, entitled to a right of inheritance afforded by law”.\(^{326}\)

Under section 12(a) of the *WA Administration Act 1903*, “entitlement to participation in distribution of intestate estates”, paragraph (b) of subsection (2) does not apply to or in respect of a relationship established by the *Artificial Conception Act 1985* -

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\(^{323}\) NHMRC. 1996: 7.

\(^{324}\) Council of Europe. 1998: 44-45.


where the father and mother are not, or have not been married to each other, the relationship between a child and his father, and all other lineal or collateral relationships, shall be recognized only -

(a) if paternity is admitted by or established against the father in his lifetime; and

(b) where the purpose for which the relationship is to be determined enures for the benefit of the father, if paternity has been so admitted or established in the lifetime of the child.

The Select Committee acknowledged the obvious intent to have a family in the situation where embryos had already been created and stored and believed that it was in the best interest of the future child to be born rather than to be allowed to succumb or to be donated to another couple. The majority of the Select Committee considered the possibility if a wife died and the remaining partner would be required to find a surrogate. FINNRAGE rejected the “false equity embedded in the surviving partner having the right to make decisions re the embryos. This implies that a man could decide to have an embryo implanted into a ... surrogate ... which FINNRAGE opposes on principle”.

Recommendation 8j

That posthumous use of embryos by the surviving partner be allowed in Western Australia following -

- prior written consent of the deceased party;
- a sufficient “cooling off” period;
- mandatory counselling;
- consideration of the welfare of the future offspring; and

The Member for Joondalup dissented.

8.4 CONSENT TO THE USE OF GAMETES AND EMBRYOS

Direction 3.3 provides that the “person responsible must ensure that no consent is given for a use not permitted under the HRT Act, including the use of gametes of a person known to be dead”. According to the Commissioner of Health “this stance is becoming increasingly controversial in cases where the spouse requests access to her partner’s sperm after his death, especially where there is a desire to refer to evidence that the deceased spouse had consented to such posthumous use”.

The NHMRC states that, for gametes, consent should -

327 Submission 4 - FINNRAGE.
328 Submission 36 - Commissioner of Health.
give an advance directive as to what should be done with the gametes if the gamete provider dies, becomes incapable of varying or revoking the consent, or fail to give further instructions at the expiry of the maximum time period of storage.

The issue of consent is relevant in the Blood case. Mr Blood fell into a coma prior to giving written consent to the use of his semen. Researcher Dr Helen Watt stated that it was “doubtful that an unwitnessed or oral exchange between husband and wife can be seen as formal consent to something as momentous as the posthumous creation of a child” 330

McLean (1998) found that the majority of respondents (86%) to the consultation document “Consent and the law: Review of the current provisions of the Human Fertilisation and Embryology Act 1990” believed that the law should not be changed to permit non-consensual removal of gametes. 331 She was of the view that -

arguments both from principle and from policy seem to weigh heavily on the side of not reducing the quality of consent which is currently demanded by the common law for the removal of gametes. It is, therefore, recommended that, unless one of the current exceptions to the general rule can be established, the requirement that formal consent following adequate disclosure of relevant information is legally necessary should remain.

According to the NHMRC, for use of embryos, consent should 332 -

give an advance directive as to what should be done with the embryos if either member of the couple, or both, should die, become incapable of varying or revoking the consent, or fail to give further instructions at the expiry of the maximum time period of storage.

All consents require couples to address the situation where one or both of them dies. The Select Committee felt that the couple must have completed a consent form prior to the creation of the embryo outlining their choice to the State to either allow the embryos to succumb, to be donated to another couple or to be used by the surviving partner.

Recommendation 8k

That all consent forms require couples to consider the situation where either or both member(s) of the couple die(s) or become(s) incapable of varying or revoking the consent, prior to the creation of any embryo.

The Member for Joondalup dissented and opposed the posthumous use of embryos.

8.5 OFFENCES


Under section 7(5) of the HRT Act, a person who being a licensee, keeps or uses any gametes, or any egg in the process of fertilisation or embryo in contravention of this Act, commits an offence with a penalty of $10 000 or two years imprisonment.

8.6 RIGHTS OF THIRD PARTIES

A number of submissions stated that there should be no rights for third parties, while others specified that there should be no third party rights to gametes or embryos without consent from the gamete providers or couple respectively. The RTC considers consent of the gamete provider to be of fundamental importance for all uses of the gametes. Without the gamete provider’s consent there should be no transfer of rights to any others, including spouses or relatives;

where the gamete provider is consenting to donation of gametes for an artificial fertilisation procedure the Council considers it important that the current spouse also consents, although this should probably not be mandatory;

without consent of the relevant couple there should be no third party rights to an embryo.

The fate of reproductive material in storage, where people have died or the licensee cannot otherwise obtain instructions or consent in relation to storage, control and power of disposal of the material is discussed previously in this Chapter.

8.6.1 Rights of subsequent spouses

The Victorian Infertility Treatment Act 1995 (sections 15 and 30) addresses objections by a later spouse. If after the donor has given consent under section 12 in respect to an oocyte, sperm, zygote or embryos, the donor marries or is living in a de facto relationship, the oocyte, sperm, zygote or embryo must not be used in any treatment procedure, or a treatment procedure of a particular kind or in a particular case if the donor’s spouse objects. Similarly, if after a donor has consented to research, he or she marries or is living in a de facto relationship, the oocyte, sperm, zygote or embryo must not be used in the research if the donor’s spouse objects to its use.

The Select Committee felt that subsequent spouses had no rights with regard to the use of their new partner’s donated reproductive material. However, the spouse should be encouraged to give their consent if the gametes are to be used in a donor assisted fertilisation procedure where the offspring conceived would be half siblings to any children conceived by the spouse and their partner.

The Select Committee recommended that there should be no rights for third parties in relation to gametes and embryos.

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333 Submission 1 - Mr Richard Egan; Submission 16 - Mr Haydn Lowe; Submission 21 - Mrs Rosa Tognela.

334 Submission 27 - RTC; Submission 29 - RTCCC.

335 Submission 27 - RTC.
Recommendation 8l

That there be no rights for third parties in relation to gametes or embryos.
### Recommendation 8a

That section 26(1)(c) of the *Human Reproductive Technology Act 1991* be amended by deleting “at the moment fertilisation begins” and substituting “when the oocyte is exposed to the sperm”.

### Recommendation 8b

That posthumous use of gametes not be allowed in Western Australia.

### Recommendation 8c

That collection of gametes after a person is dead or is no longer capable of giving consent be prohibited.

### Recommendation 8d

That under the *Human Reproductive Technology Act 1991*, gametes not be considered to be property for inheritance purposes.

### Recommendation 8e

That licensees keep accurate records of use of gametes imported or exported for the gamete provider’s own use or as donated material.

That the standard of the records be the same as if the gametes were to be used in Western Australia.
Recommendation 8f

That export of gametes for posthumous use be banned but that export of embryos for posthumous use be permitted, if prior written consent by the deceased partner is available.

Recommendation 8g

That the National Health and Medical Research Council’s ethical guideline 3.2.8, as for the time being prescribed, that states “where disputes arise between couples about storage of embryos, those embryos shall be kept and not allowed to succumb until the dispute has been resolved and a decision taken about the embryos” be incorporated into the Human Reproductive Technology Act 1991 to include eggs in the process of fertilisation as well as embryos with the addition of “until a statutory time has elapsed when the embryo would be allowed to succumb”.

Recommendation 8h

That where no consent has been given by the parties with rights to and responsibilities for the embryos, embryos be allowed to succumb.

That the Commissioner of Health only permit third party use of embryos if explicit written consent has been given by the couple.

Recommendation 8i

That consent forms be altered to ensure that prior written consent be obtained before embryos are created.
Recommendation 8j

That posthumous use of embryos by the surviving partner be allowed in Western Australia following -

- prior written consent of the deceased party;
- a sufficient “cooling off” period;
- mandatory counselling;
- consideration of the welfare of the future offspring; and

Recommendation 8k

That all consent forms require couples to consider situations where either or both member(s) of the couple die(s) or become(s) incapable of varying or revoking the consent, prior to the creation of any embryo.

Recommendation 8l

That there be no rights for third parties in relation to gametes or embryos.
CHAPTER NINE

STORAGE OF GAMETES, EGGS IN THE PROCESS OF FERTILISATION AND EMBRYOS

9.1 INTRODUCTION

The Select Committee was asked to address the issue of storage of gametes, eggs in the process of fertilisation and embryos (including the duration of storage and procedures for extension of storage periods).

9.1.1 Human Reproductive Technology Act 1991

Section 24 of the HRT Act addresses storage. In 1996, the HRT Act was amended by passage of the Human Reproductive Technology Amendment Act 1996 to allow, for special reasons, case by case extensions to the three year embryo storage limit set by the principal Act.

24(1) In relation to the storage of any eggs, sperm, egg in the process of fertilisation or embryo -

(a) the primary purpose stated in any consent to the storage of an egg in the process of fertilisation or any embryo must relate to the probable future implantation of that egg or embryo; and

(b) the Code may make provision as to what, in particular circumstances, constitutes an excessive time for the storage of -

(i) eggs or sperm;
(ii) an egg in the process of fertilisation; or
(iii) an embryo,

but no egg in the process of fertilisation or embryo shall be stored for a period in excess of the permitted storage period except with the approval of the Council under subsection (1a).

(1a) The Council may approve in writing a longer storage period for an egg in the process of fertilisation or an embryo if it considers that there are special reasons for doing so in a particular case.

(1b) An approval under subsection (1a) may be subject to conditions and is to specify the date on which the longer storage period ends.

(1c) An approval under subsection (1a) can only be given before the end of the permitted storage period, or if a longer storage period has previously been approved under subsection (1a), before the end of that period.

(1d) The Council is to inform the Minister of each approval given under subsection (1a), but in such a manner that the identity of the biological parents cannot be ascertained from the approval.

(2) Where the persons on behalf of whom the storage of any gametes, egg in the process of fertilisation or embryo was undertaken have died, or the licensee otherwise does not have
and can not obtain any instructions or consent required for the purposes of this Act in relation to the storage the control and the power of disposal are deemed to vest in the Commissioner of Health who shall, subject to section 22(6) and any instructions or conditions to which effect may then be given, direct that any such egg or embryo be made available for the purpose of providing treatment for a specific recipient, unless a court of competent jurisdiction otherwise requires.

(3) Where a licensee is directed by the Commissioner to allow any gametes, egg in the process of fertilisation or embryo to succumb the licensee shall be required thereupon to comply and shall not be liable to any person for so doing.

(4) In this section -

“permitted storage period” means -

(a) in the case of the storage of an egg in the process of fertilisation or embryo starting before 8 October 1993, the period ending 7 October 1996; and

(b) in any other case, 3 years.

9.2 EMBRYO STORAGE

At 30 June 1998, there were 6,108 embryos in storage in WA. The number of embryos in storage has increased over the past five years. In the last year, 2,429 stored embryos were used for treatment by Frozen Embryo Transfer (FET) (Table 7). Only five FET cycles used donated embryos (0.5%) compared with 14 (1.9%) at 30 June 1997.

Table 7: Dispersal of embryos in Western Australia, 1997 - 1998

<table>
<thead>
<tr>
<th>Fate of Embryos</th>
<th>Number of Embryos</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transferred between clinics in WA</td>
<td>71</td>
</tr>
<tr>
<td>Transferred to clinics outside WA (Patients moving interstate)</td>
<td>37</td>
</tr>
<tr>
<td>Transferred into WA clinics from interstate and overseas (Patients moving interstate)</td>
<td>28</td>
</tr>
<tr>
<td>Used in frozen embryo transfer treatments</td>
<td>2,429</td>
</tr>
<tr>
<td>Allowed to succumb with consent of couples</td>
<td>216</td>
</tr>
</tbody>
</table>


9.3 DURATION OF STORAGE

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9.3.1 Current situation

Gametes

No time limit for gamete storage is set in the HRT Act but a limit is set by the Directions (Direction 6.5). Consents to store gametes must be renewed every five years up to a maximum of 15 years. However, where gametes are to be used in the treatment of the gamete provider or for research, the person responsible may apply in writing to the RTC for an extension. The RTC considered that renewal of consent to store gametes should be sought every five years. Under Direction 3.2, the person responsible must ensure that consent is renewed every five years.

In Victoria, gametes must not remain in storage for more than 10 years or such longer period approved by the Infertility Treatment Authority (ITA).

Embryos

Under the HRT Act, embryos can be stored for three years with the possibility of an extension. The extension period is not specified but is left up to the discretion of the RTC.

9.3.2 Criteria for establishing the end point for storage

According to Ms Leigh Newman, difficulties in the area of storage “relate to the lack of clarity in the criteria to be used for establishing the final end point to the storage period”. Ms Newman suggested a number of possibilities for determining the end point -

- beyond reproductive life;
- using eligibility criteria set out in section 23;
- age;
- duration, e.g. five - ten years;
- potential welfare of the child weighed up with the ban on posthumous use beyond the life of one or both partners.

Submissions received indicated that no storage should be allowed beyond the normal reproductive lifespan of the gamete provider. Gametes and embryos should be allowed to succumb if the gamete providers are not found and gametes should not be stored following the death of the donor.
In Victoria, the *Infertility Treatment Act 1995* provides that embryos, where one or both gamete providers have died, where the parties consent to removal and on expiry of the permitted storage time are allowed to succumb.

The NHMRC’s ethical guidelines state that “where no consent exists for storage of embryos, or for withdrawal of support ... the embryo should remain in storage until the expiry of the maximum period of storage and may then be allowed to succumb”.

In the UK, when embryos reach the end of their storage period they must be removed from storage and either used in accordance with the couple’s wishes or allowed to perish. Where possible couples should be made aware of the event.

**Gametes**

The Select Committee decided that gametes should be stored initially for 15 years with the requirement for clinics to renew contact with the gamete providers, including donors, every five years. It is incumbent upon individuals to notify the clinic of any change of address. After 15 years, it will be left to the discretion of the RTC to allow further extension. However, the limit for storage should be when the gamete provider reaches 55 years of age except in exceptional circumstances. The majority of the Select Committee felt that this was consistent with its earlier Recommendation 5c (see page 50).

**Recommendation 9a**

That donated gametes and gametes for self-use be stored for up to 15 years with renewals every 5 years.

That beyond 15 years there be a general discretion for the Reproductive Technology Council (RTC) to extend storage until the gamete provider reaches 55 years of age.

That there be no extension beyond 55 years of age except in exceptional circumstances as decided on by the RTC and taking as the paramount consideration the welfare of the potential offspring.

The Member for Joondalup dissented and requested that “55” be substituted by “45”.

**Embryos**

The RTC informed the Select Committee that the current three year storage limit for embryos is too short to allow suitable family spacing. A number of submissions called for an extension to the

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343 NHMRC. 1996: 11.


345 Submission 27 - RTC.
embryo storage time to five years initially with the possibility of further extension. Dr Jennifer Kurinczuk felt that “after ten years extension would be considered on a case-by-case basis but would be potentially very important to women who have had IVF embryos created because of medical treatment early in their life.” It was also felt that storage should not be permitted beyond the normal reproductive life of the gamete providers.

The Select Committee was told that “Section 24(3) is very unclear. The Act does not specifically provide for the removal of embryos from storage. It is implied that on expiry of storage time they should be removed. This causes a lot of disquiet in the clinics”. Members were also informed that “there is currently no discretion for extending the storage time once the permitted time has expired. It may assist the clinics if there is a transitional period between the expiry time and the time of removal”.

According to the RTC, the statutory time limits it proposed (five years initially with possibility of further extension) would provide a clear basis for monitoring compliance and at least five yearly contact with couples to remind them of their responsibilities and rights and seek renewal of their consent.

In February 1996, the UK Human Fertilisation and Embryology (Statutory Storage Period for Embryos) Regulations 1996 extended the statutory storage period for embryos in the 1990 Act from five years to 10 years with further extension for special reasons. Special provision was made for women undergoing cancer treatment or suffering from premature menopause to store embryos until their 55th birthdays.

In South Australia, the Code of Practice sets a 10 year time limit for embryo storage, while the Infertility Treatment Act 1995 in Victoria permits embryos to be stored for 5 years or longer if approved by the ITA.

The NHMRC’s ethical guidelines state that:

- storage of gametes and embryos should be in accordance with relevant State legislation and the Code of Practice of the accreditation body [currently RTAC].

- Embryos may be kept for a period not exceeding 10 years, following which, if not used by the couple, they may be donated or allowed to succumb. These arrangements may be varied on compassionate grounds with approval by an IEC.

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346 Submission 19 - Confidential; Submission 27 - RTC; Submission 29 - RTCCC; Submission 30 - Dr Jennifer Kurinczuk; Submission 33 - Ms Sue Midford, et al.
347 Submission 30 - Dr Jennifer Kurinczuk.
350 Submission 27 - RTC.
352 NHMRC. 1996: 11.
The Select Committee acknowledged that the current storage limit for embryos is too short and supported the current NHMRC guidelines that storage should be extended to 10 years with the possibility for extension in exceptional circumstances.

**Recommendation 9b**

That in accordance with National Health and Medical Research Council’s ethical guidelines, embryos be stored for 10 years and that clinics contact couples after five years and again at nine years (12 months prior to the termination of the storage period) to determine the couples’ wishes.

That couples be allowed to apply to the Reproductive Technology Council (RTC) for an extension of storage in exceptional circumstances taking as the paramount consideration the welfare of the future offspring.

That in the event that embryos are not used by a couple or consent has not been given for donation, or unless the RTC has determined that special circumstances exist, embryos be allowed to succumb after 10 years.

That in the event that a couple cannot be contacted after five years, embryos remain in storage until the 10 year storage period has expired and subsequently be allowed to succumb.

**Consent to store gametes and embryos**

According to the NHMRC, consent should “specify the maximum period of storage (if this is to be less than the permitted maximum)”.

9.3.3 Procedure for extension of storage periods

In WA, the RTC has an Embryo Storage Committee. With the agreement of the Minister for Health as required under section 10(4) of the HRT Act, the RTC, by resolution under section 11(1) of the HRT Act, may delegate the Committee to:

- make decisions on applications for the extension of the periods of storage of embryos on a case-by-case basis, based on the criteria agreed to by the Reproductive Technology Council, and to provide to the next meeting of Council details of all decisions made since the previous meeting; and
- provide other advice or carry out other functions relating to the storage of embryos, as instructed by the Council.

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354 *Embryo Storage Committee of the Reproductive Technology Council*. Document supplied by the RTC.
The Select Committee was told that an application for extension of embryo storage should only come from the people who have the right to make an application under the HRT Act and that clinics should not make an application for extension on behalf of the couples.\(^{355}\)

**Recommendation 9c**

That application for extension of embryo storage time only be made by the people who have the right and responsibility to make a decision about the embryo and that clinics not make an application on their behalf.

When granting an application for extension of the period of storage of an embryo, the RTC considers the “*Extensions of periods of storage: Principles to guide case-by-case decisions of the Reproductive Technology Council*” including the following, but not excluding any other -

- the respect due to human life at all stages of its development;
- that the primary purpose of storage of an embryo must relate to its probable future implantation;
- that the implantation of the embryo must conform to requirements set out in section 23 of the Act;
- the welfare of any child to be born consequent upon an artificial fertilisation procedure;
- that any extension of a period of storage of an embryo must only be according to consent given by those with the right to give consent;
- the welfare of the participants and their desire to have as much control as possible over their reproductive lives;
- the indefinite storage of embryos is undesirable and any extension of a period must have regard to that principle;
- the principles of equity, welfare and general standards prevailing in the community;
- that an embryo may be allowed to succumb if its condition is such that any attempt at implantation would be unsuccessful, or there is no couple available to accept the embryo for implantation.

The HRT Act’s Directions 6.6 and 6.7 discuss methodology to deal with both -

- impending expiry of the permitted storage period of embryos generally; and
- impending expiry of the permitted storage period of embryos where the licensee has no relevant instructions from the couple.

\(^{355}\) Dr Sandra Webb. Personal communication to the Select Committee.
9.3.4 Number of requests for extension

Up to 30 June 1997, the RTC granted 47 extensions to permitted storage in response to applications from couples. The most common reasons given for extension were to allow adequate family spacing (14.9%) or medical reasons (34%). In addition, there were 59 requests for extension from clinics. In many cases clinics lose contact with the couples concerned or the couples fail to complete the relevant paper work in time.356

As of 8 July 1997, extensions to embryo storage had been granted as follows357 -

Prior to 7 October 1996 (mainly related to embryos stored prior to the Act) by full Council
- 16 cases on application by couples who had stored embryos;
- 48 cases on application by clinics on behalf of couples who had failed to respond in time or with whom they had lost contact.

After 7 October 1996 (all cases where embryos were stored after the Act) by full Council
- 31 cases on application by couples who had stored embryos;
- 9 cases on application by clinics on behalf of couples who had failed to respond in time or with whom they had lost contact.

From 1 July 1997 - 30 June 1998, the RTC received 140 applications for extension of storage.358 The majority (87%) came from couples and the remaining 18 (13%) came from clinics on behalf of couples they could not locate. All requests for extension were granted, and all but two cases were granted two year extensions.

9.3.5 Embryos stored prior to the Human Reproductive Technology Act 1991

Dr Sandra Webb informed the Select Committee that there are approximately 85 “pre-Act” frozen embryos still in storage.359 Thirty six embryos are still in storage as requested by couples and 49 are being stored following clinics’ requests on behalf of couples with whom they have lost contact.

According to the Commissioner of Health360 -

Crown Law advice recommended that the Council should strongly consider granting extensions to storage of all embryos where a couple failed to issue explicit instructions, particularly where the embryos had been stored prior to the introduction of the Act. There was considerable uncertainty about the information and consent given by these couples and there was also considerable difficulty in interpretation of the Act.

359 Dr Sandra Webb. Correspondence with Select Committee, 20 January 1999.
According to Ms Leigh Newman\textsuperscript{361} -

at present clinics are concerned as to the quality or content of the information they provided to clients [prior to the legislation] and the resultant doubtful nature of the clients’ consent, e.g. Relating to storage time, so are reluctant to let some embryos succumb.

It was suggested that there must be provision to ensure clinics are indemnified (i) for allowing embryos stored before the WA legislation was operational, to succumb, in the situation where people with the right to make a decision about the embryo cannot be found and no further instructions can be procured, and (ii) for allowing embryos to succumb where the people with the right to make a decision about the embryo cannot be found and the storage period is coming to an end.

In the UK, couples who stored their embryos prior to the new storage regulations (May 1996) were required to renew their consents to storage if they wished to store their embryos for more than five years.\textsuperscript{362} The HFEA indicated that if the storage period had expired and consent to extend the storage period could not be obtained, the storage had to cease.\textsuperscript{363}

The Select Committee recognised the concern from clinics and believed that embryos should be allowed to succumb where the people with the right and the responsibility to make decisions about them cannot be found.\textsuperscript{364} However, Members would wish every attempt to be made to contact the donors first.

\begin{center}
\textbf{Recommendation 9d}
\end{center}

\begin{quote}
That embryos created prior to the operation of the \textit{Human Reproductive Technology Act 1991} (HRT Act) be deemed to be covered by the HRT Act.

That there be no liability on the part of the clinics for any action taken in accordance with the provisions of the HRT Act.

That the storage period for such embryos be calculated from the date of their creation.
\end{quote}

9.3.6 Limit of number of embryos in storage

Direction 8.4 rules out repeated ovarian stimulation for IVF where a couple has more than two embryos already in storage, and the RTC considers this to be a reasonable way to limit some of the excessive

\begin{flushleft}
\textsuperscript{361} Submission 86 - Ms Leigh Newman.
\textsuperscript{363} Human Fertilisation and Embryology Authority. \textit{HFEA reports on DI and IVF clinics’ birth rates; storage of human embryos; and payments for egg and sperm donors}. Press release. 22 July 1996.
\textsuperscript{364} Dr Sandra Webb. Personal communication to the Select Committee.
\end{flushleft}
build up of surplus embryos in storage.\textsuperscript{365} The Select Committee received submissions that suggested that freezing of embryos should only occur in emergencies and all embryos fertilised in a particular cycle should be implanted.\textsuperscript{366}

\section*{9.4 STORAGE OF IMMATURE REPRODUCTIVE MATERIAL AND REPRODUCTIVE TISSUE FROM MINORS}

Ms Leigh Newman told the Select Committee that there should be no prohibition against “the storage of gametes from children with malignant conditions who will receive chemotherapy, when they may need those gametes for potential future use”.\textsuperscript{367} However, Ms Newman felt there should be prohibitions against the use of oocytes from a fetus.

The Select Committee endorsed several suggestions from the RTC with amendments.\textsuperscript{368}

\begin{center}
\textbf{Recommendation 9e}
\end{center}

\begin{quote}
That the \textit{Human Reproductive Technology Act 1991} be amended to ensure that the definition of “gamete” includes immature gametes, primordial follicles and cells at all stages of sperm development in testicular tissue and that appropriate definitions of all of these terms also be included.
\end{quote}

\subsection*{9.4.1 Storage licence}

Section 6(1)(a) of the HRT Act states that a storage licence is required for the storage of “an egg intended for use in an IVF procedure”. The RTC felt it could be argued that the broad term egg could include immature ovarian tissue. However, it is not clear whether section 6(1)(b) of the HRT Act, which states that “no person shall cause or permit sperm ... to be kept” without a license, would include immature sperm.

United Kingdom

In the UK, testicular tissue from pre-pubertal boys can be stored on unlicensed premises.\textsuperscript{369} However, if such material were subsequently developed \textit{in vitro} to create gametes, the storage and use of the material would require a licence. At that stage, an effective consent would also have to be given in accordance with the \textit{Human Fertilisation and Embryology Act 1990}. If the pre-pubescent child is not

\textsuperscript{365} Submission 27 - RTC.
\textsuperscript{366} Submission 1 - Mr Richard Egan; Submission 3 - Mr and Mrs Bertino-Clarke; Submission 8 - Dr ED Watt.
\textsuperscript{367} Ms Leigh Newman. Evidence to the Select Committee, 9 April 1998.
\textsuperscript{368} RTC. Correspondence to the Select Committee, 15 June 1998.
\textsuperscript{369} Human Fertilisation and Embryology Authority. Policy statement. \textit{Storage and use of testicular tissue}. 
capable of understanding what is proposed and of expressing their own wishes, the person with parental responsibility would consent to the removal of testicular tissue where this is in the child’s best interests.

A licence is only required for ovarian tissue if a gamete or gametes (as defined by the Act) are present. Where a licence is required, effective consent to storage must be complied with. If a female is under 16 years of age, effective consent can only be given if she is capable of understanding the implication of the proposed course of action. Parents cannot provide effective consent under the Human Fertilisation and Embryology Act 1990. 370

9.4.2 Consent for use and storage

Section 22(1)(a) and (b) of the HRT Act sets out the need for consent from the gamete provider for use or storage of gametes. Therefore, the HRT Act does not appear to allow consent from a person other than the provider. However, it is silent on the issue of consent with regard to immature tissue.

<table>
<thead>
<tr>
<th>Recommendation 9f</th>
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<tr>
<td>That the Human Reproductive Technology Act 1991 be amended to clarify -</td>
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<tr>
<td>(i) the requirement for consent from the gamete provider for any use or storage of immature tissues; and</td>
</tr>
<tr>
<td>(ii) the mode by which consent for storage of either immature reproductive tissue or gametes be obtained on behalf of minors who are too young to give their legal consent.</td>
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In WA, the common law position applies regarding consent of minors under 18 years of age. This means that minors may consent validly to medical treatment in advance of attaining adulthood provided there is an awareness of the nature of the treatment. In the event that the child is not mature enough to give consent, the Select Committee believed that parents, guardians and clinicians should err upon the side of caution and ensure that tissue is collected.

In Victoria, Regulation 11 of the Infertility Treatment Regulations 1997 allows for the collection of gametes from a person under 18 years of age. 371 The Infertility Treatment Act 1995 allows collection of ovarian tissue from teenage girls undergoing chemotherapy. 372

The Select Committee felt that the HRT Act should be amended to facilitate the collection of reproductive material from minors. Members noted that the significant decision to use the genetic material would be made well after the child had reached maturity.

370 Human Fertilisation and Embryology Authority. Policy statement. Storage and use of ovarian tissue.


372 Infertility Treatment Authority. Meeting with the Select Committee, Melbourne, 23 March 1998.
** Recommendation 9g **

That the *Human Reproductive Technology Act 1991* be amended to specify that the parents and the doctor be allowed to consent to storage of tissue for a minor too young to consent.

That in the event of a disagreement, the issue be resolved by the Reproductive Technology Council.
CHAPTER NINE - RECOMMENDATIONS

Recommendation 9a

That donated gametes and gametes for self-use be stored for up to 15 years, with renewals every five years.

That beyond 15 years there be a general discretion for the Reproductive Technology Council (RTC) to extend storage until the gamete provider reaches 55 years of age.

That there be no extension beyond 55 years of age except in exceptional circumstances as decided on by the RTC and taking as the paramount consideration the welfare of the potential offspring.

Recommendation 9b

That in accordance with National Health and Medical Research Council’s ethical guidelines, embryos be stored for 10 years and that clinics contact couples after five years and again at nine years (12 months prior to the termination of the storage period) to determine the couples’ wishes.

That couples be allowed to apply to the Reproductive Technology Council (RTC) for an extension of storage in exceptional circumstances taking as the paramount consideration the welfare of the future offspring.

That in the event that embryos are not used by a couple or consent has not been given for donation, or unless the RTC has determined that special circumstances exist, embryos be allowed to succumb after 10 years.

That in the event that a couple cannot be contacted after five years, embryos remain in storage until the 10 year storage period has expired and subsequently be allowed to succumb.

Recommendation 9c

That application for extension of embryo storage time only be made by the people who have the right and responsibility to make a decision about the embryo and that clinics not make an application on their behalf.
Recommendation 9d

That embryos created prior to the operation of the Human Reproductive Technology Act 1991 (HRT Act) be deemed to be covered by the HRT Act.

That there be no liability on the part of the clinics for any action taken in accordance with the provisions of the HRT Act.

That the storage period for such embryos be calculated from the date of their creation.

Recommendation 9e

That the Human Reproductive Technology Act 1991 be amended to ensure that the definition of “gamete” includes immature gametes, primordial follicles and cells at all stages of sperm development in testicular tissue and that appropriate definitions of all of these terms also be included.

Recommendation 9f

That the Human Reproductive Technology Act 1991 be amended to clarify -

(i) the requirement for consent from the gamete provider for any use or storage of immature tissues; and

(ii) the mode by which consent for storage of either immature reproductive tissue or gametes be obtained on behalf of minors who are too young to give their legal consent.

Recommendation 9g

That the Human Reproductive Technology Act 1991 be amended to specify that the parents and the doctor be allowed to consent to storage of tissue for a minor too young to consent.

That in the event of a disagreement, the issue be resolved by the Reproductive Technology Council.
CHAPTER TEN

CODE OF PRACTICE, DIRECTIONS AND REGULATIONS

10.1 INTRODUCTION

The Select Committee examined the appropriateness and effectiveness of the RTC’s obligation to compile a Code of Practice, the Commissioner of Health’s power to issue directions, and the power to make regulations, and the scope and effect of existing directions and regulations under the HRT Act.

The regulatory framework provided by the HRT Act comprises:

- provisions of the Act;
- regulations;
- Rules and Guidelines comprising a Code of Practice (to have the status of subsidiary legislation);
- directions given by the Commissioner of Health which have been gazetted and which have the status of subsidiary legislation;
- ungazetted directions given by the Commissioner of Health, which have no legislative status, but may be enforceable to the extent that they are terms or conditions of licenses under the Act;
- terms and conditions of licenses.

According to the Commissioner of Health, the HRT Act is complex and should be streamlined. In addition, there should be flexibility under the HRT Act to take into account the rapid changes in technology and society. The Commissioner of Health also pointed out that “the layout of the Act is unclear in places making relevant provisions difficult to quickly access”.

Recommendation 10a

That the Human Reproductive Technology Act 1991 be rewritten in a clear and concise manner to reflect the recommendations of the Select Committee.

The Select Committee was of the view that the principles of the HRT Act should remain in the principal legislation.

10.2 CODE OF PRACTICE

Section 14(1)(c) of the HRT Act, addresses the Code of Practice.
Subject to section 13(2), the functions of the Council are -

after consultation with bodies representing persons having relevant expertise or sections of the public having appropriate interests, to compile and to cause to be published, to review, and to amend, a Code of Practice which -

(i) sets out Rules, guidelines and relevant information;
(ii) establishes the ethical standards required of licensees, and gives effect to the principles specified in, and the requirements of, this Act; and
(iii) provides for such other matters as may be instructed by the Minister, or as the Council may determine,

regulating the proper conduct of any reproductive technology practice, and of any procedure, required to be licensed and the proper discharge of the functions of the person responsible and other persons to whom a license applies, having due regard to this Act.

According to the RTC, “the Code of Practice envisaged by the Act appears to be unwieldy ... and would be too slow to respond to change as the setting of standards of practice in this complex and fast moving area of medicine requires rapid consideration and flexibility of approach”. 376

To date, no Code of Practice has been produced although Directions and draft Guidelines have been issued that relate to matters that should be in the Code. The original Directions given when the HRT Act came into operation were very comprehensive and “dealt with every aspect of practice which might ... have been covered by a Code of Practice”. 377

Under the current scheme, there is inconsistency in coverage of issues dealt with in the HRT Act and in the Directions which leads to disjointed results. Major areas affected include “storage periods” where embryos are covered by the HRT Act but gametes are addressed in the Directions. Likewise, posthumous use of embryos is implied by the HRT Act but posthumous use of gametes is contained in the Directions.

According to briefing notes from the Commissioner of Health 378 -

the Code is potentially a more inflexible and less dynamic tool for regulation of behaviour in a highly technical and rapidly developing field than would regulations be themselves. However, the potential for inappropriate amendment of highly technical regulations in Parliament is also of concern.

The RTC shared this concern. 379

The Commissioner of Health also advised the Select Committee that 380 -

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376 Submission 27 - RTC.
377 Submission 27 - RTC.
379 ibid.
380 Submission 36 - Commissioner of Health.
Select Committee on the Human Reproductive Technology Act

a desired objective is the streamlining of the regulatory framework so that the Commissioner of Health and the Council have an Act that is readily understandable and gives them the flexibility to keep abreast of developments in the area by publishing instruments in the Gazette that have the effect of subordinate legislation.

The RTC agreed with the Commissioner of Health. RTC members considered that the setting of standards through Directions given by the Commissioner as provided for by the HRT Act, has been convenient and effective. The Directions have been more readily amended than the Code (as envisaged by the HRT Act) could have been. This has allowed a combination of a quick response and flexibility with adequate enforceability.  

The RTC added that it was not aware of any criticism arising from the lack of the Code of Practice. It consulted widely on the adequacy of the Directions at nine months and 18 months after the introduction of the HRT Act. “Eighteen months after the introduction of the Act, the Council again consulted with all licensees ... indicating few major difficulties with the operation of the Directions from their perspective”.

Ms Leigh Newman was of the view that the definition of the Code be deleted from the HRT Act and the concept of the Code be replaced by the power of the Council to make Directions governing the issues covered by the HRT Act, using the same mechanism of the Commissioner of Health’s direction-making power, including the power to make Directions in relation to any persons or classes of persons generally.

In a submission to the Select Committee, Mr Eric Blyth outlined that -

legislation should provide for a separate code of practice ... that is capable of relatively rapid revision and amendment to take account of technological innovations. The maintenance and updating of such a code should be the responsibility of a government appointed agency. The basic legislation should make it clear that adherence to the Code of Practice is a requirement of the granting of a licence to practice ART.

10.2.1 Alternative codes of practice

The NSW Review of the Human Tissue Act 1983 pointed out that codes of practice regulating ART already exist in Australia. These are the NHMRC’s “Ethical Guidelines on Assisted Reproductive Technologies” and “RTAC Guidelines”. Medical practitioners who practice ART should follow these guidelines but there is no legal sanction in the event of a breach.

South Australia

381 Submission 27 - RTC.
382 ibid.
383 Submission 86 - Ms Leigh Newman.
384 Submission 70 - Mr Eric Blyth.
385 NHMRC. 1996.

Section 20(4) states that -

regulations under this Act (including a regulation promulgating the code of ethical practice or any amendments to it) will take effect as follows -

(a) if the regulation has lain before both Houses of Parliament for 14 sitting days and a notice of disallowance has not been given in either House during that period the regulation will take effect at the expiration of the period;

(b) if notice of disallowance has been given in either House during that period but the regulation has not been disallowed, the regulation will take effect when the motion for disallowance is defeated or lapses or, if such a notice has been given in both Houses, when both motions have been defeated or have lapsed or one motion has been defeated and the other motion lapsed.

United Kingdom

The Human Fertilisation and Embryology Act 1990 requires the HFEA to produce a Code of Practice to guide clinics on how they should carry out their licensed activities. The Code is reviewed regularly and updated in light of advances in techniques and to deal with issues which emerge from the licensing process. Revisions must be approved by the Secretary of State and laid before Parliament in accordance with section 26 of the Human Fertilisation and Embryology Act 1990.

The HFEA have recently published the fourth edition of the UK Code of Practice. The Code incorporates policy decisions made by the HFEA since December 1995. The object of the Code is “wider than to secure the safety and efficacy of particular clinical and scientific practices. It is concerned with areas of practice which raise fundamental ethical and social questions”.

The Select Committee was impressed by the UK Code of Practice. However, the Select Committee noted that revisions to both the South Australian and UK Codes were required to be laid before Parliament.

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388 ibid: 5.
The Select Committee supported the development of a Code of Practice, similar to the current Directions, that is flexible and readily amended if necessary. The Select Committee agreed that the Reproductive Technology Council should, by way of Directions, establish a Code of Practice which will deal with matters of ethics, rules, procedures and guidelines. Members did not wish the Code of Practice to be laid before Parliament but it should be gazetted. The Select Committee acknowledged that Parliament would be able to exert its will through legislation and Regulations which will continue to be laid before Parliament (Figure 1).

**Recommendation 10b**

That the Reproductive Technology Council, by way of Directions, establish a Code of Practice that will deal with matters of ethics, rules, procedures and guidelines.

That there be no requirement for the Code of Practice to be laid before Parliament but that it be gazetted.

That Regulations continue to be laid before Parliament.

The Select Committee acknowledged that the recommendations made will necessitate the reworking of the HRT Act, particularly Part 3. For example, the Select Committee noted that section 15(1)(a) should be amended so that Rules are no longer subsidiary legislation. However, the Select Committee believed that the changes are necessary to achieve the desired simplification of the HRT Act.


10.3 DIRECTIONS

Under section 5(5) of the HRT Act, Directions given by the Commissioner of Health shall have effect, except to the extent of any inconsistency with the regulations or the Code, in accordance with section 31. Under section 31, the Commissioner of Health may give Directions, or Directions varying or revoking other Directions.

In framing the Directions, the following requirements of the HRT Act were taken into account\footnote{389} -

- the respect which should be given to human life at all stages of its development;
- the help and encouragement that should be given to couples who are unable to conceive children naturally or whose children may be affected by a genetic disease;
- the welfare of any children who may be born as a result of treatment; and
- the recognition that the responsible pursuit of medicine and science may lead to benefits for individuals and for society.

These requirements are almost identical with those used by the HFEA to frame the UK Code of Practice.\footnote{390} According to the RTC, Directions given by the Commissioner of Health should be retained as the primary mode for setting standards of practice in the future.\footnote{391}

Use of Directions is the speediest and most flexible and direct way to regulate behaviour under the HRT Act. However, the regulatory structure of the HRT Act results in Directions being one of the least powerful tools.

Where a regulation or Rule of the Code of Practice applies, or any direction is inconsistent with any other provision of the Code which has been specifically applied, the regulation, Rule or other provision of the Code prevails.\footnote{392}

Ms Leigh Newman was of the view that the HRT Act should provide for all substantive matters in relation to reproductive technology practice and the Directions should be the mechanism for implementation of the procedures and practices the HRT Act allows, such as storage and posthumous use of gametes.\footnote{393}

10.3.1 Contravention of directions

Under section 34 of the HRT Act, a contravention of a condition or a direction “shall not be taken as an offence, unless the regulations specifically otherwise provide but any such contravention may


\footnote{390} HFEA. Code of Practice. 1998: 5.

\footnote{391} Submission 27 - RTC.

\footnote{392} Commissioner of Health. Briefing notes to the Select Committee, 14 July 1997.

\footnote{393} Ms Leigh Newman. Personal communication to the Select Committee.
constitute grounds for disciplinary action and may be taken into account when considering any application”.

10.4 GUIDELINES

Section 15(1)(b) of the HRT Act provides for Guidelines to be formulated as part of the Code of Practice. Draft Guidelines were published in April 1993. They were intended to assist licensees in following the Directions given by the Commissioner of Health, and to explain some aspects of the HRT Act. However, as there is no Code, it appears that the existing draft Guidelines have no status under the HRT Act.

The Commissioner of Health suggested three options for the appropriate mechanism for incorporation of guidelines into the HRT Act. These include -

- retaining the current mechanism of a Code of Practice;
- empowering the Commissioner of Health or delegate to incorporate guidelines, standards, either promulgated by him, or by reference, directly into the Act; or
- empowering the Commissioner of Health or delegate to issue directions requiring compliance with specified guidelines or standards, promulgated by the Commissioner of Health or by reference.

Ms Leigh Newman suggested that the “guidelines to the Directions be retained. These explain and set out how to comply with the Directions”. The Select Committee felt that Guidelines were a valuable tool to assist licensees. Members believed that the Commissioner of Health should have the ability to make them as required and that they should be included within the Code of Practice. The Commissioner of Health may delegate this power to the RTC with the permission of the Minister for Health.

Recommendation 10c

That guidelines form part of the Code of Practice.

That the Commissioner of Health have the ability to make guidelines as required.

That the Commissioner of Health delegate the power to make guidelines to the Reproductive Technology Council with the permission of the Minister for Health.

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395 Submission 36 - Commissioner of Health.

396 Submission 86 - Ms Leigh Newman.
10.5 SELF-REGULATION

Mrs Stephanie Knox, President of the Genesis Infertility Group, felt that the reproductive technology industry should be allowed to develop its own code of practice and become self-regulating. 397

During the Select Committee’s visit to New South Wales, Members heard from Professor Douglas Saunders, Head of Obstetrics and Gynaecology, University of Sydney, that self-regulation was working in a state that has no reproductive technology legislation. 398

Professor Con Michael told the Select Committee that “people who run the clinics ... were given adequate opportunity before the Act was passed for self-regulation, but that never worked. Hence legislation was imposed upon them at community request”. 399

The Select Committee heard that the RTAC’s self-regulation only addresses technical procedures and that legislation and directions are necessary to cover ethical and social issues.

According to the NHMRC400 -

The practice of ART involves social issues ... which are beyond the remit of AHEC in relation to medical research. In revising the (ethical) guidelines AHEC resolved that these social issues should be addressed by complementary ART legislation in all States and Territories.

The Select Committee believes that public concern in the area of reproductive technology is sufficient to require the continuation of legislation. However, the Select Committee has attempted to simplify the legislation process and has allowed the RTC to continue to oversee the HRT Act. The Select Committee has tried to introduce flexibility while recognising that the area is still fraught with moral and ethical issues. Members believe that total self-regulation is not an option and that both the HRT Act and the RTC are necessary to regulate assisted reproductive technology in WA, especially for areas of reproductive technology not covered by RTAC and the NHMRC’s ethical guidelines.

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397 Submission 17 - Mrs Stephanie Knox.
399 Professor Con Michael. Evidence to the Select Committee, 9 March 1998.
400 NHMRC. 1996: v.
CHAPTER TEN - RECOMMENDATIONS

Recommendation 10a

That the *Human Reproductive Technology Act 1991* be rewritten in a clear and concise manner to reflect the recommendations of the Select Committee.

Recommendation 10b

That the Reproductive Technology Council, by way of Directions, establish a Code of Practice that will deal with matters of ethics, rules, procedures and guidelines.

That there be no requirement for the Code of Practice to be laid before Parliament but that it be gazetted.

That Regulations continue to be laid before Parliament.

Recommendation 10c

That guidelines form part of the Code of Practice.

That the Commissioner of Health have the ability to make guidelines as required.

That the Commissioner of Health delegate the power to make guidelines to the Reproductive Technology Council with the permission of the Minister for Health.
CHAPTER ELEVEN

ENFORCEMENT AND DISCIPLINARY PROVISIONS,
OFFENCES AND PENALTIES

11.1 INTRODUCTION

The effectiveness of powers of enforcement and disciplinary provisions under the HRT Act, and the adequacy of offences and penalties were examined by the Select Committee.

11.2 OFFENCES

11.2.1 Human Reproductive Technology Act 1991

Specific offences are created under Part 1 of the HRT Act. Section 6 states that -

(1) no person shall cause or permit -

(a) any procedure to be carried out related to the storage of -

(i) an egg intended for use in an in vitro fertilisation procedure;
(ii) an egg in the process of fertilisation; or
(iii) an embryo;

(b) sperm, having been obtained from different men, to be kept; or

(c) an artificial fertilisation procedure, other than an artificial insemination to which section 28(3) applies, to be carried out,

except pursuant to a licence or exemption by which it is authorized under this Act.

The RTC stated that the offences in section 6 that enforce the system of licensing appear to be appropriate and are fundamental to the operation of the HRT Act. In addition, the RTC suggested that the offences in section 7(5) (below) should be incorporated into section 6 for greater prominence and consistency. “This is where an offence for storing embryos beyond expiry of the permitted storage time comes from, for example, whereas from s24 it is not entirely clear that this would be an offence”.

Section 7(5) states that -

a person who -

(a) being a licensee, keeps or uses any gametes, or any egg in the process of fertilisation or embryo in contravention of this Act; or

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401 Submission 27 - RTC.
402 ibid.
Section 7 of the HRT Act covers “offences relating to reproductive technology”. The Commissioner of Health drew the Select Committee’s attention to all offences under section 7(1), in particular parts 1(a) and (b) read with section 14(2)(a). The RTC felt that section 7(1)(a) and (b) should be retained but references to “the egg in the process of fertilisation” removed and section 14(2) carefully reconsidered.\textsuperscript{403}

Section 7(1) states that -

- a person, whether or not a licensee, who causes or permits -
  - research to be conducted upon or with an egg in the process of fertilisation, or any embryo, not being research in respect of which the Council has already granted relevant approval or all requisite specific prior approvals have been sought and obtained under section 20.
  - a diagnostic procedure to be carried out upon or with an egg in the process of fertilisation, or any embryo, not being a procedure which is -
    - authorised by the Code; or
    - specifically approved by the Council;

commits an offence.

The RTC also said it would be helpful to make clear that the ban only applies to live gametes and embryos (section 3(3)).\textsuperscript{404} In addition, the power of the RTC to define embryonic death may need clarification in the HRT Act.

The Commissioner of Health felt that section 7(1)(d), (e) and (f) of the HRT Act, should be considered in light of rapid developments in the technology and their implications.\textsuperscript{405} The RTC was concerned that

\textsuperscript{403} \textit{ibid.}
\textsuperscript{404} \textit{ibid.}
\textsuperscript{405} Submission 36 - Commissioner of Health.
“procedures that may be regarded to be ethically sound (e.g. PGD [pre-implantation genetic diagnosis]) may inadvertently be ruled out by careless definitions and clauses”. Section 7(1)(d), (e), and (f) refer to any procedure to be carried out directed at -

(d) human cloning;

(e) a nucleus of a cell of an egg in the process of fertilisation or any embryo to be replaced;

(f) the genetic structure of any cell to be altered while the cell forms part of an egg in the process of fertilisation or any embryo.

According to the RTC

terms must be clearly defined ... to allow separate consideration of distinct ethical differences between artificial twinning by embryo splitting; nuclear transfer without cloning, (e.g. to avoid transmission of a mitochondrial disease); cloning an embryo, e.g. to produce a cell line or to carry out PGD (which may be a form of cloning); and cloning with an adult cell with the intention of copying a person.

None of these offences rules out transfer of the nucleus of an unfertilised oocyte to produce a human cellular clone, providing this is not experimental and providing there is no intention to produce a live born child. The required prohibition of this procedure under the Act, however, should also be carefully considered, in the light of increasing evidence of beneficial medical applications that may come from cloning technology.

The Select Committee noted that the submission from the RTC refers to beneficial medical applications that may come from cloning technology and that such research be closely monitored and regulated. The Select Committee was also aware of the recent position statement on human cloning from the Australian Academy of Science which considered that “reproductive cloning to produce human fetuses is unethical and unsafe and should be prohibited” but which also recommended that “it is important that research on human therapeutic cloning is not inhibited by withholding federal research funds or prevented by unduly restrictive legislation in some States”.  

The Select Committee was of the opinion that the ban on reproductive human cloning as defined by the HRT Act (section 3) should remain but that therapeutic research in the area associated with technology to develop tissues and organs for transplantation should be permitted. Members also wished to ensure that diagnostic procedures such as PGD should not be prevented.
Recommendation 11b

That reproductive human cloning, as defined by the Human Reproductive Technology Act 1991, remain as a prohibited practice.

That such prohibition not extend to research associated with beneficial medical application that may result from therapeutic cloning technology such as the development of tissues and organs for transplantation.

That such research be closely monitored and regulated by the Reproductive Technology Council.

The RTC indicated that offences under section 7(1)(d)(ii) “embryo flushing” and section 7(1)(d)(iii) “chimaera production” refer to procedures which may already be associated with medical applications and these applications should be considered by experts before continuing the WA bans. However, the Select Committee was aware that embryo flushing is currently banned in WA, South Australia and Victoria and by the NHMRC’s ethical guidelines.

The Select Committee received submissions that addressed offences. One submission indicated that section 7(1) should be retained in its entirety. The RTC requested that section 7(1)(c), (g), (h), and (j) should be retained. Another submission suggested that current offences were appropriate but that they needed some attention. Specifically the submission requested that “the pros and cons from cloning technology and genetic testing of embryos etc; are considered carefully” and that “policy decisions are made about each separate aspect of these complex areas of technology”. Ms Kath Smith indicated that cloning, genetic engineering, surrogacy and other procedures that are “morally or medically illegal should continue to be disallowed”.

The Select Committee noted the opinions received with regard to offences under the HRT Act. Members believed that the current bans under the HRT Act should remain.

11.2.2 Australian Jurisdictions

Victoria

Part 5 of the Infertility Treatment Act 1995 addresses offences - prohibited procedures, storage and general offences including import and export of reproductive material, compensation for gamete donation or providing false or misleading information. Penalties are provided with each offence.

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408 Submission 27 - RTC.
409 NHMRC. 1996: 15.
410 Submission 40 - Institutional Ethics Committee, St John of God Hospital.
411 Submission 27 - RTC.
412 Submission 19 - Confidential.
413 Submission 25 - Ms Kath Smith, Association of Relinquishing Mothers.
According to the NSW Review, the definition of cloning in the Victorian legislation should not prevent certain research into DNA cloning which may “play a diagnostic role in the early detection of genetic defects”.  

South Australia

The Reproductive Technology (Code of Ethical Clinical Practice) Regulations 1995 (which came into operation in accordance with section 20(4) of the Reproductive Technology Act 1988) address prohibited practices.

11.2.3 International perspective

United Kingdom

Sections 3 and 4 of the Human Fertilisation and Embryology Act 1990, contain prohibitions in connection with both embryos and gametes. Offences are addressed under section 41.

Council of Europe

In January 1998, representatives from 19 members of the Council of Europe signed a ban on human cloning as part of the European Convention on Human Rights and Biomedicine. The protocol still allows the cloning of cells for research purposes. The UK declined to sign because it felt the ban was too restrictive.

11.3 PENALTIES

11.3.1 Human Reproductive Technology Act 1991

Under the HRT Act, penalties are outlined in sections 6 and 7.

Under section 7(3), a body corporate that commits an offence against section 7(1) is liable to a fine not exceeding $50,000, while under section 7(4), a person other than a body corporate is liable to a fine not exceeding $25,000 or to imprisonment for five years or both.

If a licensee keeps or uses gametes, eggs in the process of fertilisation or embryos in contravention of the HRT Act or if the person to whom a licence applies or applied, fails to comply with a direction given for the purpose of section 30(4)(a) -

where a license has been varied or has ceased to have effect, or is to be varied or cease to have effect, directions may be given for the purpose of securing the continued discharge of the functions of the person responsible under that licence and, in particular, may -

(a) require any gametes, egg in the process of fertilisation, embryo or other thing kept or record held under that licence, or information available to a person to whom


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that licence applied, to be transferred to the licensing authority or any other person.

they commit an offence with a $10,000 fine or two years imprisonment.

Under section 40, the Commissioner of Health may “in relation to any disciplinary action in respect of which a determination has been made under this Act” impose one or more of a range of penalties from a reprimand through to disqualification of a licensee from holding a license or exemption and the payment of monetary penalties.

11.4 DISCIPLINE

11.4.1 Human Reproductive Technology Act 1991

Under section 14(3) -

where a person contravenes -

(a) any provision of, or requirement under, this Act, not being a direction; or

(b) any direction given by the Commissioner, being a direction which is consistent with the Code or is not inconsistent with -

(i) ethical guidelines laid down by the National Health and Medical Research Council, as for the time being prescribed;

(ii) criteria established by the Reproductive Technology Accreditation Committee for the Fertility Society of Australia, as for the time being prescribed; or

(iii) a provision of, or any principal set out in, or requirement under, this Act, as from time to time amended,

the Council shall endeavour to ensure, if necessary by disciplinary action under section 38, that effect is given to that provision, requirement or direction.

Disciplinary proceedings, including suspension or cancellation of licenses, are undertaken by the Commissioner of Health and/or the RTC pursuant to Division 3 of Part 4 of the Act. Section 38 addresses disciplinary action and section 39 outlines matters that may be the subject of disciplinary action.

Under section 34 of the HRT Act -

a contravention of a condition or a direction applicable to a licence or exemption ... shall not be taken as an offence, unless the regulations specifically otherwise provide, but any such contravention may constitute grounds for disciplinary action and may be taken into account when considering any application.
The Country Women’s Association was of the view that medical practitioners who contravene the HRT Act should lose their license for life.\textsuperscript{416} The Select Committee did not agree with this point of view. However, Members recognised that the ultimate sanction for clinics and practitioners would be the withdrawal of licences and the withdrawal of access to free drugs through removal of RTAC endorsement.

\subsection{Disciplinary proceedings in Western Australia}

Up to 14 July 1997, only two clinics had been reprimanded by the Commissioner of Health, following disciplinary proceedings initiated under the HRT Act. Although no prosecutions for offences were laid by the Commissioner, two other situations resulted in extensive Crown Law investigations.\textsuperscript{417}

During the period 1 July 1997 - 30 June 1998, the Commissioner of Health issued a summary determination to two different clinics in accordance with section 38 of the HRT Act. Neither summary determination was contested. However, no penalty was imposed on either clinic, as in each case the clinic concerned had attempted to rectify the breaches.\textsuperscript{418}

During the current financial year, up to 12 April 1999, the RTC has investigated two events at different clinics, although a summary determination was not made in each case.\textsuperscript{419} In one case, the RTC was satisfied that the clinic had already taken steps to preclude a further breach. However, the Commissioner of Health, as advised by the RTC, issued a warning to the clinic that a further similar breach may attract discipline. At the second clinic, the RTC accepted the clinic’s explanation for a study it had carried out and reported, and requested that the clinic update its protocol manual to include routine treatment options.

\subsection{ENFORCEMENT}

Enforcement is covered by Part 5 of the HRT Act. Division 1, sections 54 and 55 address the “powers of authorized officers” and “entry, search and seizure, by warrant”. Section 44(6)(c) states that “a person who, being a person to whom the relevant licence applies or applied, fails to make such a record available for inspection by an authorized officer, commits an offence”.

According to the RTC “powers for an authorised officer under section 54 and section 44(6) should be retained, in order to carry out investigations of contraventions or to validate information reported to the Registers”.\textsuperscript{420} The RTC added that “at all times this must be handled with sensitivity to confidentiality and patient interests”. The Select Committee concurred with the view of the RTC.

\subsection{LEGAL ADVICE}

\begin{itemize}
\item \textsuperscript{416} Submission 21 - Mrs Rosa Tognela.
\item \textsuperscript{417} Commissioner of Health. Briefing notes to the Select Committee, 14 July 1997.
\item \textsuperscript{418} RTC. Annual Report, 1 July 1997 - 30 June 1998: 12.
\item \textsuperscript{419} Dr Sandra Webb. Correspondence to the Select Committee. 12 April 1999.
\item \textsuperscript{420} Submission 27 - RTC.
\end{itemize}
The RTC discussed the value of legal advice and was of the view that dedicated legal advice within the Health Department of WA should be retained to assist with ongoing implementation of the HRT Act.\textsuperscript{421} The Select Committee considered that the legal advice should be retained.

\textsuperscript{421} ibid.
CHAPTER ELEVEN - RECOMMENDATIONS

**Recommendation 11a**

That section 7(5) of the *Human Reproductive Technology Act 1991* (HRT Act) be incorporated into section 6 of the HRT Act.

**Recommendation 11b**

That reproductive human cloning, as defined by the *Human Reproductive Technology Act 1991*, remain as a prohibited practice.

That such prohibition not extend to research associated with beneficial medical application that may result from therapeutic cloning technology such as the development of tissues and organs for transplantation.

That such research be closely monitored and regulated by the Reproductive Technology Council.
CHAPTER TWELVE

LEGISLATION

12.1 INTRODUCTION

The Select Committee examined the impact on the Human Reproductive Technology Act 1991 (HRT Act) of relevant Commonwealth and State legislation, and aspects of legislation of other jurisdictions which could be incorporated into the HRT Act.

12.1.1 Human Reproductive Technology Act 1991

The RTC was of the view that the provisions of section 4(c) and section 49(2)(e) of the HRT Act that allow for communication of information under authorisation of another written law should be retained, because Council can envisage legislation either federally or in other states that seeks to make information available to a national data base that would enable good follow-up of treatments and their outcomes or to provide access to information by donor offspring about their origins.

12.1.2 Regulation of reproductive technology in Australia

The NHMRC’s report on “Long-term effects on women from assisted conception” clearly differentiates between legislation, regulation and guidelines. It states that -

legislation commands compliance by its ability to impose sanctions. State and Territory Governments have constitutional power over clinical medicine and biomedical research. There are significant philosophical concerns about the appropriateness of legislation in an area, since it may prove cumbersome and inflexible. A comprehensive legislative approach would require time consuming and extensive consultation between Commonwealth, States and Territories. Amendments are difficult as these also require the legislative process, further inhibiting flexibility.

12.1.3 Review of legislation

The Select Committee was told that there needs to be a review of current State, interstate and Commonwealth legislation. The department for Family and Children’s Services felt that -

appropriate changes be made to all relevant state legislation, regulations and codes of practice governing reproductive technology, donor programs and other interventions (including surrogacy) in order to reflect the child’s best interests, as identified by schedule 1 of the Adoption Act.

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422 Submission 27 - RTC.
424 Submission 36 - Commissioner of Health.
425 Submission 69 - Family and Children’s Services.
12.2 STATE LEGISLATION

12.2.1 Western Australia

Artificial Conception Act 1985

The Artificial Conception Act 1985 relates to the status of persons conceived by artificial means and for related purposes. It outlines the rules relating to maternity (section 5) where a married woman undergoes a fertility procedure (with her husband’s consent), using a donor egg and becomes pregnant “for the purposes of the law of the State, the married woman is the mother of any child born as a result of the pregnancy”. The rules relating to paternity (section 6) state that -

where a married woman undergoes, with the consent of her husband, a fertilization procedure in consequence of which she becomes pregnant, then for the purposes of the law of the State, the husband -

(a) shall be conclusively presumed to have caused the pregnancy; and
(b) is the father of any child born as a result of the pregnancy.

In every case in which it is necessary to determine for the purposes of this section whether a husband consented to his wife undergoing a fertilization procedure, that consent shall be presumed, but the presumption is rebuttable.

Section 7 of the Act addresses donation of genetic material.

7(1) Where -

(a) a woman becomes pregnant in consequence of a fertilization procedure; and
(b) the ovum used for the purposes of the procedure was taken from some other woman,

then, in a case to which section 5 applies, for the purposes of the law of the State, the woman from whom the ovum was taken is not the mother of any child born as a result of the pregnancy.

(2) Where -

(a) a woman becomes pregnant in consequence of a fertilization procedure; and
(b) a man (not being the woman’s husband) produced sperm used for the purposes of the procedure,

then in a case to which section 6 applies, for the purposes of the law of the State, the man referred to in paragraph (b) -

(c) shall be conclusively presumed not to have caused the pregnancy; and
(d) is not the father of any child born as a result of the pregnancy.

The Select Committee was informed that in Western Australia, it is currently unclear whether gamete donors are exempted from the child support and maintenance provisions of the Family Law Act 1975 where donated gametes are used by women undergoing an artificial fertilisation procedure without the
consent of their husband. The uncertainty rises because of the limited scope of the Artificial Conception Act 1985.426

The Select Committee was told that there is an urgent need to amend the Artificial Conception Act 1985 to “clarify the legal rights and responsibilities of all parties to assisted conception procedures where the woman does not have the consent of a husband”.427 The Select Committee acknowledged the need to amend the Artificial Conception Act 1985 and wished to ensure that the amendment would also cover gamete donors in situations where single women or same sex couples have undergone artificial conception procedures (DI). In New Zealand, the Status of Children Amendment Act (1987) established that gamete providers did not have rights or responsibilities with regard to offspring.

Despite being apprised of the uncertainty surrounding gamete donors’ rights and responsibilities, the Select Committee felt that the Family Law Act 1975 and the Child Support (Assessment) Act 1989 (pages 161 and 162) appeared to deal with the uncertainty. However, Members did feel that uncertainty, with regard to the status of the child, may remain.

**Recommendation 12a**

That gamete donors have no legal responsibilities for offspring and that any conflicting legislation, such as the Artificial Conception Act 1985 be amended accordingly.

**Administration Act 1903**

Under section 12a of the Administration Act 1903 “entitlement to participation in distribution of intestate estates”, paragraph (b) of subsection (2) does not apply to or in respect of a relationship established by the Artificial Conception Act 1985 -

where the father and mother are not, or have not been married to each other, the relationship between a child and his father, and all other lineal or collateral relationships, shall be recognized only -

(a) if paternity is admitted by or established against the father in his lifetime; and

(b) where the purpose for which the relationship is to be determined enures for the benefit of the father, if paternity has been so admitted or established in the lifetime of the child.

**Freedom of Information Act**

There is currently no conflict with regard to the Freedom of Information Act (FOI Act). Children born as a result of donor programs have the right to clinical and medical information about genetic parentage. However, donors must also be assured of confidentiality. The FOI Act specifically rules out access under the HRT Act to any identifying information held on the Registers.428 The RTC was

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426 Correspondence from Ms Carol Whish-Wilson to the Australian Law Reform Commission, 22 January 1998.

427 Submission 27 - RTC.

of the view that any review of the FOI Act should be carried out in consultation with “persons such as the Reproductive Technology Council”.429

The Select Committee was told that “legislation should impose a duty of confidentiality upon ART service providers and donors of gametes except where such confidentiality would be of detriment to the best interests of a person who had been created by ART and was seeking information”.430

In Chapter Fifteen, the Select Committee recommends that offspring should have access to donor information. Therefore, if the recommendation in Chapter Fifteen (Recommendation 15a) is accepted, the FOI Act will have to be amended to ensure that there is no inconsistency.

Recommendation 12b

That consequentially upon amendment to the Human Reproductive Technology Act 1991 to allow access to donor identifying information, the Freedom of Information Act be amended to remove inconsistency.

Equal Opportunity Act 1984

Section 9 of the Equal Opportunity Act 1984 addresses discrimination on the ground of marital status.

A person ... discriminates against another person ... on the ground of the marital status of the aggrieved person if, on the ground of the marital status of the aggrieved person the discriminator treats the aggrieved person less favourably than, in circumstances that are the same or are not materially different, the discriminator treats or would treat a person of a different marital status.

The impact of the Equal Opportunity Act 1984 was addressed previously in Chapter Five (page 51).

Human Tissue and Transplant Act 1982

The Human Tissue and Transplant Act 1982 does not have any direct impact upon the HRT Act but there is an indirect relationship with regard to Part V “prohibition on trading in tissue”.

Only section 6 of the Human Tissue and Transplant Act 1982 states that in Part II, “reference to tissue shall not be read as including a reference to foetal tissue, spermatozoa or ova”.

12.2.2 Victoria

The Victorian Infertility Treatment Act 1995 places the interests of children as paramount. Offspring conceived after the Act became law will have the right of access to identifying information on donors. All donors were given the option of renewing their consent after 1 January 1998. This gave them the chance to agree to identifying information about themselves being released to any offspring after the offspring reach 18 years of age.

429 Submission 27 - RTC.

430 Submission 65 - Mrs Christine Whipp.
12.2.3 Australian Capital Territory

Currently, there is no general reproductive technology legislation in the ACT. However, the Select Committee was told that the ACT may be considering the introduction of legislation.\(^{431}\)

**Artificial Conception Amendment Bill**

The *Artificial Conception Amendment Bill* was introduced into the ACT Parliament in December 1997. The intention of the Bill was to allow the commissioning parents in a surrogacy arrangement to be regarded as the child’s real parents even if only one of the commissioning parents is a genetic parent. The birth mother could not be a genetic parent. The Bill was not passed.

12.2.4 New South Wales

**Status of Children Act 1996**

The *Artificial Conception Act 1984* has been repealed and replaced by the *Status of Children Act 1996*. Under the new Act, a husband must consent to his wife’s ART treatment with donor sperm in order for him to be presumed to be the father of the child.\(^{432}\) The NSW review suggested that obtaining the husband’s consent was a good practice and should be documented.\(^{433}\) Other presumptions under the Act are -

- when a married woman has undergone a fertilisation procedure as a result of which she has become pregnant, she is presumed to be the mother of any child born as a result of the pregnancy even if she did not provide the ovum used in the procedure;
- If a woman (whether married or unmarried) becomes pregnant by means of a fertilisation procedure using any sperm obtained from a man who is not her husband, that man is presumed not to be the father of any child born as a result of the pregnancy;
- If a woman (whether married or unmarried) becomes pregnant by means of a fertilisation procedure using an ovum obtained from another woman, that other woman is presumed not to be the mother of any child born as a result of the pregnancy.

**Human Tissue Act 1993**

The Act is being reviewed at the present time.

12.2.5 South Australia

**Reproductive Technology Act 1988**

The SA legislation differs from the HRT Act in a number of ways -

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\(^{431}\) Dr Sandra Webb. Personal communication to the Select Committee.


\(^{433}\) *ibid.*
• It has a Code of Practice (that is implemented by regulations).
• Unlike WA and Victoria, the South Australian Act does not define “embryo”.
• The SA Code of Practice sets a time limit for storage of embryos of 10 years.

12.2.6 Queensland

In 1983, a committee under the chairmanship of Mr Justice Demack enquired into the laws relating to artificial insemination, IVF and other related matters. As a result some changes to existing legislation occurred but no comprehensive reproductive technology legislation was established.

12.2.7 Tasmania

There is no comprehensive reproductive technology legislation in Tasmania but the State does have surrogacy legislation which is discussed in Chapter Eighteen.

12.3 COMMONWEALTH LEGISLATION

12.3.1 Sex Discrimination Act 1984

The Sex Discrimination Act 1984 (SDA) has been discussed previously in Chapter Five with regard to eligibility for treatment.

There have been a number of cases in different states where State legislation restricting access to married couples or couples living in a de facto relationship, has been challenged.

The Joint Standing Committee on Treaties was concerned that -

the existence of Commonwealth legislation that is in conflict with the Victorian Infertility Treatment (Medical Procedures Act 1984), the South Australian Reproductive Technology Act 1988 and the Western Australian Human Reproductive Technology Act 1991 may deter other States and the Territories from introducing legislation that will protect children and ensure that those using this technology will consider the best interests of the child.

The RTC felt that a review of the relationship between the HRT Act and anti-discrimination laws at both State and Federal level is urgently required. Further discussion of this issue can be found in Chapter Five.

12.3.2 Family Law Act 1975

434 Report of the Special Committee Appointed by the Queensland Government to Enquire into the Laws relating to Artificial Insemination, In Vitro Fertilisation and Other Related Matters, (chaired by Mr Justice Alan Demark), Brisbane, 1984.

435 Pearce v South Australian Health Commission & Ors; and MW & Ors v Royal Women’s Hospital & Ors.


437 Submission 27 - RTC.
Section 60H of the *Family Law Act 1975* addresses children born as a result of artificial conception procedures.

(1) If -
(a) a child is born to a woman as a result of the carrying out of an artificial conception procedure while the woman was married to a man; and
(b) either of the following paragraphs apply-

(i) the procedure was carried out with their consent;
(ii) under a prescribed law of the Commonwealth or of a State or Territory, the child is a child of the woman and of the man;

then, whether or not the child is biologically a child of the woman and of the man, the child is their child for the purposes of this Act.

(2) If -
(a) a child is born to a woman as a result of the carrying out of an artificial conception procedure; and
(b) under a prescribed law of the Commonwealth or of a State or Territory, the child is a child of the woman;

then, whether or not the child is biologically a child of the woman, the child is her child for the purposes of this Act.

(3) If -
(a) a child is born to a woman as a result of the carrying out of an artificial conception procedure; and
(b) under a prescribed law of the Commonwealth or of a State or Territory, the child is a child of a man;

then, whether or not the child is biologically a child of the man, the child is his child for the purposes of this Act.

Under subsection 5, the Act states that for the purposes of subsection (1), a person is to be presumed to have consented to an artificial conception procedure being carried out unless it is proved, on the balance of probabilities, that the person did not consent.

According to the RTC\(^\text{438}\) -

there are still uncertainties relating to Part VII of the *Family Law Act* which contains extensive additional provisions about children including the making of parenting and child maintenance orders and there has as yet been no determination by a Court as to whether these provisions could refer to a donor of sperm.

### 12.3.3 Child Support (Assessment) Act 1989

Under section 26 of the *Child Support (Assessment) Act 1989* -

application may be made to the Registrar for administrative assessment of child support for a child only if the application seeks payment of the child support from a person who is -

(a) a parent of the child; and

(b) a resident of Australia on the day on which the application is made.

Under section 5, “parent” means “when used in relation to a child born because of the carrying out of an artificial conception procedure - a person who is a parent of the child under section 60H of the *Family Law Act 1975*”.

It has been settled by the Family Court of Australia that^439^ -

the donor of sperm will not be subject to the requirements of the Child Support (Assessment) Act unless the donor is married to, or becomes married to, or is in, or enters into, a genuine domestic relationship with the woman who subsequently gives birth to the child.

### 12.4 OVERSEAS LEGISLATION

#### 12.4.1 United Kingdom

In the UK, a woman’s husband will be the legal father of a child born as a result of treatment using donated sperm, unless they are judicially separated or he can prove that he did not consent to the treatment.^440^ If a woman is treated with a male partner using donated sperm and she is unmarried, or judicially separated or her husband does not consent to the treatment, her male partner will be the legal father of any resulting child. Under the *Children Act 1989*, when a child is born to an unmarried couple the male partner may not have parental responsibility for the child.

#### 12.5 UNIFORM LEGISLATION

In March 1988, the Australian Health Ministers’ Advisory Council (AHMAC) agreed to establish the National Bioethics Consultative Committee (NBCC). The NBCC was charged with advising the Ministers on the social, ethical and legal issues arising from a number of areas, particularly reproductive technology. The NBCC submitted reports on record keeping and access to information; birth certificates and birth records, reproductive technology counselling, access to reproductive technology programs; and surrogacy to the Health Ministers. As yet no uniform legislation or regulations has resulted in Australia.

Ms Leigh Newman informed the Select Committee that^441^ -

a uniform National legislation would be favourable to promote and ensure -

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^439^ *ibid*: 17.


^441^ Submission 86 - Ms Leigh Newman.
• ability to apply national standards, e.g. Uniform administration and standards;
• would allow for mutual benefits from sharing of differing rates of progress in methods and techniques developed;
• would enable uniform eligibility criteria in line with Commonwealth and State legislation;
• access to information contained on IVF and Donor registers;
• uniform treatment of posthumous use of gametes and embryos; storage issues; import, export and use issues; donation; research and experimentation.

The uniform treatment and application of these matters would promote consistency and would prevent the situation which is occurring now of “shopping around” in jurisdictions by both researchers and participants.

Other submissions called for uniform legislation nationwide. The Select Committee agreed with the concept of consistency across States and recommended that consistent uniform, national legislation be developed as a matter of priority.

**Recommendation 12c**

That consistent uniform and/or national legislation on human reproductive technology be developed as a matter of priority and that the Standing Committee on Uniform Legislation and Intergovernmental Agreements be requested to address it.

### 12.6 LACK OF LEGISLATION

The issue of self-regulation was discussed previously in Chapter Ten (see page 142).

Dr Jennifer Kurinczuk pointed out some of the problems that can arise when there is no legislation in place. She focussed on the problems faced in the USA where the practice of ART is subject only to minimal standards and guidelines from the American Society for Reproductive Medicine (ASRM) and the Society for Assisted Reproductive Technologies (SART). These include -

• unacceptable variations in quality of service, care and results between clinics;
• highest patient charges in the world;
• problems with advertising claims;
• excessive and unacceptably high levels of multiple pregnancies, due to replacement of large number of embryos;
• associated common use of selective fetal reduction;

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442 Submission 21 - Mrs Rosa Tognela.

443 Submission 30 - Dr Jennifer Kurinczuk.
• high levels of use of high-risk obstetric care and neonatal intensive care as a result of multiple births;
• social and personal costs associated with multiple birth families.

Mr Eric Blyth said that “codification of procedures through legislation and regulation is ultimately a necessary measure that any responsible state should take to ensure the well-being of its citizens and for the community as a whole”.

The Select Committee has previously stated that legislation to regulate ART should continue and that self-regulation is not appropriate at this stage.
CHAPTER TWELVE - RECOMMENDATIONS

Recommendation 12a

That gamete donors have no legal responsibilities for offspring and that any conflicting legislation, such as the Artificial Conception Act 1985, be amended accordingly.

Recommendation 12b

That consequentially upon amendment to the Human Reproductive Technology Act 1991 to allow access to donor identifying information, the Freedom of Information Act be amended to remove inconsistency.

Recommendation 12c

That consistent uniform and/or national legislation on human reproductive technology be developed as a matter of priority and that the Standing Committee on Uniform Legislation and Intergovernmental Agreements be requested to address it.
CHAPTER THIRTEEN

LICENSING

13.1 INTRODUCTION

The Select Committee had to assess the effectiveness of the current licensing regime, including fee structure, reporting requirements, powers of inspection and powers of obtaining information.

13.1.1 Human Reproductive Technology Act 1991

Part 4 of the HRT Act provides specifically for licensing and the standards of practice, personnel and premises required for either a practice licence or a storage licence are outlined in section 1 of the Directions. The regulations prescribe some forms for applications and fees.

Under section 29, an application for a licence or an exemption must be made to the Commissioner of Health who, in turn, seeks the advice of the RTC as to the suitability of the applicant. The RTC makes a recommendation to the Commissioner of Health based upon RTAC and NATA accreditation and on other investigations it requires. Subsequently, the Commissioner of Health may grant the following -

- a storage licence;
- a practice licence;
- both a storage and a practice licence; or
- an exemption under section 28 [exemptions relating to artificial insemination].

Storage licences

A storage licence authorises the licensee to carry out any procedure related to the storage of sperm (having been obtained from different men), eggs intended for use in IVF, eggs in the process of fertilisation and embryos, and any research project related to storage and approved under section 20.

Practice licences

A practice licence may authorize the licensee to carry out any artificial fertilisation procedure and any project of research approved under section 20.

Period of the licence

Under the Draft Guidelines, review of licensee compliance will normally be carried out at six months, followed by further review at two and three and a half years.\(^{445}\)

The licence continues in force, unless it is suspended or cancelled, for five years or a shorter specified period. Under Direction 1.6, a licensee must apply for renewal of a licence no later than three months before its expiry.

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The Select Committee felt that unless there was cogent reason for removal of a licence, renewal should be automatic subject to payment of application fees.

**Recommendation 13a**

That licence renewal be automatic subject to payment of application fees, unless, in the opinion of the Reproductive Technology Council, there is cogent reason for removal of a licence.

Exemption relating to artificial insemination

A licence is not required for artificial insemination (AI) if the procedure is carried out by a currently registered medical practitioner who has applied for exemption from the licensing requirement. The practitioner must notify the Commissioner of Health of the procedures to be carried out.

Under section 28(2)(a), a person who holds an exemption is subject to “the like disciplinary procedures in relation to that exemption as would have been applicable had the exemption been a licence under this [the HRT] Act”.

Under section 28(3) a licence or exemption for AI is not required where the procedure is “carried out by prescribed persons in prescribed circumstances”.

Section 1.9 of the Draft Guidelines states that “several other groups of persons who are not medical practitioners are excluded by regulation from any requirement for licensing or exemption for artificial insemination”. These include people such as nurses and spouses, who are “acting under the direction of a licensee or exempt medical practitioner, on the condition that they give a written undertaking to report the outcome of the use to the supplier of the semen”.

In South Australia, a licence is required to carry out AI except where -

- it is carried out by a medical practitioner who has submitted his or her name for registration to the Health Commission and has made an undertaking to the Health Commission to observe the Code of Ethical Practice under the Act; or
- it is carried out gratuitously.

### 13.2 CURRENT LICENCES

At 30 June 1998, four practice licenses, two practice (AI only) licenses and five storage licenses were current under the *Human Reproductive Technology Act 1991*.\(^{446}\)

**13.2.1 Exemptions granted**

At 31 August 1998, 48 medical practitioners were exempt from the requirement to be licensed to practice artificial insemination.\(^{447}\)

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\(^{446}\) RTC. Annual Report, 1 July 1997 - June 30 1998, Appendix I: i.

\(^{447}\) ibid. Appendix I: ii.
13.3 LICENSING REGIME

One submission indicated that there was support for “the current enforceable system of licensing of clinics and any moves under this system to promote ‘best practice’”.448

13.3.1 Hierarchy of accountability

The Commissioner of Health directed the Select Committee’s attention to449-

whether the hierarchy of accountability under the Act (the Act refers to licensees, persons responsible, and persons to whom a licence applies creating various categories of responsibility for each) is effective, and whether a simpler mechanism is possible to achieve the same results in terms of standards of practice.

The Select Committee felt that the current licensing regime under the HRT Act should remain in place.

Recommendation 13b

That the current licensing regime under the Human Reproductive Technology Act 1991 remain in place.

13.4 FEE STRUCTURE

13.4.1 Current fees

Under section 29(1)(b) of the HRT Act “an application for a licence or exemption shall be accompanied by the prescribed fee, if any”. The fee payable under the HRT Act for a licence is an application fee and represents a flat rate regardless of clinic size or the term of any licence granted. The Human Reproductive Technology Act (Licensing and Registers) Regulations 1993 established the fees charged for different licences (Table 8).

Table 8: Application fees in Western Australia

<table>
<thead>
<tr>
<th>Type of Licence</th>
<th>Fee Charged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Licence</td>
<td>$500</td>
</tr>
</tbody>
</table>

448 Submission 29 - RTCCC.
449 Submission 36 - Commissioner of Health.
Select Committee on the Human Reproductive Technology Act 1991

<table>
<thead>
<tr>
<th>Type of Licence</th>
<th>Fee Charged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Storage Licence (if sperm is not to be collected at the premises to which the licence relates; or the sperm which is to be collected there is not intended for use in donor insemination)</td>
<td>$100</td>
</tr>
<tr>
<td>Storage Licence (if sperm intended for use in donor insemination is to be collected at the premises to which the licence relates)</td>
<td>$300</td>
</tr>
<tr>
<td>Storage Licence (if eggs or embryos are to be stored)</td>
<td>$300</td>
</tr>
</tbody>
</table>


An application by medical practitioners for exemption under section 28(1) of the HRT Act to carry out artificial insemination must be accompanied by a fee of $50. In 1996/97, the income from three licensed clinics was $800. In WA, administration costs per treatment cycle begun were $56 and income from licensing provided only 0.7% of administration costs.  

The RTC and the RTCCC consider the current level of fees for licence applications “inadequate” and that these could be increased. However, there were concerns that clinics would pass on increases to patients. As all Australian clinics were reported to have deliberately passed on the cost of recent cuts to the Medicare rebates to their patients as a way of causing widespread protest, it is likely that any increase in fees would be deliberately passed on to patients also. The RTCCC suggested that reduction of fees for “best practice” could be considered. However, Dr Sandra Webb thought that suggestion was not applicable. One submission stated that the cost for licences would be tax deductible for clinics so that the full cost of fees should not impact upon clinics or patients.

It was suggested that fees should be increased to cover the costs of funding the RTC, and further that, income from fee increases could be used to fund “umbrella” services (such as public education, workshops and publications) that would benefit patients. In Victoria, fees vary according to the range of services offered by the clinics being licensed. The maximum fee for a clinic would be $7000 per year.

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450 Submission 19 - Confidential.
451 Submission 27 - RTC; Submission 29 - RTCCC.
452 Submission 19 - Confidential; Submission 27 - RTC; Submission 29 - RTCCC.
453 Submission 27 - RTC.
454 Submission 29 - RTCCC.
455 Submission 19 - Confidential.
456 Submission 27 - RTC.
Fees in the UK are calculated on the basis of the number of treatment cycles per annum. At the outset 50% of the HFEA’s operational costs were recovered through licence fees.\(^{457}\) In 1995/96, income from licensing provided 70.7% of the HFEA’s expenditure to administer the *Human Fertilisation and Embryology Act 1990*.\(^{458}\)

**Recommendation 13c**

That a dual fee structure be adopted comprising a flat rate that will be the same for all clinics and an additional secondary fee based upon the number of treatment cycles performed.

### 13.4.2 Medicare Benefits Schedule

The availability of IVF programs varies significantly around the world. In France, 100% of all infertility treatment is reimbursed. IVF is limited to four attempts. However, other countries like Austria and Switzerland provide no reimbursement of costs.\(^{459}\)

In 1990, the Australian Federal Government acknowledged that infertility was a medical condition and part-funded treatment by the Medicare Benefits Schedule.\(^{460}\) Currently up to six cycles of IVF, GIFT and similar procedures are available (in a woman’s lifetime) under the scheme (Table 9). Medicare covers 75% of the scheduled fee for inpatients and 85% of the scheduled fee for outpatients.\(^{461}\)

The Select Committee noted that women who are not infertile but who are unable to bear a child for other reasons are not currently able to access Medicare Benefits for assisted reproductive services and felt that the Minister for Health should raise the issue at the Australian Health Ministers’ Council.

The Select Committee was told by a commissioning mother who was technically fertile but unable to bear children for medical reasons, that as part of the surrogacy arrangement\(^ {462}\) -

> our routine cycle blood tests and the ultrasound procedures were covered but the drugs I had to use were not. If we had done IVF, the first six cycles of treatment and the drugs would have been covered by Medicare.

Costs in relation to surrogacy are also addressed in Chapter Eighteen (see page 267).

\(^{457}\) *ibid.*


\(^{460}\) *ibid.*


\(^{462}\) Mrs Carmel DeBruin. Evidence to the Select Committee, 3 February 1999.
Recommendation 13d

That the Western Australian Minister for Health raise the issue that women who are not infertile but who are unable to bear a child for other reasons are not currently able to access Medicare Benefits for assisted reproductive services, at the Australian Health Ministers’ Council.

Table 9: Medicare benefits for assisted reproductive services (at 1 July 1998)

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Miscellaneous Therapeutic Procedures (Subgroup 3 - Assisted reproductive services)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13200</td>
<td>Assisted reproductive services (such as IVF, GIFT and similar procedures) involving the use of drugs to induce superovulation and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services - but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13203, 13206 or 13218 applies - being services rendered during 1 treatment cycle, if the duration of the treatment cycle is at least 9 days - a maximum of 6 claims per patient. Fee: $1492.90 Benefit: 75% = $1119.70 85% = $1442.80</td>
</tr>
<tr>
<td>13202</td>
<td>Ovulation monitoring services, for superovulated treatment cycles of less than 9 days duration and artificial insemination - including quantitative estimation of hormones and ultrasound examinations, being services rendered during 1 treatment cycle but excluding a service to which item 13200, 13206, 13212, 13215 or 13218 applies. Fee: $373.20 Benefit: 75% = $279.90 85% = $323.10</td>
</tr>
<tr>
<td>13206</td>
<td>Assisted reproductive services (such as IVF, GIFT or similar procedures), using unstimulated ovulation or ovulation stimulated only by clomiphen citrate, and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services - but excluding artificial insemination, frozen embryo transfer or donated embryos or ova or treatment involving the use of drugs to induce superovulation - being services rendered during 1 treatment cycle but only if rendered in conjunction with a service to which item 13212 applies. Fee: $639.80 Benefit: 75% = $479.85 85% = $589.70</td>
</tr>
<tr>
<td>13209</td>
<td>Planning and management of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies including IVF, GIFT and similar procedures, or for artificial insemination - payable once only during 1 treatment cycle. Fee: $63.90 Benefit: 75% = $47.95 85% = $54.35</td>
</tr>
<tr>
<td>Item Number</td>
<td>Miscellaneous Therapeutic Procedures (Subgroup 3 - Assisted reproductive services)</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>13212</td>
<td>Oocyte retrieval by any means including laparoscopy or ultrasound-guided ova flushing, for the purposes of assisted reproductive technologies such as IVF, GIFT or similar procedures - only if rendered in conjunction with a service to which item 13200 or 13206 applies (Anaes. 17707 = 4B + 3T). Fee: $271.90 Benefit: 75% = $203.95 85% = $231.15</td>
</tr>
<tr>
<td>13215</td>
<td>Transfer of embryos or both ova and sperm to the female reproductive system, by any means but excluding artificial insemination or the transfer of frozen or donated embryos - only if rendered in conjunction with a service to which item 13200 or 13206 applies, being services rendered in 1 treatment cycle (Anaes. 17709 = 6B+ 3T). Fee: $85.35 Benefit: 75% = $64.05 85% = $72.55</td>
</tr>
<tr>
<td>13218</td>
<td>Preparation and transfer of frozen or donated embryos or both ova and sperm, to the female reproductive system, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in 1 treatment cycle and excluding a service to which item 13200, 13203, 13206, 13212 or 13215 applies (Anaes. 17709 = 6B + 3T). Fee: $639.80 Benefit: 75% = $479.85 85% = $589.70</td>
</tr>
<tr>
<td>13221</td>
<td>Preparation of semen for the purposes of assisted reproductive technologies or artificial insemination. Fee: $38.90 Benefit: 75% = $29.20 85% = $33.10</td>
</tr>
<tr>
<td>13290</td>
<td>Semen, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required. Fee: $152.55 Benefit: 75% = $144.45 85% = $129.70</td>
</tr>
<tr>
<td>13292</td>
<td>Semen, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required, under general anaesthetic, in a hospital or approved day hospital facility (Anaes. 17708 = 4B + 4T). Fee: $305.10 Benefit: 75% = $228.85 85% = $259.35</td>
</tr>
</tbody>
</table>


Genesis believed that the current Medicare support (especially the six cycle limit) remains out of touch and disproportionate with the real expense of treatment. It would encourage removal of the limit imposed on infertile couples. Consumers need assurance that the charges can be justified.  

463 Submission 17 - Mrs Stephanie Knox.
According to ANZICA\textsuperscript{464} -

it is clear that a six cycle limit applied to all women and not to men is discriminatory. Some ANZICA members have recommended that assisted reproductive technology that is applied for the treatment of male infertility should not be ascribed to a woman’s six cycle limit;

and

if a woman exhausts her six cycles because of her male partner’s low sperm count, she is unable to access IVF for treatment of her own subsequent infertility, perhaps in a new relationship. Her original partner however, is free to pursue his options with another woman who has six cycles of IVF.

The Select Committee felt that the six cycles appeared to be a generous amount by overseas standards and sufficient and did not require to be increased.

Country residents raised the issue that many clinics require couples to pay a scheduled fee for a broad number of services which include several procedures such as blood testing, ultrasound examinations and routine medical examinations which are more conveniently performed in the couples’ own home town or city. This causes some frustration as additional, separate medical expenses must then be met by the couples in their own home town.

Clearly the schedule fee does not acknowledge that for some couples accessing IVF, only the bare minimum medical service is required from a clinic in Perth.

\begin{quote}
\textbf{Recommendation 13e}

That the Western Australian Minister for Health make necessary representations to the Federal Minister for Health to adjust the scheduled Medicare fees so that country couples accessing assisted reproductive technology not be required to pay clinics for ancillary services currently accessed in their home towns at personal cost.
\end{quote}

\section*{13.5 \hspace{1em} REPORTING REQUIREMENTS

\subsection*{13.5.1 Licensees}

Sections 2 and 4 of the Directions relate to reporting obligations of licensees and the information requirements of the Registers. The \textit{Human Reproductive Technology (Licences and Registers) Regulations 1993} also provide for Registers and the type of information which is required to be provided.

Licensees are required to record a range of information. Practice licensees are required to keep complete records of all artificial fertilisation procedures. Storage licensees must record information on storage or use of semen for AIH or DI and on all embryos stored.

Under Direction 2.6, licensees and exempt practitioners must retain required records for 25 years.

\textsuperscript{464} Australian and New Zealand Infertility Counsellors’ Association (ANZICA). A submission to the Australian Health Technology Advisory Committee (AHTAC). 12 February 1998.
The Select Committee was told that the quality of data reported by licensees can be poor but that it is difficult to improve this through disciplinary measures.  

FINNRAGE (Australia) felt that the HRT Act “should demand mandatory reporting and subsequent deregistering of individual(s) and/or clinics when failing to comply”.  

The Select Committee felt that licensees must be required to report to the RTC. The RTC must supply licensees with clear instructions about what information it requires.

**Recommendation 13f**

That reporting be mandatory and that clinics be expected to provide more complete information in a standardised format.

That the Reproductive Technology Council supply clear instructions about the information required.

**Timing of annual reporting**

All licensees who store eggs or embryos, and who collect and store donor semen, must submit an annual report to the Commissioner of Health by 31 July each year relating to the previous financial year from 1 July to June 30, as required by Direction 2.25.

It was suggested that directions could be amended to require reporting from licensees to be their activities for the previous calendar year rather than financial year.  

Reporting by calendar year is required by the RTAC for reports to the NPSU. The RTC felt that reporting by calendar year “may make clinic compliance easier and yield better information. In addition, these data would allow direct comparisons and application to other relevant and important data collections that all refer to calendar years”.

The Select Committee noted the requirement for licensees to be able to report to the RTC and the RTAC at the same time.

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465 Submission 19 - Confidential; Submission 27 - RTC.

466 Submission 4 - FINNRAGE.

467 Submission 27 - RTC.

468 ibid.
Recommendation 13g

That annual reporting requirements to the Reproductive Technology Council by licensees coincide with reporting to the Reproductive Technology Accreditation Committee.

That a comprehensive program be developed to simplify and standardise reporting requirements.

The Select Committee expected that as a “trade-off” for simplification and standardisation, clinics would be expected to provide more comprehensive information.

13.5.2 Reproductive Technology Council

The RTC also has annual reporting requirements under the HRT Act. These are set out under Section 5(6) and Clause 11 of the Schedule. The RTC is required to report to the Commissioner of Health “who shall thereafter submit the annual report required by Clause 11 of the Schedule to the Minister” who shall in turn report to Parliament.

Recommendation 13h

That the Reproductive Technology Council continue to report to Parliament via the Commissioner of Health.

Reporting is addressed further in Chapter Fourteen.

13.6 POWERS OF INSPECTION AND OBTAINING INFORMATION

Officers required to carry out licensee compliance must be authorised officers who are specifically appointed by the Commissioner of Health and must carry a certificate of identity that indicates their powers and functions.\textsuperscript{469} Powers and duties of authorised officers are outlined in sections 49 and 54. Under section 54, an authorised officer has, at any time, power to enter and inspect any premises, equipment, examine records and to take possession or account of gametes, eggs in the process of fertilisation or embryos.

The Commissioner of Health informed the Select Committee that “powers of inspection are necessary to validate the accuracy and completeness of data reported by licensees to the Registers, and to administer the Act in other ways”.\textsuperscript{470} He also drew the Select Committee’s attention to “the tension between the necessity to retain powers of inspection (including records retained by the clinic) and medical confidentiality”.


\textsuperscript{470} Submission 36 - Commissioner of Health.
The Select Committee heard from the HFEA that they overcame the confidentiality problem by making inspectors employees of the Authority.  

Ms Leigh Newman informed the Select Committee that the RTC needs power of entry and inspection so that it can carry out its functions under Section 14 of the HRT Act. Although site visits and inspections occur, there is no protection for inspectors under the HRT Act. Authorised officers are covered if they are public servants and most RTC members are not.

The Select Committee believed that authorised officers should have the same protection as other public servants carrying out similar duties. Protection of RTC members is addressed in Schedule 10 of the HRT Act.

Recommendation 13h

That power for an authorised officer to inspect records held by licensees be retained in the Human Reproductive Technology Act 1991.

That authorised officers have the same protection as other public servants carrying out similar duties.
CHAPTER THIRTEEN - RECOMMENDATIONS

Recommendation 13a

That licence renewal be automatic subject to payment of application fees, unless, in the opinion of the Reproductive Technology Council, there is cogent reason for removal of a licence.

Recommendation 13b

That the current licensing regime under the Human Reproductive Technology Act 1991 remain in place.

Recommendation 13c

That a dual fee structure be adopted comprising a flat rate that will be the same for all clinics and an additional secondary fee based upon the number of treatment cycles performed.

Recommendation 13d

That the Western Australian Minister for Health raise the issue that women who are not infertile but who are unable to bear a child for other reasons are not currently able to access Medicare Benefits for assisted reproductive services, at the Australian Health Ministers’ Council.

Recommendation 13e

That the Western Australian Minister for Health make necessary representations to the Federal Minister for Health to adjust the scheduled Medicare fees so that country couples accessing assisted reproductive technology not be required to pay clinics for ancillary services currently accessed in their home towns at personal cost.
Recommendation 13f

That reporting be mandatory and that clinics be expected to provide more complete information in a standardised format.

That the Reproductive Technology Council supply clear instructions about the information required.

Recommendation 13g

That annual reporting requirements to the Reproductive Technology Council by licensees coincide with reporting to the Reproductive Technology Accreditation Committee.

That a comprehensive program be developed to simplify and standardise reporting requirements.

Recommendation 13h

That the Reproductive Technology Council continue to report to Parliament via the Commissioner of Health.

Recommendation 13i

That power for an authorised officer to inspect records held by licensees be retained in the Human Reproductive Technology Act 1991.

That authorised officers have the same protection as other public servants carrying out similar duties.
CHAPTER FOURTEEN

MANAGEMENT OF INFORMATION REGISTERS

14.1 INTRODUCTION

The Select Committee was required to examine the management of information registers including -

(a) confidentiality of information;
(b) use of data research;
(c) use of data for purposes of national data collection; and

Operation of information registers is regulated by Division 5 of Part 4 of the HRT Act, the Regulations and section 4 of the Directions.

14.1.1 Registers under the Human Reproductive Technology Act 1991

Under the HRT Act, the Commissioner of Health must establish and maintain registers of information about all assisted fertilisation procedures carried out in WA. The following registers have been established under the Act:

- IVF (public health) Register - contains details (including name-identifying information) of all IVF treatments and their outcomes by 20 weeks of pregnancy;
- Donor register - contains details (including name-identifying information) of all Donor Insemination (DI) treatments and their outcomes by eight weeks of pregnancy and medical, social and demographic information about all donors;
- Register of Licensees;
- Exempt practitioner register;
- Register of Research and Innovative Procedures granted the specific approval of the Council;
- Register of Extensions to embryo storage granted by the Council;
- Register of Disciplinary Procedures.

The Commissioner of Health indicated that it is necessary for the IVF and Donor Registers to include name-identifying information to enable the linkage of these Registers to other Registers of information held in the Health Department of WA, (e.g. Midwives’ Data Collection, Birth Defects Registry and Cancer Registry). 474

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474 ibid: 32-33.
The Select Committee felt that the current information registers under the HRT Act should continue to operate.

**Location and maintenance of records**

Section 44(3)(b) gives power to the Commissioner of Health to specify where records are to be kept.

According to the Draft Guidelines to the HRT Act “the records at each clinic should be kept at the discretion of each person responsible, to comply with good medical practice and other requirements of the Act, code or directions as to content”. Section 44(5) of the HRT Act refers to the Commissioner of Health’s power to name a location for records that are to be held when a person ceases to be a licensee. Under section 44(5) -

where a person ceases to be a licensee, any record required to be kept under this section [section 44] by that person shall be retained, in a manner and at a place approved by the Commissioner of Health for that purpose, by or on behalf of that person or may be lodged with the Commissioner.

Under Direction 2.6, “licensees and exempt practitioners must retain required records for 25 years.” The Select Committee was told that an unpublished RTC policy manual indicates that records should be maintained on the IVF and Donor registers for 80 years.

A number of submissions said that central registers should exist where records on donors and donor offspring be kept indefinitely.

The NSW Law Reform Commission felt that no time limit should be placed upon the retention of IVF clinic records. According to the RTAC’s Code of Practice “permanent records must be kept of ART procedures, identifying patients, gamete or embryo donors and recipients, and outcomes of attended fertilisation and conceptions”. The NHMRC’s ethical guidelines state that arrangements should be made by clinics for ART and donor records to be maintained indefinitely and any practitioner who ceases to practice should make arrangements to transfer these records to another

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475 Dr Sandra Webb. Personal communication to the Select Committee.
476 Submission 56 - Mr Kevin Coleman.
477 Submission 53 - Ms Maggie Camp.
478 Submission 58 - Ms Sarah Berryman.
479 Submission 48 - Mr and Mrs L Galvin; Submission 49 - Mrs Shirley Lock; Submission 60 - Mr and Mrs Warren Hewitt; Submission 61 - Ms Mandy Robinson; Submission 62 - Ms N Ruscoe; Submission 71 - Ms Michele Tardin; Submission 72 - Ms Wendy Hayler; Submission 73; Submission 74 - Ms Dennise Hughes; Submission 75 - Miss H Curry; Submission 76 - Ms L. Gower; Submission 77 - Mr and Mrs K Adelsbury; Submission 78 - Mr and Mrs MJ Hull; Submission 79 - Mr and Mrs S Moffitt; Submission 81 - Ms Rose McBryde; Submission 82 - Mrs P McCann; Submission 83 - JG Cronin; Submission 84 - Mrs Jill Murphy; Submission 87 - Mr and Mrs P Long.
482 NHMRC. 1996: 12.
suitable person or location, and should leave instructions on how this is to be carried out in the event that he or she dies or is otherwise unable to make the arrangements.

The WA Adoption Legislative Review Committee recently recommended that the period that adoption records be stored should be increased from the current minimum of 75 years to 100 years.\(^\text{483}\)

The Select Committee believed that records should be retained indefinitely by clinicians and central registers.

**Recommendation 14a**

That records be retained indefinitely by clinicians and central registers under the *Human Reproductive Technology Act 1991*.

Some submissions felt that a “comprehensive and complete” sibling register must be established and maintained.\(^\text{484}\)

The Select Committee was swayed by concerns from donor offspring that they could have a relationship with a half sibling without realising. While the Select Committee noted that the current regime provides that donor gametes are not used for more than five families and that the likelihood of a half sibling relationship arising was remote, Members wished to minimise the doubt and felt that identifying information about half siblings should be stored on a register and that offspring should be able to access the information.

**Recommendation 14b**

That central registers include identifying information about siblings resulting from donated gametes.

**14.2 CONFIDENTIALITY**

Many of the provisions under the HRT Act, Regulations and Directions relate to confidentiality requirements. The Minister for Health approved the place and manner of keeping of these registers, with additional requirements to enhance confidentiality of the Registers. The RTC is not involved directly with the Registers, but retains an active interest in them.

\(^{483}\) Adoption Legislative Review Committee. November 1997: 92.

\(^{484}\) Submission 48 - Mr and Mrs L Galvin; Submission 49 - Mrs Shirley Lock; Submission 56 - Mr Kevin Coleman; Submission 60 - Mr and Mrs Warren Hewitt; Submission 61 - Ms Mandy Robinson; Submission 62 - Ms N Ruscoe; Submission 71 - Ms Michele Tardin; Submission 72 - Ms Wendy Hayler; Submission 73; Submission 74 - Ms Dennise Hughes; Submission 75 - Miss H Curry; Submission 76 - Ms L. Gower; Submission 77 - Mr and Mrs K Adelsbury; Submission 78 - Mr and Mrs MJ Hull; Submission 79 - Mr and Mrs S Moffitt; Submission 81 - Ms Rose McBryde; Submission 82 - Mrs P McCann; Submission 83 - JG Cronin; Submission 84 - Mrs Jill Murphy; Submission 87 - Mr and Mrs P Long.
Section 44(3)(b) requires a licensee to keep records secure and confidential, while section 49 establishes offences related to breaches of confidentiality which could relate to licensees retaining records under the HRT Act. Draft guideline (2.3(ii)) highlights the means to maximise confidentiality of transfer of identifying information about donation between licensees and directly to the Register.

Several submissions stressed the importance of confidentiality. “There should be no publication of results that identify any individual”. The RTCCC is concerned that all the confidentiality provisions of the HRT Act remain to ensure that “information collected and stored is as secure as possible, in spite of its wish to see a move towards informed openness about artificial fertilisation procedures”. There was concern that the statement in the HRT Act that any officer of the RTC can examine the notes of any patient undergoing assisted conception “appeared to give rise to a gross breach of patient confidentiality”. The concern may be ill-founded because section 54 of the Act refers to authorised officers and records, not notes. Despite section 54(5) which states that “a person who discloses to an authorized person ... information that would otherwise be confidential shall not be taken to have committed thereby any breach of a principle of professional ethics”, Dr Anne Jequier informed the Select Committee that she received legal opinion which led her to believe that she would be “correct to refuse those Officers of the Council the right to view the notes of any patient undergoing treatment without first obtaining that patient’s written consent”.

The Select Committee acknowledged the concern about possible breaches in confidentiality but since authorised officers are bound by confidentiality, no amendments are required.

Guidelines to the Directions specify that named identifying information and treatment details should not be sent to the RTC at the same time, and that named information should not be faxed.

According to Dr Robert Mazzuchelli and Dr Bruce Bellinge, recent changes to Directions relating to annual reporting required that confidential data be submitted with treatment data (Direction 2.29, July 1997). When the database was established the principle of confidentiality was stressed and required that identifying data be kept separate from treatment data. “Now these principles ... are to be eroded”. Dr Sandy Webb indicated that this was not the case because Direction 2.29 refers only to reporting by ID number.

In their submission, Broderick and Walker reported that a primary concern of both donors and recipients in their survey was the issue of confidentiality of the information held in the registers (non-
identifying and identifying). If access to information was more readily available, the great majority of donors and recipients would be less likely to participate in the use of the technology. On the other hand, a number of submissions called for access to donor information for offspring. This is discussed in Chapter Fifteen.

14.3 REPORTING BY LICENSEES

Section 2 of the HRT Act’s Directions outlines the reporting requirements for licensees to provide information about IVF participants and treatments to the IVF Register and information about the use of donated human reproductive material to the Donor Register. The Directions also address annual reporting requirements. Licensees are required to submit data to both the Health Department of WA and the Australian Institute of Health and Welfare’s National Perinatal Statistics Unit (NPSU). The Select Committee heard from licensees that they were unhappy about the dual reporting - “it is very time-consuming and expensive” and “I would make a plea that this whole exercise is simplified with the collection of only one set of information”. Dr Gordon Baker, Chairman of the RTAC, acknowledged the duplication but he felt the problem would be overcome with the advent of electronic data transfer.

According to the RTC, initial reporting of the data by all clinics continues to adhere to the times set under the HRT Act, but data provided is still often inaccurate and incomplete.

According to the NHMRC, data reporting should be standardised. In particular, the reporting of treatment cycles should use the definition of a treatment cycle as defined in the Medicare Benefits Schedule -

a treatment cycle is a series of treatment for the purposes of in vitro fertilisation, gamete intrafallopian transfer or similar procedures and is defined as beginning either on the day on which treatment by superovulatory drugs is commenced or on the first day of the patient’s menstrual cycle, and ending not more than 30 days later.
14.4 USE OF COLLECTED DATA

The NHMRC’s ethical guidelines state that detailed clinical and laboratory records should be kept because of the unique nature of reproductive medicine.\(^\text{497}\) Records should be adequate to -

- facilitate both short and long-term follow-up of the effects of treatments undertaken including psychosocial effects;
- enable linkage studies with other health data, e.g. registers such as cancer and congenital abnormalities; and
- facilitate the study of the short-term and long-term outcomes of any ART procedure that is commenced, including the occurrence of singleton and multiple pregnancies, pre-term births and multiple births; and the health of the women and offspring.

Professor Fiona Stanley highlighted the greater risks faced by IVF infants compared to spontaneously conceived infants.\(^\text{498}\) She believed that -

the IVF Register ... will in the future ... contribute enormously valuable information which will allow us to start to ask and answer questions about the risks and why those risks might exist for infants conceived by IVF. The public health implications of the IVF register cannot be underestimated.

Dr Jennifer Kurinczuk felt that WA has the opportunity through the HRT Act, to continue to collect high quality, population-based information, which will have enormous value.\(^\text{499}\)

FINNRAGE stressed that there should be no publication of results that identifies any individual.\(^\text{500}\) Broderick and Walker’s findings showed that between 56% and 75% of donors and recipients thought that medical personnel or researchers should be able to access non-identifying information about themselves and resulting children only for research and medical purposes.\(^\text{501}\) Between 40% and 60% of donors and recipients thought that medical personnel or researchers should be able to access identifying data for research or medical purposes.

The Select Committee referred previously to the importance of data to examine the long-term effects of assisted reproductive technology procedures such as ICSI (Chapter Two).

14.4.1 Overseas perspective

Since 1991, the HFEA has collected data on all IVF cycles carried out in the UK. The database was analysed to identify factors that affect outcome of treatment. Age, duration of infertility, previous

\(^{497}\) \text{ibid; 12.}

\(^{498}\) Submission 31 - Professor Fiona Stanley, Institute for Child Health Research.

\(^{499}\) Submission 30 - Dr Jennifer Kurinczuk.

\(^{500}\) Submission 4 - FINNRAGE.

\(^{501}\) Submission 22 - Dr Pia Broderick and Dr Iain Walker.
pregnancy and previous unsuccessful IVF attempts each significantly affect the likelihood of a successful outcome after IVF treatment.\textsuperscript{502}

In the USA, the ASRM states that\textsuperscript{503} -

accurate reporting of data assists in the formation of realistic expectations and promotes patient confidence in the integrity of assisted reproductive technology (ART) programs.

The non-reporting of cycles which are part of research protocols is unacceptable.

\section*{14.5 NATIONAL DATA COLLECTION}

In Australia, there is one national centralised collection of IVF data held by the NPSU. In 1996, all 28 assisted conception units in Australia and New Zealand contributed summary data on treatment cycles and notified all pregnancies to the register. The NPSU provides important information about the success of IVF in Australia. However, it only collects non-identifying data and thus the collection can not be used to follow-up the long-term effects of treatment on either the mother or children.

The RTCCC supports a move to “cohesive, nationally held data collections”.\textsuperscript{504}

The Commonwealth Department of Health and Family Services has established a Working Party on National Data Collection in Assisted Reproductive Technology. The Working Party was asked to identify a number of issues -

\begin{itemize}
  \item constraints of gathering data at a national level, paying particular attention to informed consent, access to and use of the stored data, privacy principles, confidentiality and security issues in addition to the practical and financial aspects of the collection;
  \item practicalities of maintaining such data collection at a national level (or alternatives);
  \item need for complementary legislation in all states and territories.
\end{itemize}

The Select Committee was told that the Working Party’s Draft Report has just been released for consultation.\textsuperscript{505}
14.5.1 Advantages of a national register

National registers have some advantages over studies of results from individual IVF centres.\textsuperscript{506} They provide population-based data on pregnancy rates, giving the average likelihood of achieving a pregnancy or a live-birth. In addition, registers can provide a large number of treated women and pregnancies for analysing outcomes and evaluating the risks of some adverse outcomes. The data obtained can be used to inform prospective parents, clinicians, scientists and the general community about outcomes and possible risks.

14.5.2 Limitations of a national register

Assisted conception registers may lack adequate information on complications resulting from ovarian hyper stimulation or pregnancy.\textsuperscript{507} The study of long-term effects of treatment on women and their children are usually beyond the resources of the registers.

In addition, in order to ensure compliance, the amount of data must be kept within reasonable limits.

\begin{center}
\textbf{Recommendation 14c}
\end{center}

\begin{quote}
That the Western Australian Minister for Health approach all States and the Commonwealth to establish a national register.

That Western Australia cooperate in the event that a national register is established.
\end{quote}

14.5.3 Electronic transfer of data

The NPSU has a new computerised data collection system that should ease data reporting. Clinics are only required to submit minimum data sets.\textsuperscript{508}

As electronic data transfer becomes more widely used, other information in computerised clinical and laboratory data systems can be included in the registers but each additional data item must be justified.\textsuperscript{509} The Commissioner of Health felt that “electronic transfer of data would be cost effective for all parties, but there would be considerable time and cost implications for licensees”.\textsuperscript{510}

\begin{itemize}
\item \textsuperscript{506} Lancaster PAL. \textit{Registers of in-vitro fertilization and assisted conception}. Human Reproduction 1996; 11(suppl. 4): 89-104.
\item \textsuperscript{507} ibid.
\item \textsuperscript{508} Ms Monica Johns, Secretary, Working Party on National Data Collection in Assisted Reproductive Technology. Meeting with the Select Committee, Canberra, 26 March 1998.
\item \textsuperscript{509} Lancaster PAL. 1996; 11(suppl. 4): 89-104.
\item \textsuperscript{510} Submission 36 - Commissioner of Health.
\end{itemize}
14.5.4 Reporting to RTAC

The RTAC collects data to assess the results of ART clinics. The data is confidential and is used to compare yearly results.
CHAPTER FOURTEEN - RECOMMENDATIONS

Recommendation 14a

That records be retained indefinitely by clinicians and central registers under the Human Reproductive Technology Act 1991.

Recommendation 14b

That central registers include identifying information about siblings resulting from donated gametes.

Recommendation 14c

That the Western Australian Minister for Health approach all States and the Commonwealth to establish a national register.

That Western Australia cooperate in the event that a national register is established.
CHAPTER FIFTEEN

ACCESS TO INFORMATION ABOUT GENETIC PARENTAGE

15.1 INTRODUCTION

The Select Committee had to consider the issue of access to information about genetic parentage. This has been an area of much public debate. To date, unless legislation has dictated otherwise, donor anonymity has been regarded as the norm.

In 1988, the WA Select Committee inquiring into the Reproductive Technology Working Party’s Report found “arguments for children to have the right to information which identifies their biological parents persuasive, but recognise(d) that this is a contentious issue which requires further public debate”\(^{511}\).

In 1989, the Council of Europe determined to uphold donor anonymity as a general principle but recognised the right of individual States to allow offspring access to information about their conception or to the identity of the donor.\(^{512}\)

15.1.1 Human Reproductive Technology Act 1991

Under the HRT Act, a Donor register has been established that contains identifying information for all sperm donors involved in an artificial fertilisation procedure, whether or not a clinical pregnancy was achieved. In addition, identifying information is kept for each recipient of donor sperm for DI where there is an ongoing clinical pregnancy at eight weeks. However, there is no right of access to identifying information provided to offspring about a donor, or to donors about offspring. The right of access is restricted to non-identifying information for participants (including donors) and offspring.

Registers

Information for both the IVF and Donor Registers is reported on forms contained within the Directions to the Act.\(^{513}\) Figure 2 shows the flow of data into the Donor Register. Data is maintained in the Register.

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\(^{511}\) WA Legislative Assembly. 1988: 19.


Under Direction 2.13 -

a licensee or holder of an exemption who is required to provide information about the use of donated human reproductive material in an artificial fertilisation procedure to the Donor Register must provide information in accordance with Forms 4 - 7 of the Schedule.

However, Direction 2.14 exempts licensees or holders of exemptions from supplying donor identifying information in particular circumstances.

15.1.2 Non-identifying information

According to FINNRAGE, relevant non-identifying medical, social and demographic information should be recorded in a central register for access by offspring and donors.\textsuperscript{514} The Select Committee heard from Dr Pia Broderick and Dr Iain Walker about research they had conducted in 1994 with clients (both donors and recipients) from three Perth fertility clinics.\textsuperscript{515} They concluded that both

\textsuperscript{514} Submission 4 - FINNRAGE.

\textsuperscript{515} Submission 22 - Dr Pia Broderick and Dr Iain Walker.
donors and recipients were satisfied with the non-identifying information available and current access to it. They felt that neither the type of information, nor the process of providing or accessing it should be changed.

15.2 RIGHTS AND WELFARE OF OFFSPRING

The Select Committee was aware of the need to consider the rights and welfare of the offspring resulting from reproductive technologies with regard to access to information about genetic parentage. The term “offspring” has been used to acknowledge that the issues under consideration extend beyond childhood. According to Harvey (1997), “we are confronting possible life-long implications from being born as a consequence of assisted conception involving donated gametes”.

Many articles and submissions refer to “the child”. Therefore, both “offspring” and “child” are used in this section.

Dame Mary Warnock, the Chair of the UK Committee of Inquiry into Human Fertilisation and Embryology, felt that the difficulty for a child coming to terms with its DI origins is inconsequential compared to the effects of deception which the child suffers through not being told. She felt that the deception involves not only the child but also grandparents, aunts, uncles, cousins and family friends.

The child is being used as a means to the parents’ ends, namely to have or seem to have a normal family and I do not think that using one person as a means to another’s ends can ever be right, unless the person has consented to be so used ... I cannot argue that children who are told their origins, if they are AID children are necessarily happier or better off in any way that can be estimated. But I do believe that if they are not told, they are being wrongly treated.

According to Article 7 of the United Nations (UN) Convention on the Rights of the Child, “the child shall have ... as far as possible, the right to know and be cared for by his or her parents”. However, according to Blyth (1998) “exercise of this right hinges on the definition of ‘parent’ ”. He pointed out that in the UK, “a donor whose consent to donation has been properly obtained is not regarded in law as a parent of the child”. He continued that it may be argued that Article 7 has no relevance to the issue of donor anonymity in the UK. Article 8 addresses “the right of the child to preserve his or her identity”.

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517 Warnock M. *The good of the child*. Bioethics. 1987; 1(2).


The Joint Standing Committee on Treaties examined the status of the UN Convention in Australia and recommended that “the [Federal] Government request that information identifying gamete donors be registered in all jurisdictions”.\(^{521}\) The Joint Standing Committee believed that -

all clinics and institutions involved in reproductive technologies should be required to keep relevant identifying information on gamete donors. Until the issue of whether parental information should be provided to the offspring is resolved, unless this information is kept, this will not be an option for those children.

The NHMRC’s ethical guidelines stated that\(^ {522}\) -

children born from the use of ART procedures are entitled to knowledge of their biological parents. Any person, and his or her spouse or partner, donating gametes and consenting to their use in an ART procedure where the intention is that the child may be born must ... be informed that children may receive identifying information about them.

Submissions indicated that children born as a result of ART should have the right to accurate information about their genetic parentage.\(^ {523}\) The lack of knowledge about genetic and family history, with the attendant secrecy, can adversely affect the child’s development of a secure identity, with consequences throughout their adult lives.\(^ {524}\)

The Select Committee received a submission from a 26 year old DI offspring who felt that the “rights and interests of children/offspring ... often seem to be overlooked”.\(^ {525}\) She felt there should be legislation to protect DI offsprings’ “right to access information about our origins, heritage, ethnicity, medical history and family members”.

Preliminary research findings confirmed that “the view that the right to know one’s biological origins is a basic human right. And that such a right must be enshrined and protected by state law”.\(^ {526}\) Harvey (1997) stated that\(^ {527}\) -

increased knowledge and a gradual shift in attitudes has enabled us to acknowledge that in our contemporary culture young people have strong moral claims to know their genetic identities. It is now time for these moral claims to be converted to legal rights.

\(^{521}\) Joint Standing Committee on Treaties. 1998.

\(^{522}\) NHMRC. 1996

\(^{523}\) Submission 4 - FINNRAGE; Submission 16 - Mr Haydn Lowe.


\(^{525}\) Submission 47 - Ms Jo Rose.

\(^{526}\) Submission 50 - Dr Edda Simeoni.

\(^{527}\) Harvey J. 1997.
15.2.1 Reasons for access to information

Mr Haydn Lowe indicated that there are many good reasons why children should have access to information about their genetic parents. He stated that “these have been extensively covered by the adoption debate and apply equally to children born as a result of human reproductive technology”.  

Associate Professor Ken Daniels felt that the reasons for more openness were:

- not so much to do with the rights of the child but the high risk of damaging family relationships;
- honesty and openness will contribute to the lessening of the stigma associated with DI procedures.

According to Shirley Pratten of the New Reproductive Alternatives Society in Vancouver “once the secrecy is gone, DI should be able to assume its rightful place as an important and accessible reproductive alternative”.

The Select Committee was told that many DI parents were concerned about the possible impact of this gap in knowledge on their children as they grew into adults.

15.2.2 Views of offspring

DI offspring, now young adults, clearly identify a need to know the identity of their biological father and express a desire to make contact so that they can feel more complete.

I am deeply concerned about the denial of information that I feel is essential to my sense of identity and my health.

Neither of us wanted the donor as a dad, far from it ... the only reason (at the moment!) that we wanted to have information ... on our donor’s was so that we could have a full medical background, the reassurance that if we ever wanted to, we could contact our donor and so that we could have a complete idea of ourselves.

It would eliminate questions, anxieties, fantasies and wasted energy ... it would make me feel more complete in some way ... on an emotional level.

528 Submission 16 - Mr Haydn Lowe.
532 Submission 59 - Mr Bill Cordray.
533 Submission 55 - Miss Geraldine Hewitt.
534 Submission 62 - Ms Nicky Ruscoe.
I wanted to know how he could have sold what was the essence of my life for $25 to a total stranger, then walked away without a second thought ... Why couldn’t he connect the semen to the human being it would create?535

I personally don’t think of my biological father as a dad because he was never there for me.536

15.2.3 Impact of and attitudes towards recording of identifying information

The Select Committee heard from clinicians that the recording of identifying information has significantly reduced the number of both male and female donors prepared to donate. “With males this has reduced the numbers by almost 90% ... This is also reflected in our female donors with only 10% to 20% now prepared to donate”.537 The decline in the number of semen donors is reflected in Chapter Seventeen (Table 10). The Select Committee was told that in Victoria, donors numbers declined initially but that they appear to be recovering. However, data are currently not available to confirm the trend and Victoria is continuing to monitor the situation. It was also noted in Victoria that the profile of donors appeared to have changed from students to older men with families. A similar situation has been noted in Sweden (see page 202).

Dr Broderick and Dr Walker’s research found that 65% of recipients believed that a register of identifying information should not be kept.538 Recipients did not want to know the donor’s name and address nor did they want the donor to know their name or address. Donors were more in favour of a register but 45% believed a register should not be maintained. However, the authors recommended that access could perhaps occur “where both donors and recipients agreed to such access prior to donating or receiving gametes or embryos”.

The Select Committee was aware that all donors who had donated subsequent to the introduction of the HRT Act in 1993 were advised under Direction 4.2 about the possibility of developments in policy and legislation that would make identifying information available to donor offspring.

15.2.4 Suitable age for access

The Select Committee received a number of submissions that recommended that “donor offspring should be given access to their genetic parentage once they reach the age of 18 yrs”.539
Under the Victorian *Infertility Treatment Act 1995*, donor offspring may access donor information at the age of 18 years.

In Switzerland, access to information about genetic parentage is permitted “upon demonstration of sufficient knowledge and understanding”. Harvey indicated that the uncertainty of determining capacity may make such an approach unacceptable.

In Sweden, identifiable information is available to offspring when they reach “maturity” (no age is specified) while in Austria, offspring can access information at 14 years of age.

The Select Committee received evidence that addressed access to identifying information. Members were mindful of the potential impact upon donor numbers if access was permitted. However, the Select Committee’s paramount concern was for the welfare of the future offspring. Therefore, Members agreed that access to donor identifying information should be available in future and were of the opinion that 16 years of age was an appropriate age for access to identifying information to occur.

**Recommendation 15a**

That in future, access to donor identifying information be available on request to any donor offspring upon attaining the age of 16 years.

**15.2.5 Protection for offspring**

Ms Maggie Camp suggested that a Contact Veto System should be available to protect the privacy of adult offspring who do not wish to be contacted.

Chowdhury (1998) felt that concerns were raised about children born as a result of DI having impossibly high expectations of themselves, “not only upon finding out who their biological father is, but also as a result of knowing that they were born as a result of treatment and knowing the mental anguish that their parents went through in order to give birth to them”. The author continued that “DI may also lead children to fantasise about their biological father”.

The Select Committee stated previously that the interests of the child should be paramount. The view of the Select Committee accords the donor no rights to obtain identifying information about the child (unless the child wants it). The Select Committee considered that it would be very unsettling for the child to be contacted by the donor, especially if they were unaware that they were conceived using artificial fertilisation technology. The Select Committee, while encouraging parents to tell their children about their parentage, was told that many parents choose not to tell their children.

540  Harvey J.  1997: 5.

541  Blyth E.  1998

542  Submission 53 - Ms Maggie Camp.

The Select Committee did not want to see the situation arise where donors donate in order to have contact with their biological children in the future. However, Members felt that donors have a right to know how many children have resulted from their donations.

15.2.6 Maintenance of records

The Select Committee was aware that there is debate concerning the period of time for maintaining records. Members were told by donor offspring that they would like records of donors to be kept indefinitely. The issue of maintenance of records has been addressed in Chapter Fourteen (see page 182).

15.3 COUNSELLING

The importance of counselling is generally recognised in the field of reproductive medicine. However, the Australian and New Zealand Infertility Counsellors Association (ANZICA) pointed out that “the counselling for those couples wishing to use donated gametes and those people who donate gametes requires special attention”. Currently in WA, counselling is addressed in section 5 of the Directions. Counselling of recipients of donated reproductive material is not mandatory (other than in cases where the donor is known to the recipients) (Direction 5.8). Some members of the RTC “consider that counselling should be mandatory for all recipients of donated material”.

In South Australia, there is recognition of the role for counsellors in assisting recipients to consider the potential impact of DI upon themselves, their child and family and their social network.

According to Durna, et al. (1995), a study of couples who had a child by DI at four NSW clinics indicated that the high acceptance of donor insemination - 96% of couples studied had no regrets about it - reflected the policy of mandatory counselling before beginning a DI program. Daniels, et al. (1996) found that for many couples the acceptance of the DI program was low and suggested that there was a need for “psychosocial assistance to be made available to couples prior to the commencement of treatment”.

A number of other submissions stated that recipients of donor material should receive mandatory counselling from counsellors with “experience specific in this field”. Ms Jo Rose indicated that “the

544 Submission 55 - Miss Geraldine Hewitt.
545 RTAC. Code of Practice. Attachment B. ANZICA guidelines for RTAC accreditation of counselling services.
546 Submission 27 - RTC.
549 Submission 48 - Mr and Mrs L Galvin; Submission 49 - Mrs Shirley Lock; Submission 56 - Mr Kevin Coleman; Submission 60 - Mr and Mrs W Hewitt; Submission 61 - Ms Mandy Robinson; Submission 62 - Ms N Ruscoe; Submission 71 - Ms Michele Tardin; Submission 72 - Ms Wendy
provision of counselling and education for couples prior to the use of donor gametes ... should be comparable to that which is provided for applications for adoption”.  

Counselling should start at a very early stage and be ongoing. Several submissions also recommended mandatory counselling for donors and that “facilities and strategies should be in place for long-term counselling for donors, offspring and recipients”.  

ANZICA suggested that recipients should be asked to consider -

- their feelings about not being the genetic parents of the child; and
- their perceptions of the needs of the child throughout his or her childhood and adolescence;

while donors should be asked to consider -

- their reasons for wanting to become a donor;
- their attitudes to any resulting children;
- the possibility of their own childlessness;
- their perception of the needs of any children born as a result of their donation;
- their attitudes to the prospective legal parents of their genetic offspring;
- their attitudes re allowing their gametes to be used for research.

The importance of counselling will be discussed further in Chapter Sixteen. In addition, the Select Committee discussed counselling for gamete donors and recipients in Chapter Five and recommended mandatory counselling for them (Recommendation 5h).

15.4 RETROSPECTIVE ACCESS TO INFORMATION

The Select Committee encountered different views about the need for retrospective access to donor information.

In Victoria, the Infertility Treatment Act 1995 deals with donations and births that occurred prior to the implementation of the Act. The Infertility Treatment Authority (ITA) is ready to establish a
voluntary retrospective register and it has received “about a dozen unsolicited applications from donors to go onto the register and to make information available about themselves if offspring inquire”.\textsuperscript{553}

Ms Jo Rose felt that there “needs to be some retrospective actions for those of us that are already there”.\textsuperscript{554} She felt that the setting up of the voluntary register in Victoria to help DI relatives to make contact is a “responsible action”. A number of submissions recommended that a “retrospective voluntary register of donors should be set up for access to information based on mutual consent”.\textsuperscript{555}

Ms Sarah Berryman said that legislation governing access to information should be retrospective to give equal rights to future children, offspring currently under 18 years of age and adult offspring.\textsuperscript{556} She suggested that there should be a six month lead-in time to inform affected parties of legislative changes.

Dr Phillip Matson felt that access to identifying information should not be made retrospective because in the past, donations were made with the assumption that the HRT Act would protect the anonymity of donors.\textsuperscript{557} He continued that “any rights to identifying information should only be effective for donations made after the Act is modified”. Dr John Yovich also expressed concern that retrospective access to information would affect current and past donors who only donate or donated on the understanding that their donation is or was anonymous.\textsuperscript{558}

15.4.1 Contact vetoes

The NSW \textit{Adoption Information Act 1990} is retrospective legislation, affecting adoptions prior to 1990. It raised “fears that people’s privacy would be abused and that non-contact wishes would not be respected. The Contact Veto system was introduced to safeguard privacy”.\textsuperscript{559} Ms Maggie Camp suggested that “a Contact Veto System should also be available for past donors who may not have

\begin{itemize}
\item \textsuperscript{553} Ms Helen Szoke, Infertility Treatment Authority. Correspondence to the Select Committee, 24 March 1999.
\item \textsuperscript{554} Submission 47 - Ms Jo Rose.
\item \textsuperscript{555} Submission 48 - Mr and Mrs L Galvin; Submission 49 - Mrs Shirley Lock; Submission 56 - Mr Kevin Coleman; Submission 60 - Mr and Mrs W Hewitt; Submission 61 - Ms Mandy Robinson; Submission 62 - Ms N Ruscoe; Submission 71 - Ms Michele Tardin; Submission 72 - Ms Wendy Hayler; Submission 73; Submission 74 - Ms Dennise Hughes; Submission 75 - Miss H Curry; Submission 76 - Ms L Gower; Submission 77 - Mr and Mrs K Adelsbury; Submission 78 - Mr and Mrs MJ Hull; Submission 79 - Mr and Mrs S Moffitt; Submission 81 - Ms Rose McBryde; Submission 82 - Mrs P McCann; Submission 83 - JG Cronin; Submission 84 - Mrs Jill Murphy, Submission 87 - Mr and Mrs P Long.
\item \textsuperscript{556} Submission 57 - Ms Sarah Berryman, Post Adoption Resource Centre.
\item \textsuperscript{557} Submission 7 - Dr Phillip Matson, Concept Fertility Clinic.
\item \textsuperscript{558} Submission 18 - Dr John Yovich.
\item \textsuperscript{559} Submission 57 - Ms Sarah Berryman.
\end{itemize}
anticipated at the time of donation, that their donor offspring may want/need contact at a future time”.

However, following a recent review of the WA Adoption Act 1994, the WA Adoption Legislative Review Committee recommended that -

the current system of contact vetoes cease and be replaced with a no contact wish within a specified period not to exceed ten years from when the Act came into effect. That consideration be given to the development of a mechanism which will allow for safeguarding individuals against unsolicited contact.

The Select Committee considered whether to make access to identifying information retrospective. Members were cognisant of the declining numbers of donors and felt that perception of major changes to the legal framework with regard to donation might deter donors because of further unforeseen changes in the future. However, Members were aware that since the HRT Act came into force, Direction 4.2 has provided that the person responsible must ensure that prior to consent being given to donation -

all donors and recipients are given oral explanations, supported by written information in a form approved by Council, including information about the possibility of developments in policy and legislation making identifying information about their biological parentage available to children of donors.

Although it is clear from Direction 4.2, that donors should have been informed about the possibility of developments in policy and legislation making identifying information about their biological parentage available to donor offspring, this is not evident on the consent form. Therefore, the Select Committee is concerned that consent forms ensure that possible policy developments such as this are clearly stated.

Members believed that if there was clear evidence that donors, who donated after the HRT Act came into effect, had been notified of the possibility of being identified in the future, it should now be possible for offspring to access donor identifying information retrospectively.

### Recommendation 15b

That donor offspring have access to donor identifying information retrospectively where -

(i) the donation was made after the commencement of the Human Reproductive Technology Act 1991; and

(ii) there is clear evidence that the donor was informed that disclosure of identifying information was likely should there be future change in policy or legislation.

The Member for Joondalup agreed in principle with this recommendation save that he believed that donor offspring access to identifying information be permitted per se.

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560 Submission 53 - Ms Maggie Camp.

For donors who donated prior to the HRT Act, Members agreed that whilst weight should be given to
the paramount interests of the child, in this situation it was outweighed by the issues of confidentiality
and privacy that was promised to the donor at the time of donation and the possible ramifications for
the donor’s family. The majority of the Select Committee felt that a compromise was required and
recommended that a retrospective voluntary register be established based on the mutual consent
between the donor and offspring and that donors are to be encouraged to place their names on the
register. Currently, information about donations which occurred prior to the HRT Act is only available
from clinics.\footnote{562}

\begin{center}
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\textbf{Recommendation 15c} \\
\hline
That a retrospective voluntary register be established based on the mutual
consent between the donor who donated prior to the Human Reproductive
Technology Act 1991 and donor offspring. \\
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The Member for Joondalup dissented and restated his position as outlined above.

\section*{15.5 LEGISLATION FROM OTHER JURISDICTIONS}

\subsection*{15.5.1 International}

There is open information exchange in a number of countries - Austria, Sweden, Switzerland and New
Zealand.

The \textit{Swedish Law of Insemination 1985} was the first of its kind in the world. Austria introduced
similar legislation in 1992. The controversial Swedish legislation provided for the DI offspring to be
able to access identifying information about the donor once they reach “maturity”. Daniels and Lalos
(1995) reported that despite a temporary decline in the number of donors at some clinics, the decline
has now been reversed.\footnote{563} The authors also noted that the donor profile had changed from mainly
students to older married men.

In Switzerland, a 1992 referendum included “a substantive rule which guarantees ‘a person’s access
to the data concerning his ancestry’”\footnote{564}. This includes information about one’s biological parents.

In New Zealand, the \textit{Status of Children Amendment Act 1987} established that gamete providers did
not have any rights or responsibilities with regard to the offspring.\footnote{565} This meant that donors could
agree to the provision of identifying information to offspring and recipients, without the fear that they

\footnotesize\textsuperscript{562} RTC. Annual Report, 1 July 1997 - 30 June 1998: 21.

\footnotesize\textsuperscript{563} Daniels K and Lalos O. \textit{The Swedish Insemination Act and the availability of donors.} Human

\footnotesize\textsuperscript{564} Harvey J. 1997.

would be required to contribute financially. In addition, recipients could tell their children without the fear that the gamete provider could make a legal claim on the offspring.

A different approach has been taken in France, where the Law of 29th July 1994 states that all contributions from donors are to be given in complete legally-backed anonymity. A couple wanting ART is required to give informed consent in writing to all legal consequences. The social parents are prohibited from denying or contesting actual parenthood. Large fines are in place if information about the identity of the donor is surrendered.566

15.5.2 Australian States

Victoria

Under the Victorian Infertility Treatment Act 1995, donors and parents of offspring born as a result of donor procedures can access non-identifying information on recipients/donors as a right from the central register. Identifying information can be accessed with the consent of the person to whom the procedure relates. Children born as a result of donor procedures and their children can access both identifying and non-identifying information about the donor in the absence of the donor’s consent.

South Australia

In South Australia, donors may consent to the disclosure of identifying information regarding themselves. Licensees can provide non-identifying information to offspring over the age of 16 years. This includes physical attributes, occupation, family circumstances, half siblings and medical history.567 Following a forum to examine donor issues, the SACRT established a working party to explore issues such as access to identifying information. To date the working party has not reported upon its findings.

15.6 DONOR ISSUES AND CONCERNS

According to the National Bioethics Consultative Committee (NBCC) report *Access to information - An analogy between adoption and the use of gamete adoption*, the promise of anonymity to semen donors was originally introduced to quiet their concerns in two areas568:

- donors feared they could be considered legally liable for the maintenance of their DI children or that these children may be able to claim inheritance rights. This concern has been dealt with by legislation which recognises the social father as the legal father;

- donors had concerns about their privacy. The NBCC felt that although it is reasonable for the donor’s privacy to be respected “it does seem to elevate the interest of the donor above those of the child ... While the donor chooses to involve him or herself ... the child is given no such choice”.


A former sperm donor from Victoria did not believe that donors have the right to remain anonymous and that any offspring should have the right to know who the donor is. However, he felt that there should be legislation to protect donors against actions taken by recipients of donor gametes and embryos or children born as a result of donor gametes or embryos, for transmission of infectious disease or inheritance of a genetic disorder, providing the donor did not provide false or misleading information.

The Select Committee was told that prior to donation, donors should be informed that information will be made available on request to the offspring. However, as discussed previously, the Select Committee was aware that Direction 4.2 ensured that donors are told that identifying information could be made available to donor offspring in the future.

Lui, et al. (1995) conducted a survey of semen donors and found that potential donors demonstrated a high level of detachment from their future offspring. However, a South Australian forum to examine donor issues found that some donors were willing to be contacted by families they had helped through the clinics. Some donors were even looking forward to meeting their genetic offspring at some time in the future. Daniels (1996) also reported that “many of them (semen providers) are quite willing to be involved and see themselves as having a responsibility to offspring”.

15.7 RESPONSIBILITIES OF PARENTS

Mr Walter Merricks of DI Network discussed the issue of “responsible parenthood” that is composed of a variety of activities and obligations, and that caring for, nurturing and nourishing a child in the context of a loving relationship is at least if not more important than physically begetting a child, however ineradicable the fact of its biological origins.

DI Network also regarded “being honest with our children about the facts of their conception as an element in responsible parenthood. Big secrets are unhealthy in intimate relationships”.

569 Submission 56 - Mr K. Coleman.
570 Submission 16 - Mr Haydn Lowe.
A number of submissions indicated that parents must be required, should be obliged or encouraged to disclose information about their child’s conception. Blyth (1998) pointed out that Swedish legislation states that parents who have children by donor insemination ought to tell the child as early as possible. However, he thought it was unlikely “that many other states would follow the Swedish example of requiring parents to tell their children the truth about their genetic origins”.

The Select Committee came across conflicting views about the attitudes of DI parents towards telling their children. Professor Susan Golombok told the Select Committee that research indicated that few parents told their children. This was reiterated by Ms Jenny Blood, at the SACRT’s Donor Issues Forum. She found that most parents still do not tell their children that they have been conceived using donated eggs and sperm although they may have intended to do so at the time of conception.

In 1997, South Australia conducted a Health Omnibus Survey of the SA community. Of the 3,019 people who responded to the question “Do you think children conceived from donor insemination should have a right to know about their genetic parents or do you think the parents that raise the child should be able to keep this confidential?”, 54.4% of respondents indicated that they believed that in cases of artificial insemination by donor (AID), the child should have the right to know about its genetic parents irrespective of the patients’ wishes. Thirty two per cent felt that the details should be kept confidential.

Ms Sarah Berryman told the Select Committee that “parents of donor ‘offspring’ should not be able to consent to or prevent contact between their child and the donor. This decision should rest on the ‘offspring’ and the donor”.

In 1990, a study at a donor insemination clinic in London found that 34% of recipients proposed to tell their offspring while 61% said they would not. By 1994, 40% said yes, 31% said no and 30% were

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574 Submission 4 - FINNRAGE; Submission 34 - Mrs Natalie Peters; Submission 55 - Miss Geraldine Hewitt.
575 Submission 48 - Mr and Mrs L Galvin; Submission 49 - Mrs Shirley Lock; Submission 56 - Mr Kevin Coleman; Submission 60 - Mr and Mrs W Hewitt; Submission 61 - Ms Mandy Robinson; Submission 62 - Ms N Ruscoe; Submission 71 - Ms Michele Tardin; Submission 72 - Ms Wendy Hayler; Submission 73; Submission 74 - Ms Dennise Hughes; Submission 75 - Miss H Curry; Submission 76 - Ms L Gower; Submission 77 - Mr and Mrs K Adelsbury; Submission 78 - Mr and Mrs MJ Hull; Submission 79 - Mr and Mrs S Moffitt; Submission 81 - Ms Rose McBryde; Submission 82 - Mrs P McCann; Submission 83 - JG Cronin; Submission 84 - Mrs Jill Murphy, Submission 87 - Mr and Mrs P Long.
576 Submission 32 - Donor Conception Support Group, Submission 57 - Ms Sarah Berryman.
581 Submission 57 - Ms Sarah Berryman.
Undecided. Durna, et al. (1997) found that only 5.2% of children had been informed that they had been conceived by DI.

In her submission, Mrs Val Rose said that “parents today should be prepared to help their children deal with these complex issues, we were not”.

Research from the UK indicated that parents using donor services were not receiving enough assistance in telling their children about their genetic origins.

In their submission, Dr Broderick and Dr Walker concluded that:

- there is no evidence that either anonymity or indeed the specific confidentiality of gamete or embryo donation is detrimental to the child. In the most recent analysis of conflicting attitudes to information exchange, Shenfield and Steele (1997) state ‘In the face of the lack of evidence on the consequences of secrecy and openness, it is concluded that future parents are best placed to decide on this matter for the potential children’.

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584 Submission 41 - Mrs Val Rose.


586 Submission 22 - Dr Pia Broderick and Dr Iain Walker.

15.7.1 Reasons for not telling offspring

The Select Committee heard that parents have a number of reasons for not telling their children about their conception. Reasons cited include fear of rejection, e.g. social fathers fear losing the love of the child. In the past, secrecy was seen as protecting the donor’s interests, the parents’ privacy and the child’s emotional wellbeing. It was seen to be well meaning. Hallebone (1988) stated that the fear of gossip hurting their children prevented couples from telling other people.

The practice of mixing semen from the husband with donor semen was more commonplace in the early 70s. The Select Committee heard from a nurse who worked in the ACT in 1982/83. At that time, she was required to give AI using a mix of donor and husband’s semen. The rationale behind semen mixing was that there was at least a minimal chance that the husband may have fathered the child. Alternatively, men were encouraged to engage in sexual intercourse with their partners around the time of insemination. In WA, Direction 8.3 prevents deliberate mixing of gametes or embryos in the procedure “in such a manner as may create confusion as to the biological parentage of any child born”.

Another reason for not telling the child is the public misconception that male virility equates with fertility. McWhinnie (1996) referred to “the question of keeping a child’s origins a secret being compounded by public attitudes to male infertility as a subject for potential derision.”

Cook, et al. (1995) identified a number of reasons given by mothers for not telling their offspring:

- concerns for the child
- exposing the father’s infertility and possible implications for family relationships;
- uncertainty about timing and method of telling, and
- the lack of genetic information to give to the child.

One of the barriers reported by parents to sharing information with their donor offspring is the lack of available information. The Select Committee heard from different sources that even if a child is told that they were conceived through DI, they may not be able to access any personal or medical information about the donor, since the donor remains anonymous. This may lead to “negative psychological consequences similar to those experienced by adoptive children.”

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589 McWhinnie A. 1996.
592 Submission 49 - Mrs Shirley Lock.
593 McWhinnie A. 1996.
15.8 PARALLELS WITH ADOPTION

The Select Committee was informed about differences and similarities between adoption and donor insemination.

The Adoption Act 1994 (WA) “recognises the need for people affected by adoption to have the opportunity to have access to adoption information”.

Parents of DI children draw parallels with the experience of adopted children searching for their biological parents when they reach maturity. Durna, et al. (1997) stated that “it may be possible for an adopted child to identify and make contact only with the birth mother, who may not identify the father to her child, a situation similar to donor insemination”.

The Commissioner of Health felt that many of the issues surrounding information about genetic parentage have some similarities with those considered during the recent review of the Adoption Act in Western Australia.

In 1988, the NBCC concluded that there are major differences between adoption and the use of donor gametes. It was felt that -

the intentions behind the practices are quite divergent. On the one hand, adoption is a legal and social salvage operation for the unwanted or abused child. On the other hand, DI and all reproductive technologies are medical and technical procedures, undertaken to deliberately procure the creation of a child.

The NBCC also felt that adoption is seen to be child-centred with the child’s interests being of paramount importance while reproductive technology tends to be parent-orientated with the interests of the recipient couple as the main concern. It recognised that the interests of the child “are not being fully represented”. It concluded “only when important gaps in our knowledge of the effects of genealogical bewilderment are filled, will the access to information issue be resolved”.

In modern adoption practice, prospective adoptive parents who indicate they would not tell the child, would be considered unsuitable. DI prospective parents are left to make their own decisions as to whether to tell the child or not.


598 Submission 50 - Dr Edda Simeoni.


600 Submission 36 - Commissioner of Health.

One submission indicated that “beyond the similarity of intent to have children, and the common facts of infertility and some disjunction of biological relationship, the two procedures are dramatically different” and lists some of the differences between the procedures.\footnote{602}

- Genetics and biology: In adoption all the child’s genes are contributed by a man and woman who do not raise the child. In assisted conception often only half the genes are contributed by a donor (oocyte/sperm) while the other half are contributed by the recipient. The mother carries the child, and gives birth and the child is born into the family that will raise it;

- Genealogy vs genetics: They feel genealogical relationships are culturally and socially constructed. They are not necessarily biological relationships;

- Motivation: Typically relinquishing parents do not choose to conceive while parents conceiving using donated gametes or embryos make a deliberate choice to conceive a child;

- Emotional attachment: While relinquishing parents in adoption experience a profound sense of emotional attachment and loss, donors do not report emotional attachment to the material they donate or to the children conceived as a result.

According to Shenfield and Steele (1997) “adopted children are ‘by definition abandoned by their genetic parents at an early stage and children of assisted reproduction, [are] very much wanted by the parents who are going to care for them, even before conception’” \footnote{603}.

Klock, et al. (1994) agreed that DI differed from adoption in four important ways\footnote{604} -

- the woman has contributed the oocyte;
- the woman has gestated and delivered the child;
- the child was not “given up” by a biological parent; and
- donor insemination is generally disapproved of by the general public.

They continued that for these reasons it cannot be assumed that “the acceptable guidelines for adoption are always applicable to every family formed using donor insemination”.

While the Select Committee acknowledges the adoption model may not be entirely applicable to DI and ART, nevertheless, the research indicating that it was in the child’s best interests to be able to access identifying information, compelled the Select Committee to support the availability of identifying information to offspring.
CHAPTER FIFTEEN - RECOMMENDATIONS

**Recommendation 15a**

That in future, access to donor identifying information be available on request to any donor offspring upon attaining the age of 16 years.

**Recommendation 15b**

That donor offspring have access to donor identifying information retrospectively where -

(i) the donation was made after the commencement of the *Human Reproductive Technology Act 1991*; and

(ii) there is clear evidence that the donor was informed that disclosure of identifying information was likely should there be future change in policy or legislation.

**Recommendation 15c**

That a retrospective voluntary register be established based on the mutual consent between the donor who donated prior to the *Human Reproductive Technology Act 1991* and donor offspring.
CHAPTER SIXTEEN

COUNSELLING AND CONSENT

16.1 INTRODUCTION

The importance of providing counselling and information prior to obtaining consent from participants in reproductive technology procedures has been recognised for a number of years.

In 1991, the NBCC recommended that information and counselling for decision-making should be provided routinely to all clients of reproductive medicine units, including those considering using donor gametes or donating gametes; the provision of information and the process of counselling for decision-making should be undertaken prior to and separately from the act of consent to treatment.

In WA, it is a condition of all licenses that each participant must be given a suitable opportunity to receive appropriate counselling about the implications of the proposed procedures and other relevant information. In addition, participants must receive information prior to giving effective consent to any artificial fertilisation procedure including information about counselling.

16.2 COUNSELLING

There are requirements under the HRT Act for counselling as provided by sections 18(2)(a), 22(7) (a) and 33(2)(c) and extensive Directions have been issued (section 5). Counselling is considered “an important element in the provision of reproductive technology services, and consideration may be useful in determining the adequacy of counselling and information about entitlements to free counselling provided by licensees”. The RTCCC indicated that the importance of counselling in relation to treatment is set out clearly in the HRT Act (Section 18(2)).

According to the NHMRC’s ethical guidelines -

- counselling of a supportive or therapeutic nature should be available as an integral part of any ART program;
- counselling may be provided within, or independently of, the clinic. It should be incorporated into the routines of the clinic and be available as part of long-term follow-up.

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607 Submission 66 - RTCCC.

In a study of women who had undergone IVF treatment, 76 - 87% of them felt that the availability of counselling would be of value at different stages of IVF treatment.609

16.2.1 Incidence of counselling

The requirements by licensees to ensure provision of counselling and assistance with decision making are set out in section 5 of the Directions.

Within certain limits, licensees in WA are required to make counselling routinely available and free of charge in association with IVF and related treatment cycles. Direction 5.2 states that -

the licensee must ensure that the cost of at least one hour with an approved counsellor for each IVF cycle begun, as well as an extra hour when the decision is being made to withdraw from further IVF treatment, is included in the overall cost of treatment.

Recommendation 16a

That Direction 5.2 which states that “the licensee must ensure that the cost of at least one hour with an approved counsellor for each IVF cycle begun, as well as an extra hour when the decision is being made to withdraw from further IVF treatment, is included in the overall cost of treatment” be endorsed and supported.

That wherever counselling is mandatory, the cost of the counselling be included in the overall cost of the treatment.

That the Western Australian Minister for Health approach the Federal Minister for Health to request that the cost for counselling of gamete donors be a fully rebateable Medicare item.

Despite the Directions, the Select Committee heard that many couples choose not to have counselling.

The Select Committee was also told that “counselling is only paid for if you have had IVF ... but that it does not involve treatment using donor gametes”.610 This is addressed in Direction 5.7 -

the licensee must ensure that all recipients of donated human reproductive material are provided with comprehensive information, in the form approved by Council in accordance with Directions 2.35 and 2.36, which is designed to strongly encourage at least one session with an ‘approved counsellor’ to assist in their decision making and cover medical, social and secrecy implications of rearing a child born after donation.

There are currently 24 “approved” counsellors in WA. In 1997/98, a total of at least 846 counselling sessions were provided in WA, to couples or individuals at the three clinics offering IVF procedures.


610 Ms Antonia Clissa. Evidence to the Select Committee, 9 March 1998.
These sessions included counselling of donors and recipients of DI as well as IVF and related procedures. Data from one clinic indicated that 15.4% of the counselling sessions were associated with the use of donated human reproductive material, including donor insemination, 73.0% were pretreatment sessions and 11.6% were for stress and support. In 1996/97, the ratio of the total number of counselling sessions carried out to the total number of IVF and related cycles begun was 0.36.

Ms Sue Midford told the Select Committee that WA undertakes the least amount of counselling of patients compared with other states. She continued that “it has the lowest rate of counsellors to patients in clinics”. WA employs sessional counsellors, whereas in other states, clinics employ full-time or part-time counsellors. “Counsellors could do much more here if they were available more, they could do innovative work”. Ms Midford perceived the situation in WA as a “cost-cutting exercise ... It is the way it is approached. Most clinics employ counsellors on an hourly rate which is considerably higher than it would be if they were employed on a full-time basis. They are paid to be available for limited periods”.

Concern was expressed to the Select Committee about the adequacy of medical direction and the compliance with requirements to inform about and promote counselling entitlements in two WA clinics.

From the information it received, the Select Committee was concerned about whether obligations with regard to counselling were being met and Members doubted that counselling was available as an integral part of ART programs as recommended by the NHMRC’s ethical guidelines. In order to determine how uptake of counselling services can be improved, the Select Committee proposed that an audit of current services should be undertaken.

**Recommendation 16b**

That an audit of counselling services in Western Australia be conducted.

That on the basis of the results of the audit, the Reproductive Technology Council in conjunction with the Health Department of Western Australia and clinics address the obvious need for mid and post-treatment counselling.

The Select Committee noted the existence of infertility and donor conception support groups in WA and acknowledged the valuable role that they play.
Recommendation 16c

That support groups be included as part of the audit referred to in Recommendation 16b.

That, at the conclusion of the audit, the support groups be properly resourced.

16.2.2 Counselling in regional areas

The Select Committee heard that there need to be more community-based counselling services for regional areas, such as telephone access. Of the 24 “approved” counsellors at June 1998, five practised outside the metropolitan area (two also had metropolitan practice addresses) and only one was qualified to assist with child-related “telling issues” associated with donor conception.

The Health Department of WA-funded Telephone Information Service (TIS) at the Family Planning Association of WA operates a 1800 telephone number. Collated figures from June 1994 to June 1995 showed that of the 15,355 calls received, at least 246 (1.8%) were about infertility. There were 1,257 calls to the service from country areas. In 1996, a pilot project funded by the RTC was conducted to promote the TIS for infertility information and counselling. The campaign resulted in an increase in infertility-related calls indicating that “the un-met need for infertility information and support in rural areas is substantial”. The RTC considered that “continued funding and promotion of the FPATIS would help redress some of the imbalance those living in rural areas face in terms of access to infertility services”. In March 1999, the RTC and FPA conducted another month-long campaign. The Telephone Information Service, re-named the Sexual Health Help Line, was promoted through rural GP surgeries and local media. The Select Committee welcomed the campaign but was concerned that the issue of infertility would be lost under the heading of sexual health. The Select Committee would like to see the establishment of a line specific to infertility issues.

The RTC has tried to address the issue of approved counsellors in regional areas and provided financial support to people to attend training. Most of those people have since “dropped off the list of counsellors” due to lack of ongoing support and the problem of increasing expertise when there is such a small population to draw upon. ANZICA acknowledged that in remote areas the only appropriate person for a position may not be eligible for ANZICA membership. It suggested that “this person should be taking active steps to upgrade qualifications and experience such that full ANZICA membership may be granted”.

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614 Ms Sue Midford. Evidence to the Select Committee, 9 March 1998.


617 RTAC. Code of Practice. Attachment B.
In Victoria, a number of satellite clinics have been established in country areas. In the early days, counsellors from the metropolitan area attended satellite clinics for three or four days to counsel patients who were due to enter programs. Now some larger regional centres engage local counsellors.

The Select Committee felt that in recognition of unmet needs in regional areas for information and counselling services, the Reproductive Technology Council in conjunction with the Health Department of WA should develop strategies to attract and retain approved counselling services in these areas.

**Recommendation 16d**

That the Reproductive Technology Council in conjunction with the Health Department of Western Australia develop strategies to attract and retain approved counselling services in regional areas.

That these services augment the telephone information service that already operates.

That the telephone information service be expanded and promoted statewide and provided with appropriate funding to achieve this outcome.

That there be a telephone line specific to infertility services that is not linked to other sexual health issues.

16.2.3 Mandatory counselling

According to the NSW Review of the *Human Tissue Act 1983*, there are many types of medical treatment where provision of counselling is very important but is not mandated by law, eg. genetic testing, and HIV services. In addition, the NSW Review suggested that in the area of ART, mandatory counselling may be regarded as an infringement of personal liberties. It may even be counter-productive where couples do not want to undergo counselling.

With the exception of the situation where a donor is known to a recipient (Direction 5.8) counselling is not mandatory in WA. However, the Select Committee was told that counselling should be mandatorily available. "People should be encouraged to use it, but they should not be forced to use it when undergoing all procedures ... our experience with mandatory counselling is that people become very cross". However, it was felt that counselling should be mandatory in some areas “such as known donors and surrogacy”. Ms Maggie Camp agreed that counselling should not be mandatory “except when making a decision to donate or receive donated material”. The Donor Conception Support

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619 Ms Sue Midford. Evidence to the Select Committee, 9 March 1998.
620 *ibid.*
621 Submission 53 - Ms Maggie Camp.
Group of WA suggested that facilities must be made available for long-term specialised counselling for donors, donor recipients and offspring.\(^{622}\)

The NHMRC felt that women and men who consider assisted conception should be strongly advised to seek counselling prior to embarking on the program. It indicated that\(^{623}\) -

"counselling should be available as part of broad infertility management and thus should be available before, during or after assisted conception. Counselling should be available within as well as independently of the reproductive medicine unit. Counselling services which are independent of reproductive units should be appropriately funded."

Ms Suzanne Midford told the Select Committee of a private surrogacy arrangement which went wrong and in her opinion “would never have happened if the couples involved had the opportunity of going through some process to enable them to think about the issues involved in surrogacy.”\(^{624}\) She felt that counselling prior to surrogacy arrangements should involve all parties, including the children who are part of the various families. Surrogacy issues are addressed in Chapter Eighteen.

Dr Edda Simeoni felt that counselling should occur in all fertility clinics.\(^{625}\) Quality counselling services must also be available to all donors. DI should not be undertaken unless all parties - couple and donor, are fully informed and counselled beforehand. She added that counselling and professional support should be available at different times in a person’s life. Issues relating to creation and parenting of DI children, for example, may not emerge until later when donors are older or have children of their own, when parents decide to tell and when children want to trace their roots.

Other jurisdictions

The Law Reform Commission of NSW recommended that counselling should not be mandatory for every IVF patient, however, “it should be a compulsory condition of practice licenses that adequate counselling facilities be available and be formally offered to all IVF clients”.\(^{626}\)

In the UK, no-one is obliged to accept counselling “but it is generally recognised as beneficial”.\(^{627}\) Under section 13(6); schedule 3 para 3 (109a) of the Human Fertilisation and Embryology Act 1990, people seeking licensed treatment (IVF or treatment using donated gametes) or consenting to the use or storage of embryos, or to the donation or storage of gametes must be given “a suitable opportunity to receive proper counselling”.

In SA, counselling is not mandatory but the SACRT has recommended counselling for clients on the paramount importance of the welfare of the child (see Chapter Three).

\(^{622}\) Submission 34 - Mrs Natalie Peters.

\(^{623}\) NHMRC. 1995: 43.

\(^{624}\) Ms Sue Midford. Evidence to the Select Committee, 9 March 1998.

\(^{625}\) Submission 50 - Dr Edda Simeoni.


\(^{627}\) HFEA. Code of Practice. 1998: 37.
However, under the Victorian *Infertility Treatment Act 1995*, a woman and her husband or *de facto* partner must have received counselling from an approved counsellor prior to undergoing a treatment procedure as must gamete and embryo donors. One submission indicated that “mandatory counselling such as under the *Infertility Treatment Act 1995* seems ... inconsistent with the underlying principles of counselling”.

According to Lui, *et al.* (1995), counselling for semen donors “should be statutory to explain the future implications of donation, as we believe potential donors may not be fully aware of all the long-term aspects of a donation”.

The Select Committee considered the issue of mandatory counselling for all parties involved with reproductive technology. Members were strongly in favour of counselling and regarded it as very important. However, Members preferred to make counselling mandatorily available and favoured strong encouragement of counselling prior to, during and after treatment.

Whilst the Select Committee did not endorse the introduction of mandatory counselling in all instances, Members agreed that mandatory counselling should continue for both donors and recipients in the situation where the donor is known to the recipient (Direction 5.8). In addition, Members recommended that there should be mandatory counselling for all gamete donors and recipients (Chapter Five, Recommendation 5h) and that counselling should be mandatory prior to posthumous use of embryos (Chapter Eight, Recommendation 8j). The Select Committee also felt that if surrogacy is allowed in WA, counselling should be mandatory for all parties involved. This is discussed further in Chapter Eighteen.

### 16.2.4 Types of counselling

As stated previously, the NHMRC indicated that “counselling of a supportive or therapeutic nature should be available as an integral part of any ART program”.

The HFEA’s Code of Practice refers to three types of counselling that should be made available in appropriate cases -

- **implications counselling** - to enable the person concerned to understand the implications of the proposed course of action for themselves, for their family, and for any children born as a result. It may include genetic counselling;

- **support counselling** - to give emotional support at times of particular stress, e.g. when there is a failure to achieve a pregnancy;

- **therapeutic counselling** - to help people to cope with the consequences of infertility and treatment, and to help them to resolve the problems which these may cause. It includes helping people to adjust their expectations and to accept their situation.
ANZICA also believes that counselling should include the three types mentioned above.\(^{632}\)

A New Zealand report “Assisted Human Reproduction - Navigating Our Future” commented that “counselling for openness in a couple considering donor insemination might include all of the types (implications, support and therapeutic)”.\(^{633}\)

Under the Human Fertilisation and Embryology Act 1990, a woman shall not be provided with treatment unless she and, where she is being treated with a man, the man have been given a suitable opportunity to receive proper counselling about the implications of the treatment steps and have been provided relevant information. Support and therapeutic counselling should be provided in appropriate cases or the people should be referred to more specialised counsellors.\(^{634}\)

16.2.5 Training and suitable qualifications for infertility counsellors

In 1991, the National Bioethics Consultative Committee (NBCC) recommended that\(^{635}\): training programs for accreditation of infertility counsellors need to be developed by appropriate educational and other bodies in each state, in consultation with the relevant Infertility Counselling Accreditation Committee.

The Australian and New Zealand Infertility Counsellors’ Association (ANZICA) is an association of professional counsellors. It has established requirements for membership. Under the RTAC’s guidelines, all clinics must have an ANZICA qualified counsellor. All donor procedures require specialist ANZICA counselling.\(^{636}\) ANZICA recommended that “all counsellors be members of ANZICA or eligible for membership”.\(^{637}\)

In WA, the RTC has set the criteria for approval of counsellors. Under Direction 1.1, “the Licensee and person responsible ... must ensure that ... counselling by an “approved counsellor” who is eligible for full membership of the Australian and New Zealand Infertility Counsellors’ Association (ANZICA) is provided, in accordance with section 5 of the Directions”. The RTC maintains two lists of approved counsellors. The first is a general list of people who have been approved by the RTC and the second lists counsellors who are skilled and knowledgeable in telling children that they have been conceived.

\(^{632}\) RTAC. Code of Practice. Attachment B.


\(^{634}\) Human Fertilisation and Embryology Act 1990 s. 13(6); Schedule 3 para 3(1)(a).


\(^{636}\) Ms Kay Oak. Meeting with the Select Committee, Melbourne, 24 March 1998.

as a result of reproductive technology.\textsuperscript{638} The Select Committee also heard that the RTC offers training opportunities for counsellors from time to time.

The HFEA Code of Practice, states that unless it is engaged only in research, a centre should ensure that at least one of its staff has suitable counselling qualifications or that a person with suitable qualifications is available as required.\textsuperscript{639}

\begin{quote}
\textbf{Recommendation 16e}

That the Reproductive Technology Council be supported in its endeavour to ensure that counsellors operating in the area of assisted reproductive technology are eligible for full membership of the Australian and New Zealand Infertility Counsellors’ Association.
\end{quote}

16.2.6 Records

Under Section 18(2)(a) and (b) of the HRT Act, the regulations or the Code may -

establish criteria as to the consent required of participants ... as to the qualifications of counsellors and the adequacy of the services provided for counselling, and as to the particular circumstances when counselling should be offered;

provide for the obtaining and recording of an effective consent on the part of particular participants.

Under Direction 2.30, licensees must include summary information on required counselling in the Annual Report. The information includes -

in numerical terms, counselling sessions provided during the previous year, the number of individual participants and couples counselled, the proportion counselled of those undergoing treatment or donating, and other counselling activities carried out on behalf of the licensee.

ANZICA stated that “documentation by counsellors is essential and should be seen as a routine system of accountability. It is usual practice for the counsellor to make an entry in the patient’s clinical record after each session”.\textsuperscript{640}

In the UK, the HFEA Code of Practice states that a record should be kept of all counselling offered and whether the offer was accepted.\textsuperscript{641} In addition, the Code states that information obtained during counselling should be kept confidential.

16.2.7 Research

\textsuperscript{638} Ms Sue Midford. Evidence to the Select Committee, 9 March 1998.

\textsuperscript{639} HFEA. Code of Practice. 1998: 9.

\textsuperscript{640} RTAC Code of Practice. Attachment B.

\textsuperscript{641} HFEA. Code of Practice. 1998: 42.
The NHMRC (1995) suggested that some approaches to counselling “appear not to have of themselves been systematically evaluated in regard to their effectiveness and/or their outcomes on physical and psychological health and wellbeing”.\(^{642}\) It recommended that “specific research studies should be undertaken to evaluate the outcomes and/or effects of various interventions and techniques used in counselling processes”.

ANZICA recommended that\(^{643}\) -

> counsellors contribute to the research projects undertaken at their Centres. Collaborative work among the professional groupings is to be encouraged. Further, counsellors working in the ART’s have the unique opportunity to document the psychosocial aspects of this technology”.

Members of the RTCCC were concerned that very little psychosocial research is taking place. Issues that need to be addressed include how couples cope with failure after they go through the technology and are unsuccessful in having a child, problems parents who use the technology have raising children or the effects of donation. The RTCCC provided a submission to the Australian Health Technology Advisory Committee indicating that it would “like to see some kind of research institute ... a national body funded by the States in some way with the capacity to provide structure and guidance to a wide variety of psychosocial research in this area”.\(^{644}\)

The Select Committee noted the lack of research. Members felt that research was important to examine the impact of reproductive technology upon the development of the offspring. The Members also noted the establishment of the Family and Children’s Policy Office within the department for Family and Children’s Services and considered that it might be a suitable body to undertake research.

### Recommendation 16f

> That the Reproductive Technology Council be encouraged to refer the need for psychosocial research in the area of reproductive technology to a research facility within the newly established Family and Children’s Policy Office within the department for Family and Children’s Services.

#### 16.2.8 Provision of information

Following consultations and the handing down of the judgment in Rogers and Whitaker (1992)\(^{645}\), the NHMRC issued its “*General guidelines for medical practitioners on providing information to patients*”.\(^{646}\) The document addressed the type of information to be given to patients, the manner in which information should be given and circumstances for withholding information.
The Select Committee was told that consumers must receive high quality information in order to be able to give properly informed consent to HRT procedures.\(^{647}\) It was suggested that licensed providers should give correct information about the entitlements of participants and offspring to identifying information.\(^{648}\)

Directions 4.1 and 4.2 address information to be provided to participants prior to them giving effective consent and additional information to be given in relation to the use of donated reproductive material.

The NHMRC’s ethical guidelines address information giving.\(^{649}\) The guidelines state that -

- prior to any ART procedure, a participant must be given all information which may be of significance;
- those who are to give consent should be given an oral explanation, supported by written information;
- informed decision-making is required for all participants, including donors of gametes and embryos;
- participants should be informed about the importance of follow-up and the need to evaluate long-term effects of treatment;
- any person and his or her spouse or partner, donating gametes and consenting to their use in an ART procedure where the intention is that a child may be born must ... be informed that children may receive identifying information about them.

The HFEA distinguishes between information giving and the offer of counselling. Under the Human Fertilisation and Embryology Act 1990, anyone to be given licensed treatment or who consents to the use and storage of embryos, or the donation or storage of gametes must be given “such relevant information as is proper”.\(^{650}\) The Select Committee received a submission that supported the HFEA’s approach.\(^{651}\)

16.3 CONSENT

The NHMRC’s ethical guidelines address consent issues.\(^{652}\) They state that -

- consent should be given in accordance with existing State legislation and with the Code of Practice of the accreditation body (currently RTAC);
- consent must be given in writing following provision of information and adequate opportunities for personal preparation;
- it is the responsibility of the medical practitioner to ensure that participants are aware of the implications of proposed treatments and that they have consented in a free and informed way;

\(^{647}\) Submission 20 - Ms Astrid Norgard.

\(^{648}\) Submission 24 - S Tarrant, Law School, University of WA.

\(^{649}\) NHMRC. 1996: 5.

\(^{650}\) HFE Act 1990 s13(b); Schedule 3 para 3(1)(b).

\(^{651}\) Submission 70 - Mr Eric Blyth.

• an ART procedure, including one where donor gametes and embryos are used, may only be carried out after the consent of the person to be treated and any spouse or partner of that person;
• the gamete provider and any spouse/partner of that person, must give consent to the keeping or use of any gametes. If the intention is to create an embryo or embryos outside the body, this consent must specify the purpose or purposes for which that embryo or embryos may be used, namely -
  ▶ to provide treatment for the provider or the provider and a named partner;
  ▶ to provide treatment for others; or
  ▶ for specified research.

The RTAC’s “Code of Practice for centres using assisted reproductive technology” includes some guidelines that address consent\(^\text{653}\) -

• it is the medical practitioner’s duty and responsibility to ensure that voluntary and informed consent is obtained in writing on approved forms prior to ART treatments;
• the patients must be able to consent to the procedures with knowledge and understanding;
• the consent form should be simple and as free as possible from complex medical and legal terms and jargon. Misleading indemnity clauses should not be included. (Attachment F to the Code of Practice provides a list of topics that should be covered in a consent form);
• patients should be given the appropriate consent forms prior to the beginning of any ART procedures and given time to study them;
• patients should be given their own copy of signed consent forms;
• consent forms should be approved by RTAC and will be examined at site visits. Forms for new procedures or major revisions should be submitted to RTAC in the intervals between site visits.

The Select Committee noted the RTAC guidelines and believed that they should be adopted by the RTC.

Recommendation 16g

That the consent guidelines contained within the Reproductive Technology Accreditation Committee’s Code of Practice, for the time being prescribed, be adopted under the Human Reproductive Technology Act 1991’s Code of Practice (referred to in Recommendation 10b).

16.3.1 Western Australia

Part 3, Division 2 of the Human Reproductive Technology Act 1991 addresses “consents”. Section 22 addresses “consents, generally”. Section 22(7) and (8) of the HRT Act states that in order for consent to be effective, each participant must have been provided with a suitable opportunity to receive proper counselling and other relevant and suitable information. In addition, consent will not be effective unless -

Consent forms

The RTC has prepared a number of draft consent forms to be used. These are included in Appendix F. According to the Draft Guidelines (3.7), although the format of the consent forms may vary between clinics, “it must be evident to the Council that all requirements of the Act, Code and directions are met. Currently, under Direction 2.35, “the person responsible” must notify the RTC of any changes to either the patient information sheet or consent form, at or before the time the new or amended sheet or form is introduced. The Select Committee was informed that the RTC is currently reviewing the consent forms.

Figure 3 indicates the stages where consent is required under the HRT Act.

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654 Memorandum to Select Committee from Ms Carol Whish-Wilson, 25 September 1997.

655 Dr Sandra Webb. Personal communication to the Select Committee.
CONSENT TO DONATE GAMETES (Form 1.1)
CONSENT FOR AN ARTIFICIAL FERTILISATION PROCEDURE (AI, IVF, GIFT)
. . . Stop here if AI only . . .
DISPERSAL OF EGGS
. . . stop here if GIFT only . . .
DISPERSAL OF EMBRYOS (all prior to start of IVF procedure)

CONSENT TO RECEIVE DONOR GAMETES (Form 1.2)
(prior to AI procedure)

CONSENT TO RECEIVE DONOR EMBRYOS (Form 1.3)
(prior to IVF procedure)

CONSENT TO STORE EMBRYOS (Form 2.1)
(at time of storage)

CONSENT TO DONATE EMBRYOS (Form 2.2)
(at time of donation)

CONSENT TO DONATE GAMETES (Form 1)

CONSENT TO RECEIVE DONOR EMBRYOS (prior to IVF procedure) (Form 2.1)

CONSENT TO THAW EMBRYOS (Form 3.1)
(at time of thaw)

CONSENT FOR INNOVATIVE PROCEDURE (Form 4)

AT TIME OF DONATION

DISPERSAL OF SEMEN (store/thaw) (Form 1.4)

DISPERSAL OF EMBRYOS

The Select Committee felt strongly that clinics should use standardised consent forms.

**Recommendation 16h**

That the Reproductive Technology Council in conjunction with clinics develop standardised consent forms.

### 16.3.2 Consent for use or storage of gametes or embryos.

Direction 3.1 states that “the person responsible must ensure that the required consents are given in relation to the use or storage of any gametes or embryo under the licence”.

Under Direction 3.2, the “person responsible” must ensure that any consent to store gametes is renewed every five years. In addition, under Direction 3.3, they must ensure that no consent is given for a use not permitted under the HRT Act, including the use of gametes of a person known to be dead.

The NHMRC’s ethical guidelines 3.26 and 3.27 address consent to the use and storage of both gametes and embryos.\(^{656}\)

Consent issues with regard to storage and use of gametes and embryos and with particular reference to disputes and posthumous use are addressed in Chapters Eight and Nine. A recent review of consent provisions in the *Human Fertilisation and Embryology Act 1990* recommended that\(^{657}\)

- for the removal of gametes, unless one of the current exceptions to the general rule, (e.g. necessity or best interests) can be established, the requirement that formal consent following adequate disclosure of information is legally necessary should remain;
- the law should be amended to provide that, where a court has declared that it is in the “best interests” of an incompetent person to have gametes removed pending their decisions once competence is restored, the Human Fertilisation and Embryology Authority has the power to waive the consent requirements for storage for the duration of the incompetence of the donor;
- ... given that - at least in part - the written consent requirement is justified by the special status of gametes, and that it has *prima facie* higher probative value as to the intention of the donor, consideration should be given to requiring that consent to all assisted reproduction provided under the terms of the 1990 Act should be given in writing.

With regard to posthumous use of embryos, the majority of the Select Committee agreed that the consent form must be amended to obtain written consent for the procedure to occur.

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\(^{656}\) NHMRC. 1996: 7.

\(^{657}\) McLean SAM. 1998.
Recommendation 16i

That in light of Recommendation 8j, consent forms be amended to ensure that an election as to whether posthumous use of embryos may proceed is made by the people with rights and responsibilities to make decisions about the embryos.

The Member for Joondalup dissented again opposing the posthumous use of embryos.

16.3.3  Consent of husband or male partner and legal fatherhood

A number of Directions address consent to an artificial fertilisation procedure.

Direction 3.4 states that -

- any person to whom the licence applies proposing to carry out an artificial fertilisation procedure must ensure that -
  - prior to an IVF procedure, effective consent is given by the recipient’s husband or de facto partner;
  - prior to an AI procedure, effective consent is given by the recipient’s husband or de facto partner, if any; and
  - any other person required under the Act to give effective consent has done so.

Under Direction 3.5 -

prior to donation of gametes or an embryo for an artificial fertilisation procedure any person to whom the licence applies overseeing such a donation must ensure that effective consent is given by the gamete provider, and that the gamete provider’s current husband, wife and/or de facto partner, also gives effective consent.

Direction 3.6 states that -

- any person to whom the licence applies or Exempt practitioner who proposes to use or direct the use of donor gametes or any donor embryo in an artificial fertilisation procedure must ensure that the husband, wife or de facto partner of the recipient has given effective consent.

As referred to previously (Chapter Twelve), if a woman undergoes treatment using donor gametes without her husband’s consent, the husband may not be regarded as the legal father. Under the Family Law Act 1975 (Cwlth), the status of the donor is unclear. The Select Committee addressed this issue in Recommendation 12a.

In the UK, “a woman’s husband will be the legal father of a child born as a result of treatment using donated sperm unless they are judicially separated or he can prove that he did not consent to the treatment”.

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CHAPTER SIXTEEN - RECOMMENDATIONS

Recommendation 16a

That Direction 5.2 which states that “the licensee must ensure that the cost of at least one hour with an approved counsellor for each IVF cycle begun, as well as an extra hour when the decision is being made to withdraw from further IVF treatment, is included in the overall cost of treatment” be endorsed and supported.

That wherever counselling is mandatory, the cost of the counselling be included in the overall cost of the treatment.

That the Western Australian Minister for Health approach the Federal Minister for Health to request that the cost for counselling of gamete donors be a fully rebateable Medicare item.

Recommendation 16b

That an audit of counselling services in Western Australia be conducted.

That on the basis of the results of the audit, the Reproductive Technology Council in conjunction with the Health Department of Western Australia and clinics address the obvious need for mid and post-treatment counselling.

Recommendation 16c

That support groups be included as part of the audit referred to in Recommendation 16b

That, at the conclusion of the audit, the support groups be properly resourced.
Recommendation 16d

That the Reproductive Technology Council in conjunction with the Health Department of Western Australia develop strategies to attract and retain approved counselling services in regional areas.

That these services augment the telephone information service that already operates.

That the telephone information service be expanded and promoted statewide and provided with appropriate funding to achieve this outcome.

That there be a telephone line specific to infertility services that is not linked to other sexual health issues.

Recommendation 16e

That the Reproductive Technology Council be supported in its endeavour to ensure that counsellors operating in the area of assisted reproductive technology are eligible for full membership of the Australian and New Zealand Infertility Counsellors’ Association.

Recommendation 16f

That the Reproductive Technology Council be encouraged to refer the need for psychosocial research in the area of reproductive technology to a research facility within the newly established Family and Children’s Policy Office within the department for Family and Children’s Services.

Recommendation 16g

That the consent guidelines contained within the Reproductive Technology Accreditation Committee’s Code of Practice, for the time being prescribed, be adopted under the Human Reproductive Technology Act 1991’s Code of Practice (referred to in Recommendation 10b).
<table>
<thead>
<tr>
<th>Recommendation 16h</th>
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<tr>
<td>That the Reproductive Technology Council in conjunction with clinics develop standardised consent forms.</td>
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<th>Recommendation 16i</th>
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<tr>
<td>That in light of Recommendation 8j, consent forms be amended to ensure that an election as to whether posthumous use of embryos may proceed is made by the people with rights and responsibilities to make decisions about the embryos.</td>
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CHAPTER SEVENTEEN

DONATION AND PAYMENT

17.1 INTRODUCTION

The Select Committee was interested in issues relating to the donation of reproductive material. Donor concerns about access to donor information are discussed in Chapter Fifteen.

17.2 SEMEN DONATION

During 1997/98, semen was donated to WA storage licensees by 28 men (Table 10).\textsuperscript{659} There were 11 new donors. The numbers of total and new donors has continued to fall over the years. Dr John Yovich told the Select Committee that recording of identifying information has significantly reduced the number of donors prepared to donate.\textsuperscript{660} However, the effect of the decline is offset partly by the use of ICSI, where sperm from a man with a low sperm count can be used to fertilise his partner’s egg in an IVF procedure.

Table 10: Number of semen donors in Western Australia, 1992/93 - 1997/98.

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<tbody>
<tr>
<td>No. current donors</td>
<td>103</td>
<td>67</td>
<td>49</td>
<td>49</td>
<td>32</td>
<td>28</td>
</tr>
<tr>
<td>No. new donors in last year</td>
<td>40</td>
<td>23</td>
<td>28</td>
<td>30</td>
<td>20</td>
<td>11</td>
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</table>


The Select Committee noted with concern the decline in the number of sperm donors and acknowledged the strong possibility that Recommendation 15a, to allow access to identifying information, may exacerbate the situation. The Select Committee noted that in Victoria “two major clinics are about to plan a joint recruitment drive for donors of sperm”.\textsuperscript{661}

**Recommendation 17a**

That the Reproductive Technology Council devise strategies to attract an increased number of semen donors who are prepared for identifying information to be made available to offspring.

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\textsuperscript{659} RTC. Annual Report, 1 July 1997 - 30 June 1998: 27.

\textsuperscript{660} Submission 18 - Dr John Yovich.

\textsuperscript{661} Ms Helen Szoke. Correspondence to the Select Committee, 24 March 1999.
17.2.1 Donor profiles

WA semen donors appear to be getting older. In 1997/98, the proportion of donors aged less than 26 years was 21.4% compared to 34.3% in the previous year. Almost three quarters (71%) of donors were single. 662

17.3 EGG DONATION

In WA, the number of egg donors is limited and many egg donors are currently being treated for infertility themselves. Dr John Yovich indicated that the effect of recording of identifying information “is also reflected in our female donors with only 10% to 20% now prepared to donate”. 663 However, the Select Committee was told that in Victoria the shortage of egg donors is thought to be more to do with the level of intervention required to harvest the eggs. 664

Egg donation has been shown to be beneficial for older, infertile women. Templeton, et al. (1996) showed that the age effect on live-birth rate can be overcome to a great extent by using donated eggs. 665

Freezing and thawing of eggs are still not standard practices. Eggs are usually fertilised and frozen for storage. However, there have been cases discussed where frozen eggs have been used. In October 1997, the birth of babies born from eggs frozen for up to 25 months were announced by two research groups working independently in the USA and Italy. 666 Recent research has shown that immature eggs survive the freeze-thaw cycle better than mature eggs. 667

17.3.1 Ovarian stimulation

Researchers have recommended that there should be a limit of three cycles of ovum donation for both the safety and potential benefit of the donor. 668
17.4 EMBRYO DONATION

In WA, embryo donation is a rarely used option. From 1 July 1997 - 30 June 1998, only five frozen embryo transfers (0.5%) used donated embryos.\(^{669}\)

17.5 PAYMENT

According to the NHMRC’s ethical guidelines, commercial trading in gametes and embryos and paying donors of gametes and embryos beyond reasonable expenses are ethically unacceptable and should be prohibited.\(^{670}\)

In WA, it is an offence under the HRT Act (section 7(1)(j)) for donors to be paid for gamete donations - “A person, whether or not a licensee, who causes or permits gametes, an egg in the process of fertilisation or an embryo to be supplied for valuable consideration, commits an offence. However, section 7(2)(b) of the HRT Act states that reference to “valuable consideration” in section 7(1)(j) “shall not be taken to include the reasonable disbursement of any expenses incurred by the supplier in relation to that supply”. Therefore, most sperm banks offer some reimbursement to donors to compensate for any inconvenience or expense.\(^{671}\)

In the United Kingdom, the Human Fertilisation and Embryology Act 1990 (UK) states that “no money or other benefits shall be given or received in respect of any supply of gametes and embryos unless authorised by directions”. In July 1996, the HFEA announced that donors would not be paid except for expenses and in February 1998, it published a paper entitled “Consultation on the Implementation of Withdrawal of Payments to Donors”.\(^{672}\)

The HFEA’s reasons for deciding against payment were\(^{673}\):

- some donors might be being financially induced to do something they would not otherwise do, and which they may regret later on in life;
- the donation of eggs or sperm to create new life should be a gift, freely and voluntarily given.

The HFEA was concerned that donors should not be out of pocket by donating, but it did not believe that it was suitable for people to donate their genetic material to create new life for profit.


\(^{670}\) NHMRC. 1996: 15.

\(^{671}\) RTC. Sperm donation: The facts. April 1996.

\(^{672}\) Human Fertilisation and Embryology Authority. Consultation on the implementation of withdrawal of payments to donors. February 1998.

The response to the policy was not very favourable, especially from doctors and scientists who provided the service. Many felt withdrawal of payment would reduce the supply of sperm and eggs.

Golombok and Cook (1994) found that the majority of DI programs were reliant on students, and clinicians felt that financial considerations were important in continuing to access that population. Cook and Golombok (1995) found that 62% of donors would not donate if they were not paid. Thirty-nine percent of donors suggested that an increased financial incentive would produce more donors.

The HFEA is keen to ensure that the supply of egg and sperm donors is not adversely affected by removal of payments. HFEA research showed that one third of male non-donors reported they might be interested in donating semen “indicating that attention should be paid to increasing public awareness of donor insemination ... Perhaps the creation of a non-profit, national donor service would be an important factor in changing the present payment culture surrounding donation”. The UK Department of Health has approved funding of the National Gamete Donation Trust - a national charity to act as a national focus for the recruitment of donors.

In France, under the Law of 29th July 1994, sperm donation must be unpaid.

The Select Committee believed that remuneration to gamete donors should continue to be confined to reasonable out-of-pocket expenses so that the primary motivation for donation remains altruistic.

**Recommendation 17b**

That remuneration to gamete donors continue to be confined to reasonable out-of-pocket expenses so that the primary motivation for donation remains altruistic.

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17.6 SELECTION CRITERIA FOR DONORS

17.6.1 Age limits

Minimum age

In WA, Direction 7.1 addresses the minimum age for donation and states that a licensee must ensure that gametes or embryos used in an artificial fertilisation procedure are not donated by a person under 18 years of age. The RTAC sets the same minimum age limit as does the UK\(^{679}\) and France.

Upper age limit

In WA, a maximum age for donors is not specified in the HRT Act or the Directions. However, the Select Committee heard that clinics tend not to use sperm from donors over 40 years of age because of the possibility of adverse changes to sperm quality. This is reflected by Table 11.

Table 11: Age of semen donors in Western Australia, 1992/93 - 1997/98.

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<tr>
<td>18-25</td>
<td>41 (39.8)</td>
<td>19 (28.8)</td>
<td>15 (30.6)</td>
<td>19 (38.8)</td>
<td>11 (34.3)</td>
<td>6 (21.4)</td>
</tr>
<tr>
<td>26-30</td>
<td>23 (22.3)</td>
<td>16 (24.2)</td>
<td>10 (20.4)</td>
<td>8 (16.3)</td>
<td>7 (21.9)</td>
<td>8 (28.6)</td>
</tr>
<tr>
<td>31-35</td>
<td>16 (15.5)</td>
<td>13 (19.7)</td>
<td>10 (20.4)</td>
<td>13 (26.5)</td>
<td>3 (6.1)</td>
<td>4 (14.3)</td>
</tr>
<tr>
<td>36-40</td>
<td>13 (12.6)</td>
<td>10 (15.1)</td>
<td>5 (10.2)</td>
<td>3 (6.1)</td>
<td>4 (12.5)</td>
<td>6 (21.4)</td>
</tr>
<tr>
<td>41-50</td>
<td>8 (7.8)</td>
<td>8 (12.1)</td>
<td>9 (18.3)</td>
<td>6 (12.2)</td>
<td>2 (6.3)</td>
<td>3 (10.7)</td>
</tr>
<tr>
<td>&gt;50</td>
<td>2 (1.9)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>1 (3.6)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>103 (100.0)</strong></td>
<td><em><em>66</em> (100.0)</em>*</td>
<td><strong>49 (100.0)</strong></td>
<td><strong>49 (100.0)</strong></td>
<td><strong>32 (100.0)</strong></td>
<td><strong>28 (100.0)</strong></td>
</tr>
</tbody>
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* one case missing.

The RTAC’s Code of Practice states that gametes should not be taken for the treatment of others from male donors over the age of 55 years or female donors over 35 years unless there are exceptional circumstances.\(^{680}\) However, gametes can be collected from men over 55 years of age or women over 35 years of age for their own treatment or for the treatment of their partner.

In Victoria, sperm donors should be 45 years of age or under except in special circumstances, but men over 45 years can use their own gametes. Oocyte donors should be 37 years of age or under unless there are exceptional reasons.\(^{681}\)

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\(^{679}\) HFEA. Code of Practice. 1998: 22-23


\(^{681}\) Infertility Treatment Authority. *Conditions of Licence. Applications for licences by hospitals and day procedure centres*. 6 November 1997.
In the UK, the upper age limit for collection of gametes for the treatment of others is 35 years of age for women and 55 years of age for men, unless there are exceptional reasons for doing so. The HFEA reviewed evidence that was available on the genetic effects of paternal age. The HFEA decided not to lower the current upper age limit of 55 years because there was not enough “compelling evidence”.

In France, donors must be less than 45 years of age.

The Select Committee felt there should be scientific determination of the most appropriate upper age limit for gamete donors.

**Recommendation 17c**

That the Reproductive Technology Accreditation Committee be encouraged to determine an upper age limit for gamete donors based upon scientific evidence.

### 17.6.2 Other criteria

The Select Committee heard that the rules of ethics established by the French CECOS (Centres for Cryopreservation of Eggs and Sperm) are as follows - donations must be anonymous, from men living in stable couples with at least one healthy living child and with the consent of the spouse.

### 17.6.3 Donor Screening

The Select Committee was told that in WA, clinics and practitioners follow the RTAC’s *Guidelines for screening gamete donation* which outline the minimum criteria for the screening and selection of donors for semen and oocyte donor programs. Both sperm and egg donors are screened to minimise the risk of transmission of any genetic or sexually transmissible disease. Donated semen must be cryopreserved and quarantined for six months. Fresh semen must not be used for donor insemination. Donated eggs should be immediately fertilised and frozen. The resulting embryos are stored and quarantined for six months prior to use.

The NSW Human Tissue Act 1983 provides a defence for authorised and exempt suppliers of blood and semen from actions taken by a recipient who has become infected with a prescribed contaminant “HIV, Hepatitis B and C, HTLV 1 and syphilis” by receiving infected blood or semen. The defence does not cover donor eggs or embryos. A similar defence for semen exists in Victoria.

In the UK, section 3.48 of the Code of Practice states that “centres should adopt whatever is current best practice in the scientific testing of semen samples and of donors of gametes and embryos”. The

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HFEA and Department of Health have set out a procedure for centres in relation to HIV screening for gamete donors. Screening for other conditions is outlined in the HFEA Code of Practice.

In France, donor insemination with fresh semen is forbidden. CECOS centres have donor screening standards which aim to eliminate infertile or subfertile donors and donors presenting a risk to recipients or the children to be born from STDs, or hereditary diseases. Blood samples for STDs are tested again six months after the last semen donation. Sperm can only be used if the last blood sample is negative.

Under the HRT Act there is no provision to protect the RTC or clinics in the event of using HIV infected human reproductive material. Ms Leigh Newman believed there was a need for indemnity for the RTC and clinic practitioners in the event they act as reasonably, safely and honestly as possible in carrying out IVF procedures and unknowingly infect a participant. Ms Newman suggested that a defence could be inserted into the WA Human Tissue and Transplant Act 1982. However, under the Human Tissue and Transplant Act 1982, reference to tissue does not include “spermatozoa or ova”.

The Select Committee referred to Schedule 10 of the HRT Act, that gave protection to RTC members and to sections of other Acts dealing with liability of practitioners and felt that it was neither necessary nor appropriate to amend the HRT Act.

17.7 LIMIT TO NUMBER OF DONOR OFFSPRING

17.7.1 Western Australia

Under the HRT Act’s Direction 8.1 “the licensee must ensure that for each donor of gametes there are no more than five known donee families, including families that may be outside Western Australia”. Dr Bronwyn Stuckey told the Select Committee that there were both social and genetic reasons for the limit.

Where embryos have been developed using donated gametes and a couple wish to donate them, and where the donation will result in the maximum being exceeded, the “person responsible” may write to the RTC for an extension.

The RTC was made aware that several men may have been donating semen at more than one clinic. Practitioners decided to report identifying information about donors to the Register immediately to allow a check for duplication at the level of the Register.

17.7.2 France

In France, no more than five to 10 living babies can be conceived from the sperm of one donor in different families to avoid risks of consanguinity.

17.7.3 United Kingdom

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685 Submission 86 - Ms Leigh Newman.
686 Dr Bronwyn Stuckey. Meeting with the Select Committee, 9 February 1998.
In the UK, donated gametes or embryos should not be used for treatment once 10 live children have been born as a result of donations from a particular donor. The limit of 10 may be exceeded only in exceptional circumstances, e.g. where a recipient wishes to have a subsequent child from the same donor.\textsuperscript{688} If the donor has specified a limit, this must not be exceeded under the 1990 Act.

The Select Committee heard from a number of people that the limitations should be placed upon the number of families that can receive donations from one donor. Donations should be limited to five families with no limit on the number of offspring within these families. Clinics should do their best to try and have the same donor for all the offspring in one family.\textsuperscript{689-690}

The Select Committee supported maintenance of the status quo.

17.8 RESPONSIBILITIES AND RIGHTS OF DONORS

17.8.1 Donor information and consent

Under Direction 3.9 -

any person to whom the licence applies or Exempt practitioner who proposes to use semen of a donor in an artificial fertilisation procedure or direct such a use of that semen, must ensure that the donor is aware of section 6 of the Artificial Conception Act 1985, unless the donor has already specifically consented to the use of his semen in such a circumstance.

The relationship between the Artificial Conception Act 1985 and gamete donors was addressed previously in Chapter Twelve (page 156).

17.8.2 Donor identity

The Select Committee was told that both men and women who become donors should do so in the knowledge that one day the children that they have helped to create will be able to access more than non-identifying information about their biological parents. A number of submissions believed that all donors should be prepared to be identified.\textsuperscript{691} There should also be a mandatory provision for donors

\textsuperscript{688} HFEA. Code of Practice. 1998: 45.
\textsuperscript{689} Submission 56 - Mr K Coleman.
\textsuperscript{690} Submission 59 - Mr Bill Cordray.
\textsuperscript{691} Submission 48 - Mr and Mrs L Galvin; Submission 49 - Mrs Shirley Lock; Submission 56 - Mr Kevin Coleman; Submission 60 - Mr and Mrs W Hewitt; Submission 61 - Ms Mandy Robinson; Submission 62 - Ms N Ruscoe; Submission 71 - Ms Michele Tardin; Submission 72 - Ms Wendy Hayler; Submission 73; Submission 74 - Ms Dennise Hughes; Submission 75 - Miss H Curry; Submission 76 - Ms L Gower; Submission 77 - Mr and Mrs K Adelsbury; Submission 78 - Mr and Mrs MJ Hull; Submission 79 - Mr and Mrs S Moffitt; Submission 81 - Ms Rose McBryde; Submission 82 - Mrs P McCann; Submission 83 - JG Cronin; Submission 84 - Mrs Jill Murphy, Submission 87 - Mr and Mrs P Long.
to update information about themselves.\textsuperscript{692} This issue has been discussed in greater detail in Chapter Fifteen.

**Recommendation 17d**

That clinics and practitioners use standardised consent forms to ensure that prospective donors are made aware that in future, all donor offspring may elect to have access to donor identifying information.

17.8.3 Counselling

Dr Edda Simeoni felt that quality counselling services must be available to all men and women who become donors and that DI should not be undertaken unless all parties - couple and donor, have been fully informed and counselled beforehand.\textsuperscript{693} Further submissions recommended mandatory counselling for donors and that “facilities and strategies should be in place for long-term counselling for donors, offspring and recipients”.\textsuperscript{694} The Select Committee strongly encouraged counselling and believed that counselling for all gamete donors and recipients should be mandatory (Recommendation 5h). Counselling for donors is discussed more fully in Chapters Five, Fifteen and Sixteen.

17.9 PERCEPTIONS OF SPERM AND EGG DONATION

17.9.1 Sperm Donation

It was felt that there needs to be a change in the way sperm donation is perceived by the community. DI may be perceived to have a sexual connotation because it is seen to involve little physical risk with the possibility of illicit pleasure.\textsuperscript{695}

\textsuperscript{692} ibid.

\textsuperscript{693} Submission 50 - Dr Edda Simeoni.

\textsuperscript{694} Submission 48 - Mr and Mrs L Galvin; Submission 49 - Mrs Shirley Lock; Submission 56 - Mr Kevin Coleman; Submission 60 - Mr and Mrs W Hewitt; Submission 61 - Ms Mandy Robinson; Submission 62 - Ms N Ruscoe; Submission 71 - Ms Michele Tardin; Submission 72 - Ms Wendy Hayler; Submission 73; Submission 74 - Ms Dennise Hughes; Submission 75 - Miss H Curry; Submission 76 - Ms L Gower; Submission 77 - Mr and Mrs K Adelsbury; Submission 78 - Mr and Mrs MJ Hull; Submission 79 - Mr and Mrs S Moffitt; Submission 81 - Ms Rose McBryde; Submission 82 - Mrs P McCann; Submission 83 - JG Cronin; Submission 84 - Mrs Jill Murphy, Submission 87 - Mr and Mrs P Long.

17.9.2 Egg Donation

Egg donation is viewed differently from sperm donation. Egg donors are perceived as passive subjects who undergo invasive and potentially harmful procedures for altruistic reasons. In addition, many egg donors are currently being treated for infertility themselves.
## CHAPTER SEVENTEEN - RECOMMENDATIONS

<table>
<thead>
<tr>
<th>Recommendation 17a</th>
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<tbody>
<tr>
<td>That the Reproductive Technology Council devise strategies to attract an increased number of semen donors who are prepared to be identified.</td>
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</table>

<table>
<thead>
<tr>
<th>Recommendation 17b</th>
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<tr>
<td>That remuneration to gamete donors continue to be confined to reasonable out-of-pocket expenses so that the primary motivation for donation remains altruistic.</td>
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<table>
<thead>
<tr>
<th>Recommendation 17c</th>
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<tr>
<td>That the Reproductive Technology Accreditation Committee be encouraged to determine an upper age limit for gamete donors based upon scientific evidence.</td>
</tr>
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<thead>
<tr>
<th>Recommendation 17d</th>
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<tbody>
<tr>
<td>That clinics and practitioners use standardised consent forms to ensure that prospective donors are made aware that in future, all donor offspring may elect to have access to donor identifying information.</td>
</tr>
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</table>
CHAPTER EIGHTEEN

SURROGACY

18.1 INTRODUCTION

After receiving a number of submissions, considering the recommendations endorsed by the 1988 Select Committee and following a seminar convened by the RTC on surrogacy in August 1997, the Select Committee believed that surrogacy should be incorporated within its Terms of Reference.

On 17 September 1997, therefore, the Select Committee’s terms of reference were amended to include an inquiry into the current status and incidence of surrogacy arrangements in Western Australia, with particular reference to human reproductive technology, and to determine what legislation, if any, was required.

The Select Committee acknowledged that not all surrogacy arrangements required reproductive technology but Members felt that it would not be possible to address IVF surrogacy in isolation and that non-IVF surrogacy could not be ignored.

The HRT Act does not address surrogacy and there is no surrogacy legislation in WA. The status of surrogate motherhood in WA is governed by common law and whatever other existing statutes addressing child protection, adoption, reproductive technology, birth registration, State or Commonwealth Family Law happen to cover.697

The Select Committee was cognisant of the implications of common law which states that “a contract will be illegal at common law if it conflicts with public policy”.698 Any surrogacy arrangements held to be contrary to the best interests of the child would be likely to be found void and unenforceable.

In considering surrogacy, the Select Committee was aware of the reality of the situation in Western Australia in 1999 compared with ten years ago when the previous Select Committee reported. IVF surrogacy has added a new dimension to the surrogacy issue. In some jurisdictions, legal systems have formalised surrogacy and made contracts binding. West Australians can now access surrogacy arrangements in both the ACT and the United States. In addition, reproductive material is accessible and surrogacy arrangements are made via the Internet. Against this background, the Select Committee has considered the question of surrogacy based upon humanitarian grounds and acknowledged the availability of new technology.

The Select Committee felt that it would be better to have some legislation in place in WA that, at least, provided a framework for the regulation and control of surrogacy.


The Select Committee believed that it is time that Parliament dealt with the issue of surrogacy legislation and that the issue can not be ignored any longer.

18.2 TYPES OF SURROGACY

18.2.1 Definitions

The NSW Law Reform Commission defined surrogacy as

an arrangement whereby a woman agrees to become pregnant and to bear a child for another person or persons, to whom she will transfer custody at or shortly after birth.

IVF and traditional surrogacy

There are two basic types of surrogacy - traditional and IVF. Traditional surrogacy cases involve insemination of the surrogate with the commissioning husband’s sperm where she provides her eggs for *in vivo* fertilisation. Insemination may be natural or artificial. The former type of traditional surrogacy has been practised for thousands of years.

In IVF (gestational) surrogacy, a commissioning couple obtain their own genetic embryo through the IVF procedure for transfer into a surrogate woman who carries the child to full-term.

Leeton (1991) suggested that the advantages of IVF surrogacy over traditional surrogacy lie in

- the concept of the commissioning infertile couple receiving their own genetic offspring; and
- the surrogate does not provide any genetic material towards pregnancy and therefore, should have a reduced risk of bonding.

The Select Committee noted that IVF surrogacy could also involve the use of donated reproductive material to create the embryo prior to implantation.

Commercial and non-commercial surrogacy

A surrogacy arrangement can take two forms - commercial or non-commercial (altruistic). Commercial surrogacy usually involves drawing up a contract with specific items to be agreed to and fulfilled by both parties. It involves payment of a fee.

A non-commercial surrogacy arrangement often occurs between either close relatives or close friends where the relationship is based upon compassion and does not involve any form of payment for the surrogate. The commissioning couple may cover the surrogate’s medical and other related expenses.

18.3 HISTORICAL DEVELOPMENTS

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18.3.1 Western Australia

A 1986 report by the *Committee to Inquire into the Social, Legal and Ethical Issues relating to in vitro Fertilization and its Supervision* determined that “surrogacy should at this time not be permitted or recognised as an acceptable procedure for the alleviation of infertility”.

In 1988, the Reproductive Technology Working Party recommended separate development of human reproductive technology legislation and surrogacy legislation, in recognition of the fact that surrogacy pregnancy “transcends reproductive technology”. The 1988 Working Party’s Guiding Principle 3.1.6 stated that the objects of the Surrogacy Act should be -

(a) to discourage and deter people from entering into surrogacy contracts; and

(b) to provide for the welfare of children born as a result of such contracts.

The recommended principles for the proposed Surrogacy Act (Guiding Principle 3.1.7) were -

(a) that the practice of surrogacy is undesirable because of its potential to cause serious disruption to the social and emotional bonds between infants and their parents, and its potential to cause or exacerbate emotional, psychological and physical problems for the birth mother and the child born as a result of such contracts; and

(b) that any involvement by a third party in surrogacy contracts is contrary to public policy and unlawful.

Recommendations of the Select Committee appointed to inquire into the Reproductive Technology Working Party’s Report

In 1988, the WA *Select Committee appointed to inquire into the Reproductive Technology Working Party’s Report* examined the Working Party’s recommendations on surrogacy. The 1988 Select Committee recommended that Guiding Principle 3.1.6 be adopted. It acknowledged that other related legislation should be fully examined and amended where necessary, with a view to achieving Guiding Principle 3.1.6. It also considered that the welfare of children born as a result of surrogacy contracts is best assured if such contracts are not in themselves illegal, as illegality could exacerbate emotional and psychological problems for these children.

The 1988 Select Committee also recommended that -

where custody of a child has been awarded under other legislation (e.g. adoption legislation) to commissioning parents the unenforceability of the surrogacy contract should create no special rights for the birth mother to regain custody of the child,

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703 WA Legislative Assembly. 1988.
and that Guiding Principle 3.1.7 should be adopted because -

- intra-family and other altruistic surrogacy arrangements, as well as commercial arrangements, are all potentially detrimental to the well-being of children born and to other parties involved and are to be discouraged;

- by law in this State (Artificial Conception Act 1985) the birth mother is the legal mother of any child born, and therefore her welfare and the welfare of the child born should be provided for by the Surrogacy Act and related Statutes; and

- by making illegal the involvement of any third party in surrogacy or procuration contracts it hopes to reduce the likelihood of the exploitation of birth mothers and of commercial aspects of surrogacy arrangements.

In addition, it recommended that Guiding Principle 3.1.7 be amended by inserting after “unlawful” in line 2 of paragraph (b), “and the Reproductive Technology Council established by the Reproductive Technology Act should address the issues of third parties in its Code of Practice”.

The 1988 Select Committee believed that the overriding principle was “to reduce the likelihood of entrepreneurial involvement in surrogacy contracts and arrangements”.

Drafted legislation in WA

The Reproductive Technology Working Party recommended that any Surrogacy Act “is more appropriately administered by the Department of Community Services [now the department for Family and Children’s Services]” and that “there should be a high level of cooperation between the Health Department of Western Australia and the Department of Community Services in the administration” of the Act.  

In 1988, the Department of Community Services was allocated responsibility for surrogacy. In 1991, Mr Keith Mason QC, Solicitor General for NSW indicated that drafting of surrogacy legislation was underway in Western Australia. Indications at the time were that the legislation would be “tougher than anything recommended by the Working Party and endorsed by the Select Committee” and an article in the West Australian on 26 June 1990 reported that “legislation being considered by the State Government would ban surrogacy in all forms and ban payment of fees for work involving surrogacy”. According to Mr Mason, comments made on behalf of the Minister for Community Services indicated that this was the Government’s policy.

Legislation did not proceed beyond the drafting stage. Responsibility for surrogacy legislation was transferred from the department for Family and Children’s Services to the Health Department of WA in November 1996.

18.3.2 Australia


706 ibid.
In May 1988, State and Federal Health and Social Welfare Ministers referred the issue of surrogate motherhood to the National Bioethics Consultative Committee (NBCC). The NBCC’s first report recommended that non-contractual or altruistic surrogacy arrangements should be permitted, but under strict controls.\textsuperscript{707} The NBCC believed it would be impossible to stop surrogacy and therefore it recommended regulation. The NBCC’s second discussion paper on surrogacy addressed the supervision and regulation of surrogacy arrangements through state-approved agencies established by uniform State and Territory legislation.\textsuperscript{708} It contained draft surrogacy legislation and made further recommendations on a number of relevant issues such as eligibility, counselling, and legal parentage of the offspring.

In response to the NBCC’s reports, the Australian Health Minister’s Advisory Committee (AHMAC) established a joint National Reproductive Technology Working Group to consider the NBCC’s recommendations. The Working Group rejected the NBCC’s findings and recommended that surrogacy arrangements should be made illegal and void, and that commercial surrogacy and advertising should be prohibited.

In 1990, it was resolved at the Social Welfare Minister’s Conference and endorsed by Ministers at the Joint Health and Social Welfare Ministers Conference in March 1991 that\textsuperscript{709} -

- States and Territories legislate to -
  - make any surrogacy contract or agreement void and unenforceable;
  - make it an offence to arrange or agree to arrange surrogacy services or contracts to provide technical or professional services to facilitate the creation of the pregnancy;
  - make it an offence to induce a person to become pregnant for the purposes of surrendering custody and guardianship of, or rights in relation to, a child born as a result of the pregnancy;
  - make it an offence to publish, or cause to be published, a statement, advertisement, notice or other document to the effect -
    \begin{itemize}
    \item that a person is or may be willing to enter into a surrogacy contract;
    \item that a person is seeking a person willing to enter into a surrogacy contract; or
    \item that a person is willing to negotiate, arrange or obtain the benefit of a surrogacy contract on behalf of another,
    \end{itemize}
  - that where, despite the provision of legislation prohibiting surrogate motherhood, it comes to the attention of authorities that a child has been born as a result of a surrogate motherhood arrangement, full records of the child’s social and biological parents should be obtained and lodged with the relevant Registrar of Births, Death and Marriages.


The Ministers further resolved that penalties and sanctions against third parties be applied through\textsuperscript{710} -

the classification of any form of assistance in the arrangement of surrogacy as instances of professional misconduct subject to penalty by the appropriate professional bodies, boards of tribunals; and

the withdrawal of licences or approval to practise reproductive medicine from medical organisations which participate in facilitating surrogacy arrangements.

18.4 RELEVANT LEGISLATION IN WA

18.4.1 Human Reproductive Technology Act 1991

Section 23(a) of the HRT Act states that “an \textit{in vitro} fertilisation procedure may be carried out where it would be likely to benefit persons who, as a couple, are infertile”. The Select Committee was told that this provision appears to leave open the possibility of interpreting the clause either in favour of surrogacy or ruling it out.\textsuperscript{711}

It may be that any person regardless of their marital or fertility status can be a surrogate if they are involved in a procedure for the benefit of an infertile couple. However, in order to ensure that fertile women, who may also be single, can act as surrogates in WA, the Select Committee has addressed this issue in Chapter Five (Recommendations 5a and 5f).

18.4.2 Artificial Conception Act 1985

The \textit{Artificial Conception Act 1985} deals with some limited situations to do with donor gametes and does refer to the fact that the woman, from whom an ovum is taken for a fertilisation procedure and implantation in another woman, is not regarded as the mother of any child born as a result of the pregnancy but the Act has no specific reference to surrogacy. The Act was discussed previously in Chapter Twelve (page 156).

18.4.3 Family Court Act 1997

The 1988 Reproductive Technology Working Party recommended a number of amendments to the Family Court Act 1975.\textsuperscript{712}

Section 62(1) of the Family Court Act should be amended to provide for the recovery, by a woman who is pregnant as the result of a surrogacy contract, of preliminary expenses (the reasonable cost of the pregnancy and birth as are presently recoverable by the mother of any ex-nuptial child from the father of that child). The amended Act should provide that -

a person is liable to provide for or contribute towards the payment of the preliminary expenses of a woman who;


\textsuperscript{711} Dr Sandra Webb. Personal communication to the Select Committee, 6 November 1998.

\textsuperscript{712} Health Department of WA. 1988: 25-26.
(a) not being his wife, is pregnant by him or has been delivered of a child or a stillborn child of which he is the father; or

(b) not being married to that person and whether that person is a male or female person, is pregnant or has been delivered of a child or a stillborn child, or has incurred expense as a result of a pregnancy entered into or continued by that woman, as a result of a surrogacy contract [sic] as defined in section (number unspecified) of the Surrogacy Act, 1988.

Section 62(2) of the Family Court Act should be amended to provide the following -

[Section 62(2)(a)] "(iii) is pregnant or has been delivered of a child or a stillborn child, or who has been pregnant but has miscarried a pregnancy entered into or continued by that woman, as a result of a surrogacy contract;"

Consequential amendments would be required to the balance of section 62 of the Family Court Act, to reflect the changes in subparagraphs (1) and (2). This change should entitle the birth mother to obtain payment of her medical expenses and maintenance for the child (if born live) from the commissioning parent or parents, without further amendment.

An alternative route would be to provide in the Surrogacy Act itself for payment of reasonable indemnity in a lump sum to a birth mother, for costs and losses incurred by a surrogacy contract. This option would not give the child an ongoing right to maintenance from the commissioning parents.

The Family Court Act 1997 repealed the Family Court Act 1975 and was proclaimed on 22 September 1998. It contains a number of relevant sections. Division 8, subdivision 2 considers the liability of a father to contribute towards child bearing expenses if he is not married to the child’s mother. Sections 165 and 166 consider the best interests of the child and sections 188 - 193 address presumption of parentage. Section 188(1) states that “if a child is born to a woman while she is married, the child is presumed to be the child of the woman and her husband”.

18.4.4 Family Law Act 1975 (Cwlth)

Under the Family Law Act 1975, the birth mother is considered to be the legal mother in all situations. According to Emmerson (1996), the Family Law Act 1975 also -

impinges on surrogacy arrangements by providing for the welfare, custody and maintenance of a child. Section 64(1)(a) provides that proceedings in relation to the custody, guardianship or access to a child must ‘regard the welfare of the child as the paramount consideration’.

Ms Whish-Wilson felt that the Family Law Act 1975 in conjunction with relevant state legislation “does not appear broad enough as yet to provide for cases where commissioning parents (not biologically related to the child) refuse to accept the child once born”.

18.4.5 Adoption Act 1994

The Adoption Act 1994 does not deal with surrogacy specifically. However, with regard to adoption after surrogacy, private adoption is illegal because it is an offence under section 8(1) to make
arrangements for the adoption of a child. If the surrogate mother gave up the child for adoption, she could not be assured that it would end up with the commissioning parents. Mr Ted Mildern, Manager, Family Information and Adoption Service, Family and Children’s Services told the Select Committee that there are currently three types of adoption available in WA - unrelated adoption, step-parent adoption and carer adoption.\(^{715}\) He felt that the best option for commissioning parents would be for them to obtain a parenting order and then to adopt the child after three years under a carer adoption arrangement.

Janu (1995) pointed out that all Australian States and Territories legislation relating to adoption provide that the welfare and interest of the child shall be the paramount consideration.\(^{716}\)

### 18.5 INCIDENCE OF SURROGACY IN AUSTRALIA AND WA

#### 18.5.1 Australia

As found by the UK Review team, it is difficult to obtain “hard evidence about the incidence, nature and outcomes of surrogacy arrangements”.\(^{717}\) The actual incidence of surrogacy arrangements in Australia is unknown. Evidence available to the NBCC suggested that “ten to fifteen couples might use this form of forming a family in a year”.\(^{718}\) Extrapolating from United States data, it was estimated that over the decade up to 1987, about 40 surrogate births would have occurred in Australia if surrogacy had been legally tolerated.\(^{719}\) However, according to Dr Martyn Stafford-Bell, there are 30 to 40 patients at the most in Australia who require surrogacy at any one time.\(^{720}\) Dr Stafford-Bell told the Select Committee that in 1997, Canberra Fertility Centre treated 14 cases of IVF surrogacy from all over Australia.\(^{721}\)

#### 18.5.2 Western Australia

The Adoption Unit at the department for Family and Children’s Services has no records of any cases of surrogacy in WA. However, Mr Ted Mildern told the Select Committee that he receives two to three

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715 Mr Ted Mildern, Manager, Family Information and Adoption Service, Family and Children’s Services - Personal communication to the Select Committee.
720 Maher S. Sisters to have surrogacy babe. Sunday Mail. 11 August 1996: 2.
721 Dr Martyn-Stafford Bell. Meeting with the Select Committee, Canberra, 26 March 1998.
telephone enquiries per month with regard to surrogacy. Dr Sandra Webb indicated that she receives a similar number of calls.

The Family Court of WA does not record cases of surrogacy arrangements *per se*. Access and custody issues are covered by the *Family Court Act 1997*.

In 1989, PIVET Medical Centre carried out surrogacy treatment for five couples resulting in two pregnancies. The Select Committee was told that the “accreditation committee of the Fertility Society of Australia” asked the clinic to cease this practice in 1989.

The Select Committee was told that couples from WA were travelling to the ACT or overseas to obtain treatment “although the process is costly ... and an added burden to the existing pressures of infertility”. Another submission pointed out that “the very fact that people in the state are having to travel to the ACT and USA in order to access the same technology we have available here is ludicrous”. In the last year, the Canberra Fertility Clinic has treated two Western Australian families involved with surrogacy arrangements. The Select Committee met one of these families - the commissioning couple, the surrogate (the commissioning father’s sister) and her husband who provided details of their experience of IVF surrogacy.

The Select Committee was also aware that traditional surrogacy occurs in WA and was familiar with the case involving Ms Suze Trappitt who acted as a surrogate for a couple who had experienced many miscarriages and IVF failures. Ms Trappitt was the genetic and surrogate mother for a child born in 1997 using the commissioning father’s sperm.

### 18.5.3 Demand for surrogacy

The Select Committee acknowledged that for some couples surrogacy may be the only way by which they could have a child that is genetically related to them. For women who have had a hysterectomy or are unable to bear children for other medical reasons or for those where other ART procedures have failed, surrogacy may be the last resort.

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722 Mr Ted Mildern. Personal communication to the Select Committee.

723 Dr Sandra Webb. Personal communication to the Select Committee.

724 Mr Sim, Registry Manager, Family Court of WA. Personal communication to the Select Committee.

725 Supplement to Submission 18 - Dr John Yovich.

726 Submission 51 - Ms Anita Henry-Peiris.

727 Submission 45 - Ms Di Pensini.

728 Mr and Mrs C. DeBruin, Mr and Mrs M. Keating. Evidence to the Select Committee, 3 February 1999.

729 Trappitt S. *Surrogate mother*. Published by Suze Trappitt. 1998.
The Select Committee heard from and received submissions from women who were seeking surrogacy and from other women who were willing to act as a surrogate.

18.6 AUSTRALIAN LEGISLATION

The Select Committee was also asked to determine what legislation, if any, is required. In Australia, there has been no progress in attempts to regulate surrogacy uniformly. At the present time, Western Australia, NSW and the Northern Territory do not have any surrogacy legislation, while a number of other Australian States and Territories - Queensland, Victoria, Tasmania, South Australia and the ACT - have legislation in place (Table 12).

Table 12: Comparison of Australian surrogacy legislation

<table>
<thead>
<tr>
<th>JURISDICTION</th>
<th>QUEENSLAND</th>
<th>VICTORIA</th>
<th>TASMANIA</th>
<th>SOUTH AUSTRALIA</th>
<th>AUSTRALIAN CAPITAL TERRITORY</th>
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<tbody>
<tr>
<td>Altruistic Surrogacy prohibited</td>
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<td>✓ s3(1)(c)</td>
<td>✓ s30(2)(b) and 30(2)(c)</td>
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<td>✓</td>
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<td>Commercial Surrogacy prohibited</td>
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<td>✓ s4(4)</td>
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<td>Arranging surrogacy service prohibited</td>
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<td>✓ s3(1)(b)</td>
<td>✓ commercial agreements only s30(2)(b)</td>
<td>✓ commercial agreements only s59</td>
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<td>✓ s10(h)(b)</td>
<td>✓ Except by a party to the proposed agreement s6</td>
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<td>Entering into a surrogacy contract prohibited</td>
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<td>✓ s10(h)(b)</td>
<td>✓ commercial agreements only s5</td>
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<td>Advertising surrogacy services prohibited</td>
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<td>✓ s30(2)(a)</td>
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<td>✓ s10(h)(c)</td>
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<tr>
<td>Receiving a reward or payment for surrogacy services is prohibited</td>
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<td>✓ X *</td>
<td>✓ s5</td>
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730 Submission 45 - Ms Di Pensini; Submission 51 - Ms Anita Henry-Peris.
731 Submission 35 - Ms Tracy Russell.
Surrogacy agreement is void or unenforceable.

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Provision of technical and/or professional services is illegal.

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Penalty for offence.

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<th>QUEENSLAND</th>
<th>VICTORIA</th>
<th>TASMANIA</th>
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<td>$7500 or three years jail</td>
<td>$5000 or two years imprisonment</td>
<td>$24,000 or two years imprisonment</td>
<td>$5000 or one year's imprisonment</td>
<td>$4000 or 12 months imprisonment</td>
<td>$10,000 or one year's jail</td>
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*Dr Brian Stoffell, Director, Medical Ethics, Flinders Medical Centre and University. Personal communication to the Select Committee.

+ The Family Relationships Act 1975 was amended by the Family Relationships Act Amendment Act 1988.

a The Northern Territory, Western Australia, and New South Wales have no specific surrogacy legislation.
b In this table the expression ‘commercial agreements’ is used to refer to agreements involving payment or reward, however worded in the individual Acts.
c This is the case for most offences under the Substitute Parent Agreements Act 1994 (ACT), except for section 7 which relates to advertising for surrogacy agreements. Under this section, the penalty for advertising a commercial surrogacy agreement is $5000 and/or 6 months imprisonment. Advertising any other surrogacy agreement attracts a $5000 fine.

Dr John Leeton pointed out that under HRT legislation, embryo transfer or ART procedures shall not be carried out unless the recipient is unlikely to become pregnant otherwise. He continued that a potential surrogate, for legal purposes must be infertile, although for clinical purposes she must be fertile and that this requirement has inadvertently outlawed IVF surrogate pregnancy. The situation in WA is discussed in 18.4.1.

18.6.1 Victoria

Victoria was the first Australian State to introduce legislation that dealt with surrogacy specifically.

The provisions of the Infertility (Medical Procedures) Act 1984 Part V.

- prohibit advertising which induces or seeks surrogacy arrangements, including those not for reward;
- render surrogacy contracts void;
- prohibit the making of surrogacy arrangements for payment, and include among those liable the commissioning parent, the surrogate mother or an intermediary.

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Section 13 of the Act provided that a woman could not undergo an IVF procedure unless she has been diagnosed as infertile or is likely to pass on an undesirable genetic disease. “The much publicised IVF surrogacy of Linda Kirkman occurred before section 13 came into operation”.\(^{734}\)

According to Ms Moira Rayner, “there were plans to legalise altruistic surrogacy exemplified by the case of the Kirkman sisters’ successful family arrangements in the late 1980s”.\(^{735}\) In mid-1993, newspapers also reported that the Victorian government was considering plans to legalise altruistic surrogacy but the proposals were dropped. It was thought that the Government was “taking an enormous risk for little electoral gain”.\(^{736}\)


### 18.6.2 Queensland

In 1984, a *Special Committee Appointed by the Queensland Government to Enquire into the Laws relating to Artificial Insemination, In Vitro Fertilisation and other Related Matters* was established under the chairmanship of Mr Justice Alan Demark. A number of recommendations from the report related to surrogacy.\(^{737}\) They stated that -

- it should be made illegal to advertise to recruit women to undergo surrogate pregnancy, or to provide facilities for persons who wish to make use of the services of such women;
- legislation should be enacted to provide that it is an irrebuttable presumption that the woman who gives birth to a child is its mother; and
- ethical guidelines should be established for the provision of medical services which involve surrogacy arrangements.

The *Surrogate Parenthood Act 1988*, implemented the first recommendation. Its provisions\(^{738}\) -

- prohibit both commercial and non-commercial surrogacy;
- apply criminal penalties to the surrogate mother, commissioning parents and third parties;
- prohibit any advertising concerning surrogacy;
- render a person liable for offence if the act occurs in Queensland regardless of their whereabouts, or if they are normally resident in Queensland, regardless of where the act occurs.


\(^{737}\) *Report of the Special Committee Appointed by the Queensland Government to Enquire into the Laws relating to Artificial Insemination, In Vitro Fertilisation and other Related Matters*. (Chaired by Mr Justice Alan Demark), Brisbane, 1984.

\(^{738}\) ACT Community Law Reform Committee. 1997.
As a result of the Act, there have been prosecutions of several women and a doctor for breaches of the law.\textsuperscript{739} There have been calls to repeal or to amend the Act so that altruistic arrangements do not attract penalties. According to Janu\textsuperscript{740} -

criminal penalties ... are not appropriate. They are unlikely to achieve a deterrent effect because the parties would not perceive they were doing anything wrong and it is not in the best interests of any child to be born in a manner tainted with criminality.

\textbf{18.6.3 South Australia}

The \textit{Family Relationships Act 1975} as amended by the \textit{Family Relationships Amendment Act 1988}\textsuperscript{741} -

- renders both surrogacy and procuration contracts “illegal and void”;
- prohibits commercial surrogacy, including acting as a third party or go-between;
- prohibits advertising in relation to a surrogacy arrangement.

The South Australian Act differentiates between a surrogacy contract and a procuration contract. The distinction between the two types of contract is that some costs are recoverable under a procuration contract. Valuable consideration paid under a procuration contract is recoverable as a debt. This is a unique feature of the South Australian legislation. Those who act for reward under either a surrogacy or procuration contract may be fined but it is not an offence for commissioning parents and birth mothers to enter into a surrogacy contract, even for money, as such. The immediate parties to a commercial surrogacy arrangement do not commit a criminal offence. Emmerson (1996) stated that the South Australian legislation “is less interventionist than the approach recommended by the Australian Health and Social Welfare Ministers as it does not impose penalties upon immediate parties to a commercial surrogacy arrangement”.\textsuperscript{742}

\textbf{18.6.4 Tasmania}

\textit{Surrogacy Contracts Act 1993}

The \textit{Surrogacy Contracts Act 1993} is similar to the Victorian legislation. The Act\textsuperscript{743} -

- renders surrogacy contracts void;
- prohibits commercial surrogacy;
- prohibits giving of technical and professional services;
- prohibits advertising.

\textsuperscript{739} Emmerson G. 1996: 36-37.
\textsuperscript{740} Janu PW. 1995.
\textsuperscript{741} ACT Community Law Reform Committee. 1997.
\textsuperscript{742} Emmerson G. 1996: 41-42.
\textsuperscript{743} ACT Community Law Reform Committee. 1997.
In addition, private adoption arrangements are prohibited by adoption legislation. The *Surrogacy Contracts Act 1993* does not penalise parties who enter into a non-commercial surrogacy arrangement.\(^{744}\)

### 18.6.5 Australian Capital Territory

**Substitute Parent Agreements Act 1994**

The Act\(^{745}\) -

- renders all substitute parent agreements void and unenforceable in the eyes of the law. No offence is committed in making a non-commercial arrangement but both parties are not held liable at law if they repudiate the agreement;
- prohibits a commercial substitute parent agreement;
- prohibits procurement of another person to enter into an agreement (commercial or not) with a third person (unless the person procuring is a party to the agreement);
- prohibits advertising.

The ACT Act is the only one that clearly does not rule out IVF surrogacy for altruistic reasons.

**Artificial Conception (Amendment) Bill**

The *Artificial Conception Act 1985 (ACT)* provides that where a married woman gives birth to a child as the result of artificial conception (either artificial insemination by donor or IVF) with the consent of her spouse, she and the spouse are presumed to be the parents, and the donor(s) of the gametes have no legal relationship at all with the child. This Act also applies to *de facto* relationships, and is conclusive for all purposes. No claim at all can be made to the child by a genetic parent. *The Family Law Act (Commonwealth) 1975* is similar to and reinforces the ACT legislation.

In December 1997, the *Artificial Conception (Amendment) Bill* was introduced into Parliament. It addressed the issue of commissioning parents being recognised as the parents of the child resulting from a surrogacy arrangement if only one of the commissioning parents is the genetic parent and the surrogate mother is not the genetic mother. The Bill was rejected by the ACT Legislative Assembly.

### 18.7 INTERNATIONAL LEGISLATION

#### 18.7.1 United Kingdom

In 1984, the Warnock Committee in the UK examined the arguments for and against surrogacy. It recommended that\(^{746}\) -


\(^{745}\) ACT Community Law Reform Committee. 1997.

legislation should be introduced to render criminal the creation or the operation ... of agencies whose purposes include the recruitment of women for surrogacy pregnancy or making arrangements for individuals or couples who wish to utilise the services of a carrying mother; such legislation should be wide enough to include both profit and non-profit making organisations;

legislation should be sufficiently wide enough to render criminally liable the actions of professionals and others who knowingly assist in the establishment of a surrogate pregnancy;

it be provided by statute that all surrogacy agreements are illegal contracts and therefore unenforceable in the courts.

The *Surrogacy Arrangements Act 1985* sought to outlaw profit-making organisations from assisting in the creation of surrogacy arrangements. It makes any payment to third parties illegal and bans advertising in relation to surrogacy.

The *Human Fertilisation and Embryology Act 1990* contains two provisions that relate to surrogacy (sections 30 and 36).  

section 30 allows the courts to make an order providing for a child to be treated in law as the child of a couple if certain conditions are met as follows -

- the child is genetically related to at least one of the commissioning couple;
- the surrogate mother has consented to the making of the parental order (or is incapable of doing so or cannot be found no earlier than six weeks after the birth of the child);
- the commissioning couple are to be married to each other and are both aged 18 years or over;
- the commissioning couple have made the application within six months of the child’s birth;
- no money other than expenses has been paid in respect of the surrogacy arrangement unless authorised by the court;
- the child is living with the commissioning couple; and
- the commissioning couple usually live in the United Kingdom, the Channel Islands or the Isle of Man.

If all the conditions are met, section 30 enables the court to order that the commissioning couple in a surrogate arrangement are to be treated in law as the parents without their having to adopt the child.

Section 30(9) provided for regulations to be made which modified the adoption legislation in respect of parental orders made under the section. The current regulations are *Parental Orders (Human Fertilisation and Embryology) Regulations 1994* and *Parental Orders (Human Fertilisation and Embryology) (Scotland) Regulations 1994* which came into effect on 1 November 1994. Under the regulations, parental rights and obligations relating to a child born from a surrogacy arrangement may be transferred from the birth parents to the commissioning parents.

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748  Brazier M, Golombok S and Campbell A. 1998: 20

The Surrogacy Arrangements Act 1985 was amended by Section 36 of the Human Fertilisation and Embryology Act 1990.

Section 36 introduced s1A into the Surrogacy Arrangements Act 1985 to provide that “no surrogacy arrangement is enforceable by or against any of the persons making it” ie. surrogacy contracts are unenforceable in the courts. This means that the surrogate mother cannot be required by the commissioning parents under any contractual provision to hand over her child, nor can the commissioning parents be required to hand over money, or recover any money paid to the surrogate mother under the terms of such a contract.\(^{750}\)

In addition, section 27 of the Human Fertilisation and Embryology Act 1990 states that “the woman who is carrying or has carried the child as a result of placing in her of an embryo or of sperm and eggs, and no other woman, is to be treated as the mother of the child”. This is considered to be relevant where IVF or DI are involved.

The British Medical Association (BMA) indicated that medical professionals can be involved with surrogacy “but only after the intended parents have exhausted other means of having a child”.\(^{751}\) The BMA was concerned about the lack of central monitoring of surrogacy.

A review of surrogacy arrangements in the UK was conducted recently and its key findings were\(^{752}\) -

- that payments to surrogate mothers should be restricted by law to genuine and verifiable expenses only;
- that DH (Department of Health)/UK Health Departments should: (i) register agencies (which will remain strictly non-commercial) involved in surrogacy arrangements and (ii) draw up a Code of Practice within which the agencies would operate. The Department of Health would also be required to collect statistics and provide guidelines on research in order to obtain better information on the incidence of surrogacy;
- that parental orders (giving commissioning parents legal responsibility for the child without having to follow adoption procedures) should only be available from the High Court and only in cases where the Code of Practice had been complied with;
- that the Surrogacy Arrangements Act 1985 (and section 30 of the Human Fertilisation and Embryology Act 1990) should be replaced by a new Surrogacy Act to put all the above on a statutory basis.

18.7.2 Israel

In Israel, IVF surrogacy is legal.\(^{753}\) The commissioning father must supply the sperm and the ovum must come from either the commissioning mother or from a donor who is not the surrogate mother. The surrogate mother must be an Israeli resident and unmarried. Arrangements will be strictly

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supervised by a committee who will approve contracts if it believes they have been reached freely and that the health of the mother and baby are not at risk. The arrangements are not commercial and the mother will be paid only for legal and insurance expenses, compensation for her time, loss of income, and pain.

18.7.3 United States of America

Surrogacy legislation exists in a number of US states. The Select Committee visited California where surrogacy arrangements are legal. California has “case law” and recognises “case law” as constituting the law in the State.

In California, prospective parents can be reasonably certain that their agreement with a gestational surrogate will be legally enforceable and that such a surrogate has no parental rights to the child she carries. This contrasts with traditional surrogacy where the surrogate is considered the legal mother of the child until an adoption is finalized. In Marriage of Moschetta (1994) 25 Cal. App. 4th 1218, a Californian court held that in the case where the surrogate (biological) mother changed her mind she had all the maternal rights to the child despite her agreement with the intended parents.

18.8 OPINIONS ON SURROGACY

A number of surveys of opinions with respect to surrogacy have been conducted in Australia.

In 1987, the NSW Law Reform Commission conducted a national survey of public opinion about surrogacy. Sixteen percent of respondents approved of surrogate motherhood as a means of providing children for married couples who could not have children because of medical problems, while 35% did not object and 33% objected. When asked about surrogacy for non-medical reasons, 79% did not approve.

More recently, in April 1994, a Morgan Gallup Poll showed that 52.7% of Australians approved of altruistic surrogacy, in which no payment was made to the surrogate.

The Select Committee received a number of submissions on surrogacy. Some supported a complete prohibition of surrogacy. Mr John Barich felt that there is a danger with compassionate surrogacy of “exploitation ... and profound disturbances for a child who discovers in time that she was actually carried by grandma, aunty or mum’s best friend”. Others said there should be no commercial

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755 ibid.


759 Submission 12 - Mr John Barich.

760 ibid.
surrogacy. Dr Anne Jequier condemned “commercial” surrogacy but felt there was a place for “altruistic/compassionate” surrogacy and requested consideration of a change in the law.

The majority of the Select Committee resolved that surrogacy arrangements as recommended (Recommendation 18g) should be permitted. The following recommendations address conditions under which surrogacy arrangements may occur.

18.8.1 Rights of offspring through surrogacy arrangements

The Select Committee received submissions about the importance of considering the rights of the child with respect to ART procedures involving tissues or the body of another person, other than the child’s biological parents as in the case of surrogacy.

Recommendation 18a

That the best interests of the child be paramount in any surrogacy legislation and resulting surrogacy arrangement.

The Member for Joondalup is opposed to all forms of surrogacy and supports the continuation of the existing Common Law on this issue and this view is intended to apply to the remaining recommendations in this Chapter dealing with the issue of surrogacy.

Since there are no uniform laws to address surrogacy, the outcome of arrangements are highly uncertain, especially from the child’s point of view. Children are completely unprotected in the surrogacy contract to which they are not a party.

The department of Family and Children’s Services suggested that -

it is not considered in the best interests of children for women to be encouraged not to bond with the children they carry and to whom they give birth, in order that relinquishment may occur. This is of particular concern where the commissioning parties then subsequently reject the child.

The Select Committee noted this concern but members were not aware of instances where commissioning parents subsequently rejected the child.

Maintenance of records

In the ACT, the Substitute Parent Agreements (Consequential Amendments) Act 1994 amended other State legislation to “require that the details of a child born as a result of a substitute parent agreement be obligatorily lodged with the Registrar-General.

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761 Submission 13 - Ms Judith Armstrong.
762 Submission 10 - Dr Anne Jequier.
763 Submission 69 - Family and Children’s Services.
The Select Committee believed that all children born as a result of surrogacy arrangements should have access to identifying information about their surrogate mother and biological parentage if donor material was used to conceive them and that all birth records should include donor information. A register of children born after surrogacy arrangements should be kept in a central location.

**Recommendation 18b**

That, from the enactment of legislative changes, children born as a result of surrogacy arrangements may elect to have access to identifying information about their surrogate mother and biological parentage, if donor material was used to conceive them, upon attaining the age of 16 years.

That all birth records include donor information.

That a register of children born after surrogacy arrangements be kept in a central location.

18.8.2 Concerns for the surrogate and their family

The Select Committee was concerned about the impact of surrogacy upon the surrogate and her family.

Professor Carl Wood has stated that one percent of surrogate mothers end up regretting their decision and that natural conception is regretted more often.\(^{764}\) Professor Wood believes that surrogates are better informed than most women and have made a conscious decision before they become pregnant. On the other hand, FINNRAGE expressed the opinion that “surrogacy ‘transfers the pain from one woman to another’ ... Surrogacy exploits ... the birth mother.”\(^{765}\) The department for Family and Children’s Services stated that\(^{766}\) -

> there is extensive evidence of psychological trauma for birth mothers (and also for siblings) in surrogacy, reinforcing and compounding what is already known about relinquishment and the experience of loss in adoption experience.

The department for Family and Children’s Services also pointed out the high risk of custody disputes with serious bonding and long-term adjustment consequences for the child and possible trauma for siblings, birth mothers and commissioning parties.\(^{767}\)

According to Emmerson\(^{768}\) -

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\(^{765}\) Submission 4 - FINNRAGE.

\(^{766}\) Submission 69 - Family and Children’s Services.

\(^{767}\) *ibid.*

\(^{768}\) Emmerson G. 1996.
proponents of surrogacy could argue that counselling could mitigate such difficulties, and that the
effect may be less in cases of altruistic surrogacy between family and friends where the surrogate
child would still be part of the children’s social environment.

However, Martin (1990) felt that the surrogate mother’s own children may be adversely affected by
seeing their mother carry a child and then relinquish it, particularly in the case of traditional surrogacy
where the child may be a half sibling.  

In the UK, the HFEA’s Code of Practice states that in the case of surrogacy the clinic should take
account of the effects of the proposed arrangement upon the existing children in both families. 

The Select Committee was aware of many personal accounts of experiences of surrogacy and of the
NBCC’s view that personal experiences of surrogacy, whether positive or negative, were not proof on
the correctness of a position. In the UK, the Select Committee met with Mrs Kim Cotton,
Chairperson of Childlessness Overcome Through Surrogacy (COTS). Mrs Cotton had experienced
both traditional and IVF surrogacy. She explained that the traditional surrogacy arrangement, through
a US agency, was anonymous so that she was unable to meet and bond with the commissioning couple
and she is opposed to that type of anonymous arrangement. She added that the IVF arrangement went
well and that when an arrangement is successful the “feel good” factor is tremendous.

More recently, a Western Australian woman, Ms Suze Trappitt published her experiences as a
surrogate mother involved in a traditional surrogacy arrangement. In the conclusion to her book she
said “surrogacy worked for us, and it can work for others, but to all contemplating it, be really
extremely careful, the potential for disappointment is not too far from the surface”.

The Select Committee met with a commissioning couple, a surrogate (the commissioning husband’s
sister) and her husband who appeared comfortable with their IVF surrogacy arrangement. The
surrogate mother did not regard the child as her own and told the Select Committee that “we have been
through this for three years. I am doing this for them; it is not my baby”.

18.8.3 Counselling

The Select Committee was told that counselling should be mandatory for surrogacy arrangements and
“should involve all parties including the children who are part of the various families”. It must be

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774 Mrs Monique Keating. Evidence to the Select Committee, 2 February 1999.
775 Ms Sue Midford. Evidence to the Select Committee, 9 March 1998.
provided by qualified counsellors and should cover a wide range of possible scenarios and their implications.  

The Select Committee was told that when PIVET Medical Centre carried out surrogacy treatment in 1989, couples underwent counselling sessions once their case was approved.  Counselling took place at a medical, emotional, psychological and legal level.

At the Canberra Fertility Centre, all parties in a surrogacy arrangement are counselled by an obstetrician on the Centre staff. All must signify in writing their agreement to the surrogacy procedure. Patients should be advised to obtain legal advice on the issues concerned. In addition, the surrogate, the genetic mother and their partners must be counselled with regard to the physical and psychological risks associated with surrogacy procedures. The counselling is committed to written statements.

The National Ethics Committee on Assisted Human Reproduction (New Zealand) (NECAHR) also recommended that the preparation of a written agreement should be encouraged “as it allows participants to work through issues and to clearly state their intentions and expectations”.  

The Select Committee recognised the importance of counselling for all parties involved in a surrogacy arrangement - the commissioning couple, the surrogate, her partner and her/their children. Members acknowledged that a surrogacy arrangement can affect more people than an IVF or other ART procedure.

**Recommendation 18c**

That counselling be mandatory for all parties involved in a surrogacy arrangement - the commissioning couple, the surrogate, her partner and her/their children.

### 18.8.4 Surrogacy and adoption

The Select Committee received different views about the relationship between adoption and surrogacy.

According to Ms Moira Rayner, surrogacy is distinguishable from adoption in several important ways:

- surrogacy requires a contract for services;
- adoption requires the mother’s consent, after the event;
- adoption laws are long-standing while surrogacy is new with regard to legislation.

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777 Supplement to Submission 18 - Dr John Yovich.

778 Submission 80 - Mrs Stephanie Knox.

A number of submissions were received from relinquishing mothers. One equated surrogacy with adoption and expressed concerns about the long-term mental effects on children, and mothers. Another mother said that “we are condoning the act of giving away a baby and their basic rights ... a baby has a right to be loved unconditionally, not to have to fill the void of infertility”.

However, in noting the point of view expressed by relinquishing mothers, the majority of the Select Committee felt that the situation of a mother relinquishing her child, often under duress from family and her own financial situation, was quite different from the situation faced by a voluntary, well-prepared and counselled surrogate who has her own family’s support.

However, the Members for Thornlie and Carine felt that the situation where the surrogate mother uses her own egg was somewhat akin to adoption and for that reason had grave reservations about that method of surrogacy.

The Select Committee also noted previously, in Chapter Two, that the opportunity for adoption is becoming increasingly limited and that infertile couples’ desires to rear children are becoming less likely to be realised via this avenue. Consequently, it is acknowledged that the pressure to allow non-commercial surrogacy will only increase.

18.9 SELECTION CRITERIA

18.9.1 Commissioning couple

In the UK, the HFEA’s Code of Practice states that -

the application of assisted conception techniques to initiate a surrogate pregnancy should only be considered where it is physically impossible or highly undesirable for medical reasons for the commissioning mother to carry the child.

The majority of the Select Committee believes that if surrogacy is to be allowed, it must be for a medical reason and after all other avenues (with the exception of adoption) have been exhausted. It should be an avenue of last resort and not seen as an alternative to IVF. The Select Committee considered that the RTC could be asked to consider applications for surrogacy on a case-by-case basis.
Recommendation 18d

That if surrogacy be allowed, it be for medical reasons and after all other avenues, with the exception of adoption, have been exhausted.

That surrogacy be an avenue of last resort and not seen as an alternative to in vitro fertilisation.

That the Reproductive Technology Council consider any applications for surrogacy on a case-by-case basis.

The Member for Joondalup agreed save that adoption should be considered as an option.

18.9.2 Surrogate

The Select Committee examined various selection criteria for women intending to become surrogates and was of the opinion that selection of surrogates mothers is of prime importance to the success of any surrogacy arrangement.

The NBCC’s working party examined eligibility criteria for prospective surrogates. It proposed that the woman be certified by a relevant medical practitioner as medically fit to undergo pregnancy and childbirth and that she should be between 18 and 35 years of age. If she is married or living in a de facto relationship, her partner should consent to her participation. 783

The Canberra Fertility Centre has established a number of criteria for surrogates784 -

- they shall not be a single woman but shall be married, separated or divorced;
- they must have had at least one child by their present husband or if separated or divorced they must have at least one child;
- the Centre must be satisfied that neither the surrogate’s financial income, nor the care of her children shall suffer from her admission to hospital during pregnancy.

At the Centre for Surrogate Parenting and Egg Donation (CSP) in Los Angeles, potential surrogate mothers go through three to five months evaluation.785 They must meet the following criteria -

- women must be between 21 and 37 years of age;
- they must have given birth and be raising at least one child;
- they must not be on any welfare or assistance.

784 John James Hospital IVF Ethics Committee. Principles to be observed regarding surrogacy arrangements.
785 The Center for Surrogate Parenting and Egg Donation, Inc. Creating your family. Our surrogate mother program.
The potential surrogates must also undergo a detailed screening process which involves psychological and medical tests. The Select Committee was told that of all the inquiries CSP receives from women interested in becoming surrogate mothers, approximately two percent of the women are accepted into the program.

In 1997, the NECAHR in New Zealand granted ethical approval for non-commercial surrogacy. The NECAHR has developed a set of draft criteria for surrogates and commissioning couples\(^{786}\):

- the commissioning parents should use their own gametes. (It) is preferred that the birth mother is either a family member or a close friend of the commissioning parents;
- the birth mother and her partner should have children and completed their family;
- there should be medical reasons for the commissioning mother not to undertake a pregnancy;
- counselling should cover a wide range of possible scenarios and their implications - for example the possibility of a breakdown in the arrangement such as a birth mother wishes to keep the child or that the commissioning parents do not wish to adopt the child;
- a report from a legal adviser to indicate that both parties clearly understand the legal issues and that in their current environment, any surrogacy contract(s) are legally unenforceable. However, a written agreement is encouraged, as it allows participants to work through issues and to clearly state their intentions and expectations; and
- it is acceptable to pay for expenses that are related to pregnancy and childbirth, but no payment should be made in lieu of employment.

Dr John Yovich outlined the selection criteria for commissioning couples that were used at his clinic in 1989\(^{787}\):

- There was a clear medical indication such as an absent or defective uterus;
- the infertile couple’s gametes were used to generate the embryos; where donor gametes are required, these had to be provided by the usual anonymous process and not by the surrogate or her partner;
- a relative or a close friend should act as the surrogate; and
- there was no commercial fee. Only specific costs could be paid by the infertile couple.

The Select Committee also received submissions that addressed selection criteria for prospective surrogate mothers. The surrogate “must have at least one child of her own aged two years and above. My experiences indicate that a childless woman would not be the best option for people entering into a surrogacy agreement because of their hormonal/emotional upheaval”\(^{788}\).

The Select Committee felt that the selection of the surrogate was of utmost importance and that a mechanism for setting, reviewing and updating selection criteria should be established.
Recommendation 18e

That surrogacy legislation establish a mechanism for setting, reviewing and updating the selection criteria for surrogate mothers from time to time.

18.10 COSTS

In Australia, Medicare benefits are not payable for assisted reproductive services rendered in conjunction with surrogacy arrangements where surrogacy is defined as “an arrangement whereby a woman agrees to become pregnant and to bear a child for another person or persons to whom she will transfer guardianship and custodial rights at or shortly after birth” 789

The NECAHR felt “it is acceptable to pay for expenses that are related to pregnancy and childbirth, but no payment should be made in lieu of employment” 790

The UK report “Surrogacy - Review for Health Ministers of current arrangements for payments and regulation” found that 791 -

payments to surrogate mothers, other than in recompense for genuine expenses, give rise to the following concerns. (1) Payments create a danger that women will give a less than free and fully informed consent to act as a surrogate. (2) Payments risk the commodification of the child to be born. (3) Payments contravene the social norms of our society that, just as bodily parts cannot be sold, nor can such intimate services.

and recommended that 792 -

- payments to surrogate mothers should cover only genuine expenses associated with the pregnancy;
- additional payments should be prohibited in order to prevent surrogacy arrangements being entered into for financial benefit;
- the basis on which expenses will be met should be established before any attempt is made to create a surrogacy pregnancy, with a requirement for documentary evidence of expenses incurred in association with the surrogacy arrangement to be produced by the surrogate mother;
- legislation should define expenses in broad terms of principle and empower ministers to issue directions on what constitutes reasonable expenses and the methods by which expenses shall be proven.

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790 NECAHR. Cited in: Submission 80 - Mrs Stephanie Knox.


792 ibid.
The Select Committee believed that any surrogacy arrangement should be non-commercial and based upon altruism. However, the commissioning couple should cover all reasonable expenses.

**Recommendation 18f**

That all surrogacy arrangements be non-commercial and that altruism be the only basis for surrogacy arrangements.

That all reasonable expenses be paid for by the commissioning couple.

That in the event that surrogacy is formalised in Western Australia, the Western Australian Minister for Health approach the Federal Government with a view to allowing *in vitro* fertilisation (IVF) surrogacy treatments to be considered by Medicare as any other IVF treatment.

**18.11 FUTURE LEGISLATION**

The Select Committee received a range of views about the form that surrogacy legislation should take. Submissions suggested that any future legislation could either be incorporated into the HRT Act or that a separate surrogacy law could be created. Dr Phillip Matson thought that surrogacy should be incorporated into the *Human Reproductive Technology Act 1991* when AI or IVF was involved.\(^{793}\)

According to Leeton (1991), in order to safeguard the best interests of the child in future surrogacy arrangements, an amendment to the existing laws relating to surrogacy must be passed or the adoption laws should be made more flexible so that the genetic mother may adopt the child.\(^{794}\)

Ms Sue Midford felt that in order to protect the interests of the child to be created “remaining silent in law is negligent”.\(^{795}\) She felt there was the need for a law which provides -

- a rigorous process for couples wanting to engage in altruistic surrogacy. The process should -
  - first and foremost protect the child to be created;
  - encourage the adults involved to examine their reasons for entering such an agreement, and also the reasons for the others involved;
  - encourage the adults to consider their expectations of the future and how they relate to those of the other adults;
  - examine the needs of any other children involved;
  - establish a negotiating process between the adults involved;
  - establish the groundwork for ongoing contact between the various parties as the child progresses through childhood.

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\(^{793}\) Submission 7 - Dr Phillip Matson.

\(^{794}\) Leeton J. 1991.

\(^{795}\) Submission 68 - Ms Sue Midford.
In regard to all forms of surrogacy, the department for Family and Children’s Services was of the view that:

- given the risks and harms involved, surrogacy legislation be introduced to discourage and deter surrogacy;
- in consideration of the interests of children and the considerable risks of harm to children, birth mother and participants in surrogacy arrangements, that such legislation be introduced to prevent the burgeoning of a surrogacy industry in this state by prohibiting the application of reproductive technology procedures to surrogacy arrangements.

The majority of the Select Committee felt that this opinion was simplistic and not supported by available evidence.

According to Emmerson (1996):

prohibition of surrogacy is one response to a complicated moral and legal issue. It however, raises its own problems, and may encourage circumvention ... Prohibition also precludes proper counselling reaching intending participants, or those experiencing adjustment difficulties. It also seriously disadvantages children born under surrogacy arrangements as there is no accurate or systematic information available to them. History suggests that surrogacies will occur regardless of government decisions.

The majority of the Select Committee agreed that surrogacy legislation should be introduced in WA to allow surrogacy arrangements to occur under certain conditions. The Select Committee examined a number of different surrogacy scenarios (Table 13) and decided which they would wish to permit in WA.

**Table 13: The Select Committee’s opinions on different surrogacy arrangements**

<table>
<thead>
<tr>
<th>Option No.</th>
<th>Surrogacy Arrangement</th>
<th>Agreement with Arrangement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Embryo created by IVF technology from commissioning parents’ genetic material and subsequently implanted into surrogate</td>
<td>The Hon. Member for Greenough, and the Members for Kalgoorlie, Carine and Thornlie agreed with this option. The Member for Joondalup disagreed with this option.</td>
</tr>
<tr>
<td>Option No.</td>
<td>Surrogacy Arrangement</td>
<td>Agreement with Arrangement</td>
</tr>
<tr>
<td>-----------</td>
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</tr>
<tr>
<td>2</td>
<td>Surrogate inseminated with commissioning father’s semen</td>
<td>The Hon. Member for Greenough, and the Member for Kalgoorlie agreed with this option. The Hon. Member for Greenough recognised that this was traditional surrogacy that has occurred for thousands of years and felt strongly that any surrogacy legislation must allow this form of surrogacy. The Member for Carine felt that this option was only acceptable if the surrogate was related genetically or by marriage to the commissioning mother, and that all parties had been counselled. The Members for Thornlie and Joondalup disagreed with this option.</td>
</tr>
<tr>
<td>3</td>
<td>Embryo created by IVF technology from commissioning mother’s egg and donor semen and subsequently implanted into surrogate</td>
<td>The Hon. Member for Greenough, and the Members for Kalgoorlie, Carine and Thornlie agreed with this option. The Member for Joondalup disagreed with this option.</td>
</tr>
<tr>
<td>4</td>
<td>Embryo created by IVF technology from donor egg and commissioning father’s semen and subsequently implanted into surrogate</td>
<td>The Hon. Member for Greenough, and the Members for Kalgoorlie, Carine and Thornlie agreed with this option. The Member for Joondalup disagreed with this option.</td>
</tr>
<tr>
<td>5</td>
<td>Donor embryo created by IVF technology subsequently implanted into surrogate</td>
<td>The Hon. Member for Greenough and the Members for Kalgoorlie and Thornlie agreed with this option. The Hon. Member for Greenough felt that this option was the least supportable but he was not opposed to it if the best interests of the child were considered. The Member for Thornlie felt that this scenario was the least favourable with respect to the best interests of the child. However, she recognised that donor embryos are used currently in IVF procedures. The Members for Carine and Joondalup disagreed with this option.</td>
</tr>
<tr>
<td>6</td>
<td>Surrogate inseminated with donor semen</td>
<td>All members disagreed with this option.</td>
</tr>
</tbody>
</table>

The majority of Members agreed that surrogacy arrangements where 100% of the genetic material is supplied by the commissioning parents should be permitted in WA. All members also supported IVF surrogacy using an embryo created from a donor egg and the commissioning father’s sperm. The
majority of members agreed that IVF surrogacy arrangements where an embryo is created from the commissioning mother’s egg and donor sperm or a donated embryo are used should be allowed.

The majority of Select Committee Members did agree to surrogacy arrangements where the surrogate was also the genetic mother of the child only where the commissioning father’s sperm was used. Some Members were concerned about the potential problems for the surrogate to hand over her genetic child and likened it to the adoption situation of “relinquishing” the child.

All Members of the Select Committee wished to prohibit insemination of the surrogate mother with donor semen.

The Select Committee felt that legislation should be drafted to provide for the above surrogacy arrangements. The Select Committee recognised that the Family Court will be required to ratify the legal status of the child born as a result of a surrogacy arrangement.

Members also believed that the Adoption Act 1994 should be amended to enable adoption to proceed where surrogate births have occurred in Western Australia pending the introduction of surrogacy legislation.

**Recommendation 18g**

That legislation be drafted to provide for surrogacy arrangements as outlined in Chapter Eighteen and to clarify the legal status of surrogate children and their commissioning parents as a matter of urgency.

That the Adoption Act 1994 be amended to enable adoptions to proceed where surrogate births have occurred in Western Australia pending the introduction of surrogacy legislation.

The Select Committee considered the complex issues surrounding “enforced relinquishment” and the rights of the birth mother. However, underpinning the Select Committee’s considerations was that the best interests of the child had to be considered paramount at all times. The view of the Select Committee was that, in principle, the interests of the child resulting from surrogacy arrangements are best served by him or her being raised by their genetic parents. Therefore, this raises the vexed question of whether the surrogate mother can be compelled to honour an agreement to forego her rights as a birth mother.

The Select Committee also felt that evidence from the US showed that voluntary, well prepared and counselled surrogate mothers had no difficulty honouring a surrogacy agreement. In the UK, the Review team found that “only in a handful of cases ... does the surrogate refuse to hand over the child”.798

However, if surrogacy arrangements are permitted where the surrogate mother is also the biological mother of the child, she should be allowed a finite period of time during which she must decide if she will honour the surrogacy agreement. The Select Committee felt that it was important to specify a

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finite time because it can not be in the best interests of the child to allow the surrogate to change her mind at some later point in time.

18.11.1 Agencies

In the UK, the review of the Surrogacy Act 1985 suggested that a new Surrogacy Act would “provide for registration by the Department of Health of non-profit making organisations who are engaged in the introduction of commissioning couples to potential surrogate mothers”. 799

The Select Committee did not want to see the establishment of commercial agencies in WA to broker surrogacy arrangements. However, Members believed that an agency or other body like the RTC is required to oversee surrogacy arrangements in the State. As discussed earlier in this report (section 18.9.1), the RTC could be asked to consider applications for surrogacy on a case-by-case basis.

In conclusion, the Select Committee recognised the huge ethical dilemmas and attitudinal differences that surround surrogacy but Members reiterate the point of view stated at the beginning of this Chapter that surrogacy is a reality and has become an issue that Parliament can no longer ignore.

CHAPTER EIGHTEEN - RECOMMENDATIONS

Recommendation 18a

That the best interests of the child be the paramount issue in any surrogacy legislation and resulting surrogacy arrangement.

Recommendation 18b

That, from the enactment of legislative changes, children born as a result of surrogacy arrangements may elect to have access to identifying information about their surrogate mother and biological parentage, if donor material was used to conceive them, upon attaining the age of 16 years.

That all birth records include donor information.

That a register of children born after surrogacy arrangements be kept in a central location.

799 ibid: 63.
Recommendation 18c
That counselling be mandatory for all parties involved in a surrogacy arrangement - the commissioning couple, the surrogate, her partner and her/their children.

Recommendation 18d
That if surrogacy be allowed, it be for medical reasons and after all other avenues, with the exception of adoption, have been exhausted.

That surrogacy be an avenue of last resort and not seen as an alternative to in vitro fertilisation.

That the Reproductive Technology Council consider any applications for surrogacy on a case-by-case basis.

Recommendation 18e
That surrogacy legislation establish a mechanism for setting, reviewing and updating the selection criteria for surrogate mothers from time to time.

Recommendation 18f
That all surrogacy arrangements be non-commercial and that altruism be the only basis for surrogacy arrangements.

That all reasonable expenses be paid for by the commissioning couple.

That in the event that surrogacy is formalised in Western Australia, the Western Australian Minister for Health approach the Federal Government with a view to allowing in vitro fertilisation (IVF) surrogacy treatments to be considered by Medicare as any other IVF treatment.
### Recommendation 18g

That legislation be drafted to provide for surrogacy arrangements as outlined in Chapter Eighteen and to clarify the legal status of surrogate children and their commissioning parents as a matter of urgency.

That the *Adoption Act 1994* be amended to enable adoptions to proceed where surrogate births have occurred in Western Australia pending the introduction of surrogacy legislation.


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## APPENDIX A

### WITNESSES WHO APPEARED BEFORE THE SELECT COMMITTEE

<table>
<thead>
<tr>
<th>Name of Witness</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Suzanne Midford</td>
<td>Chairperson, Reproductive Technology Council’s Counselling Committee</td>
<td>9.3.98</td>
</tr>
<tr>
<td>Ms Antonia Clissa</td>
<td>Member, Reproductive Technology Council’s Counselling Committee</td>
<td>9.3.98</td>
</tr>
<tr>
<td>Ms Jill Bain</td>
<td>Approved Counsellor Concept Fertility Clinic</td>
<td>9.3.98</td>
</tr>
<tr>
<td>Professor Con Michael</td>
<td>Obstetrician and Gynaecologist and Chairman, Reproductive Technology Council</td>
<td>9.3.98</td>
</tr>
<tr>
<td>Dr Sandra Webb</td>
<td>Executive Officer, Reproductive Technology Council</td>
<td>9.3.98</td>
</tr>
<tr>
<td>Dr Pia Broderick</td>
<td>Lecturer, School of Psychology, Murdoch University</td>
<td>9.3.98</td>
</tr>
<tr>
<td>Dr Iain Walker</td>
<td>Senior Lecturer, School of Psychology, Murdoch University</td>
<td>9.3.98</td>
</tr>
<tr>
<td>Dr Robert Mazzuchelli</td>
<td>Medical Director, Concept Fertility Clinic</td>
<td>16.3.98</td>
</tr>
<tr>
<td>Dr Bruce Bellinge</td>
<td>Reproductive Biologist, Concept Fertility Centre</td>
<td>16.3.98</td>
</tr>
<tr>
<td>Associate Professor Jim Cummins</td>
<td>Associate Professor in Veterinary Anatomy School of Veterinary Studies Murdoch University</td>
<td>16.3.98</td>
</tr>
<tr>
<td>Dr Jack Goldblatt</td>
<td>Director, Genetic Services Health Department of WA</td>
<td>16.3.98</td>
</tr>
<tr>
<td>Ms Leigh Newman</td>
<td>Senior Legal Officer, Legal Administration Health Department of Western Australia</td>
<td>9.4.98</td>
</tr>
<tr>
<td>Dr Peta Bowden</td>
<td>Chair, Philosophy Program Murdoch University</td>
<td>4.5.98</td>
</tr>
<tr>
<td>Ms Linda Pas de Lion</td>
<td></td>
<td>4.5.98</td>
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<tr>
<td>Mrs Stephanie Knox</td>
<td>President, Genesis Infertility Group</td>
<td>4.5.98</td>
</tr>
<tr>
<td>Name</td>
<td>Position/Positional Role</td>
<td>Date</td>
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<tr>
<td>Mr Rodney Knox</td>
<td>Member, Genesis Infertility Group</td>
<td>4.5.98</td>
</tr>
<tr>
<td>Ms Leigh Newman</td>
<td>Senior Legal Officer, Legal Administration Health Department of Western Australia</td>
<td>4.5.98</td>
</tr>
<tr>
<td>Mrs Natalie Peters</td>
<td>Donor Conception Support Group of Australia Inc (WA Branch)</td>
<td>11.5.98</td>
</tr>
<tr>
<td>Mr Bradley Peters</td>
<td>Donor Conception Support Group of Australia Inc (WA Branch)</td>
<td>11.5.98</td>
</tr>
<tr>
<td>Dr Edward Watt</td>
<td>Treasurer, Coalition for the Defence of Human Life</td>
<td>11.5.98</td>
</tr>
<tr>
<td>Mr John Barich</td>
<td>President, The Australian Family Association</td>
<td>11.5.98</td>
</tr>
<tr>
<td>Ms Helen Caceres</td>
<td>Association of Relinquishing Mothers</td>
<td>11.5.98</td>
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<tr>
<td>Ms Keeva Verschoor</td>
<td></td>
<td>11.5.98</td>
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<tr>
<td>Mr Keith Wilson</td>
<td>Member, St John of God Health Care System Ethics Committee</td>
<td>11.5.98</td>
</tr>
<tr>
<td>Ms Dianne le Cornu</td>
<td>Director of Nursing and Patient Services St John of God Hospital Subiaco</td>
<td>11.5.98</td>
</tr>
<tr>
<td>Mrs Carmel DeBruin</td>
<td></td>
<td>3.2.99</td>
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<tr>
<td>Mr Charles DeBruin</td>
<td></td>
<td>3.2.99</td>
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<tr>
<td>Mrs Monique Keating</td>
<td></td>
<td>3.2.99</td>
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<tr>
<td>Mr Mike Keating</td>
<td></td>
<td>3.2.99</td>
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</tbody>
</table>
APPENDIX B

SUBMISSIONS RECEIVED BY THE SELECT COMMITTEE

1. Mr Richard Egan - Coalition for the Defence of Human Life (CDHL)
2. Assoc. Professor Jim Cummins - Murdoch University
3. Mrs Monique Bertino-Clarke and Mr Adrian Bertino-Clarke - Disabled Advocacy
4. Laural Guymer and Renate Klein - FINNRAGE (Australia)
5. Dr Jack Goldblatt - Genetic Services WA
6. Assoc. Professor Sidney James - Department of Botany, UWA
7. Dr Phillip Matson - Concept Fertility Centre (KEMH)
8. Dr ED Watt - Right to Life Australia
9. Ms Deborah Templeman - Minter Ellison Lawyers
10. Dr Anne Jequier - Medical Director, Perth Andrology (now Fertility West)
11. Mrs Henny Ligtermoet - Personal
12. Mr John Barich - The Australian Family Association (AFA)
13. Ms Judith Armstrong - Personal
14. Dr Athel Hockey - Disability Services Commission
15. Dr Robert Mazzuchelli and Dr Bruce Bellinge - Concept Fertility Centre
16. Mr Haydn Lowe - Disability Services Commission
17. Mrs Stephanie Knox - Genesis Infertility Group
18. Dr John Yovich - PIVET Medical Centre plus supplement
19. Personal and Confidential
20. Ms Astrid Norgard - Women’s Policy Development Office
21. Mrs Rosa Tognela - Country Women’s Association plus supplement
22. Dr Pia Broderick and Dr Iain Walker - School of Psychology, Murdoch University
23. Ms Helen Caceres - Association of Relinquishing Mothers
24. S Tarrant - Law School, University of WA
25. Ms Kath Smith - Association of Relinquishing Mothers
26. Ms Helen Driesen - Personal
27. Prof Con Michael and Dr Sandra Webb and the Reproductive Technology Council
28. Ms Barbara Paterniti - Catholic Women’s League
29. WA Reproductive Technology Council’s Counselling Committee (RTCCC)
30. Dr Jennifer Kurinczuk - Institute for Child Health Research
31. Prof Fiona Stanley - Institute for Child Health Research
32. Ms Caroline Lorbach - The Donor Conception Support Group of Australia Inc. (DCSG)
33. Ms Suzanne Midford, Ms Jill Bain, Ms Maxine Chapman, Ms Antonia Clissa, Ms Deborah Foster-Gaitskell and Ms Prue Reynolds - Western Australian Human Reproductive Technology Clinic and Community Counsellors Group
34. Mrs Natalie Peters - The Donor Conception Support Group of Australia Inc (WA Branch) plus supplement
35. Ms Tracy Russell - Personal
36. Mr Alan Bansemer - Commissioner of Health, Health Department of WA
37. Mr Ray Shaw - President, Baptist Churches of WA.
38. Mrs EB Bosansky - Personal
39. M Ellis - Personal
40. Institutional Ethics Committee - St John of God Health Care System
41. Mrs Val Rose - Personal
42. Dr Roger Perkins, Obstetrician and Gynaecologist
43. Mr Cameron Robinson and Mrs Ellen Robinson - Personal
<table>
<thead>
<tr>
<th>Number</th>
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<tr>
<td>44</td>
<td>Mrs Paddy Firstenberg - The National Council of Women of WA Inc Ltd.</td>
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<tr>
<td>45</td>
<td>Ms Di Pensini - Personal</td>
</tr>
<tr>
<td>46</td>
<td>Dr RA Schibeci - School of Education, Murdoch University</td>
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<tr>
<td>47</td>
<td>Ms Jo Rose - Personal</td>
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<tr>
<td>48</td>
<td>Mr Luke Galvin and Mrs Donna Galvin - Personal</td>
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<tr>
<td>49</td>
<td>Mrs Shirley Lock - Personal</td>
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<tr>
<td>50</td>
<td>Dr Edda Simeoni - UWS Macarthur</td>
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<td>51</td>
<td>Ms Anita Henry-Periris - Personal</td>
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<tr>
<td>52</td>
<td>Ms Lesley Ford and Ms Leanne Hawke - Personal</td>
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<td>53</td>
<td>Ms Jo Rose - Personal</td>
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<td>Master Kieron Hewitt - Personal</td>
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<td>Miss Geraldine Hewitt - Personal</td>
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<td>Mr Kevin Coleman - Personal</td>
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<td>57</td>
<td>Ms Sarah Berryman - Post Adoption Resource Centre</td>
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<td>Ms Sarah Berryman - NSW Committee on Adoption and Permanent Care Inc.</td>
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<td>Mr Bill Cordray - Personal</td>
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<td>60</td>
<td>Mrs Leonie Hewitt and Mr Warren Hewitt - Personal</td>
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<td>61</td>
<td>Ms Mandy Robinson - Personal</td>
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<td>Ms N Ruscoe - Personal</td>
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<td>Ms Erika Berzins - Personal</td>
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<td>64</td>
<td>Dr CR Nichols, Honorary Secretary - Royal Australian College of Obstetricians and Gynaecologists</td>
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<td>Mrs Christine Whipp - Personal</td>
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<td>RTCCC - Submission in relation to impact upon children</td>
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<td>67</td>
<td>Ms Jean Murray - SA Council on Reproductive Technology. Submission in relation to impact upon children</td>
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<td>Ms Sue Midford - Submission in relation to impact upon children</td>
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<td>Mr Robert Fisher - Family and Children’s Services. Submission in relation to impact upon children</td>
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<td>Mr Eric Blyth - University of Huddersfield</td>
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<td>71</td>
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<td>Ms Dennise Hughes - Personal</td>
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<td>Miss H Curry - Personal</td>
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<td>Ms L Gower - Personal</td>
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<td>77</td>
<td>Mrs Helen Adelsbury and Mr Ken Adelsbury - Personal</td>
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<td>Mr MJ Hull and Mrs HR Hull - Personal</td>
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<td>79</td>
<td>Mr Shane Moffitt and Mrs Jenni Moffitt - Personal</td>
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<td>Mrs Stephanie Knox - Genesis Infertility Group</td>
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<td>81</td>
<td>Ms Rose McIvor - Personal</td>
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<td>82</td>
<td>Mr D McCann and Mrs P McCann - Personal</td>
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<td>JG Cronin - Personal</td>
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<td>84</td>
<td>Mrs Jill Murphy - Personal</td>
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<td>85</td>
<td>Mr Charles DeBruin and Mrs Carmel DeBruin, Mr Mike Keating and Mrs Monique Keating - Personal</td>
</tr>
<tr>
<td>86</td>
<td>Ms Leigh Newman, Legislation Officer - Health Department of WA</td>
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<tr>
<td>87</td>
<td>Mr and Mrs P Long - Personal</td>
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## APPENDIX C

### INTRASTATE INVESTIGATIVE VISITS

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday, 23 June 1997</strong></td>
<td><strong>CONCEPT FERTILITY CLINIC, KING EDWARD MEMORIAL HOSPITAL</strong></td>
<td>Dr Phillip Matson, Dr Terry Thomas, Mrs Jill Bain</td>
</tr>
<tr>
<td><strong>Wednesday, 24 September 1997</strong></td>
<td><strong>PIVET MEDICAL CENTRE</strong></td>
<td>Dr John Yovich, Dr Jeanne Yovich, Dr Stephen Junk, Mr Maxim Keyt, Dr Neville Phillips, Ms Deborah Foster-Gaitskell</td>
</tr>
<tr>
<td><strong>Wednesday, 24 September 1997</strong></td>
<td><strong>PERTH ANDROLOGY (FERTILITY WEST)</strong></td>
<td>Dr Anne Jequier, Associate Professor Jim Cummins</td>
</tr>
<tr>
<td><strong>Monday, 3 February 1998</strong></td>
<td><strong>REPRODUCTIVE MEDICINE RESEARCH INSTITUTE (KEOGH INSTITUTE FOR MEDICAL RESEARCH)</strong></td>
<td>Dr Bronwyn Stuckey, Mr Dennis Brennan</td>
</tr>
</tbody>
</table>
### APPENDIX D

#### INTERSTATE INVESTIGATIVE TOUR (23 - 26 MARCH 1998)

<table>
<thead>
<tr>
<th>Monday, 23 March 1998</th>
<th>MELBOURNE</th>
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</thead>
<tbody>
<tr>
<td><strong>Meeting 1</strong></td>
<td></td>
</tr>
<tr>
<td>Ms Helen Szoke</td>
<td>Chief Executive Officer, Infertility Treatment Authority (ITA)</td>
</tr>
<tr>
<td>Professor Louis Waller AO</td>
<td>Chairman, ITA and Academic Lawyer</td>
</tr>
<tr>
<td>Dr Leeanda Wilton</td>
<td>ITA Member and Research Embryologist, Melbourne IVF</td>
</tr>
<tr>
<td>Professor Tony Coady</td>
<td>ITA Member and Professor of Philosophy</td>
</tr>
</tbody>
</table>

| **Meeting 2**         |           |
| Dr Leeanda Wilton     | ITA Member and Research Embryologist, Melbourne IVF |
| Dr David Edgar        | Clinical Scientist, Melbourne IVF |

| **Meeting 3**         |           |
| Professor John Leeton | Reproductive Gynaecologist |

| **Meeting 4**         |           |
| Mrs Pauline Ley       | Origins, Advocacy and Kinship (OAK) |
| Ms Meredith Lenne     | OAK |

<table>
<thead>
<tr>
<th>Tuesday, 24 March 1998</th>
<th>MELBOURNE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meeting 1</strong></td>
<td></td>
</tr>
<tr>
<td>Mr Roger Cook</td>
<td>Counsellor and member of ANZICA (Australian and New Zealand Infertility Counsellors Association), Immediate Past President of the Fertility Society of Australia</td>
</tr>
</tbody>
</table>

| **Meeting 2**          |           |
| Dr Gordon Baker        | Chairman, Reproductive Technology Accreditation Committee (RTAC) |
| Ms Kay Oak             | Counsellor |

| **Meeting 3**          |           |
| Ms Donna Howlett       | Chief Executive of Monash IVF, and a Council member of the Fertility Society of Australia |

<p>| <strong>Meeting 4</strong>          |           |
| Ms Moira Rayner        | Lawyer |</p>
<table>
<thead>
<tr>
<th>Meeting 1</th>
<th>SYDNEY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Deborah Frew</td>
<td>Legal Officer, Health Department of NSW</td>
</tr>
<tr>
<td>Ms Karen Crawshaw</td>
<td>Director Legal, Health Department of NSW</td>
</tr>
<tr>
<td>Dr Andrew Wilson</td>
<td>Chief Health Officer, Health Department of NSW</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Meeting 2</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Professor Douglas Saunders</td>
<td>Head of the Department of Obstetrics and Gynaecology, University of Sydney, Royal North Shore Hospital Clinician</td>
</tr>
<tr>
<td>Ms Felicity Garner</td>
<td>Infertility Counsellor, social worker and member of ANZICA, and the RTAC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Meeting 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Stephen Steigrad</td>
<td>Director of the Department of Reproductive Medicine, Royal Hospital for Women</td>
</tr>
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<table>
<thead>
<tr>
<th>Meeting 4</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Robert Jansen</td>
<td>Medical and Managing Director of Sydney IVF Pty Ltd. and Head, Department of Reproductive Endocrinology and Infertility, Royal Prince Alfred Hospital and King George V Memorial Hospital, Sydney</td>
</tr>
<tr>
<td>Ms Kerrie McGowan</td>
<td>Infertility counsellor at Sydney IVF and the President of ANZICA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Meeting 5</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs Caroline Lorbach</td>
<td>Donor Conception Support Group (DCSG)</td>
</tr>
<tr>
<td>Mrs Leonie Hewitt</td>
<td>DCSG</td>
</tr>
<tr>
<td>Ms Belinda Norris</td>
<td>Donor offspring</td>
</tr>
<tr>
<td>Mrs Ros Strong</td>
<td>Ms Norris’s mother</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Thursday, 26 March 1998</th>
<th>CANBERRA</th>
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</table>

<table>
<thead>
<tr>
<th>Meeting 1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Meg Wallace</td>
<td>Senior Legal Officer, Legal Policy Division, ACT Department of Justice and Community Safety</td>
</tr>
<tr>
<td>Ms Anna Lennon</td>
<td>Executive Director, Legal and Policy Division, ACT Department of Justice and Community Safety</td>
</tr>
<tr>
<td>Ms Janice Boyle</td>
<td>Acting Director, Civil Law Section, Legal and Policy Division, ACT Department of Justice and Community Safety</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Meeting 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Martyn Stafford-Bell</td>
<td>Director, Canberra Fertility Centre, John James Hospital</td>
</tr>
<tr>
<td>Ms Kim Riding</td>
<td>Social Worker with Canberra Fertility Centre and Relationships Australia</td>
</tr>
<tr>
<td>Ms Pam McAllister</td>
<td>Biochemist and coordinator of the sperm bank</td>
</tr>
</tbody>
</table>
Dr Chris Copeland  
Owner of Canberra Fertility Centre, John James Hospital

**Meeting 3**

Ms Penny Rodgers  
Assistant Secretary, Diagnostics and Technology Branch, Department of Health and Family Services and member of the Australian Health Technology Advisory Committee

Ms Geraldine Donohoe  
Secretary to the Australian Health Technology Advisory Committee, Department of Health and Family Services

Ms Christine Polinelli  
Secretary of the Assisted Reproductive Technology Review Working Party of the Australia Health Technology Advisory Committee, Department of Health and Family Services

**Meeting 4**

Ms Sharon Tuffin  
Executive Secretary, Australian Health Ethics Committee

Ms Monica Johns  
Secretary, Working Party on National Data Collection in Assisted Reproductive Technology
APPENDIX E

OVERSEAS INVESTIGATIVE TOUR (17 JULY - 6 AUGUST 1998)

**Monday, 20 July 1998**

<table>
<thead>
<tr>
<th>Meeting 1</th>
<th>PARIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Madame Chantal Ramogida</td>
<td>Executive Director, Association Pauline et Adrien</td>
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<table>
<thead>
<tr>
<th>Meeting 2</th>
<th>PARIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Madame le Docteur Lordier</td>
<td>Direction Generale de la Sante, Ministere de l’Emploi et de la Solidarite</td>
</tr>
<tr>
<td>Madame Catherine Briand</td>
<td>Direction Generale de la Sante, Ministere de l’Emploi et de la Solidarite</td>
</tr>
<tr>
<td>Monsieur Robert Simon</td>
<td>Direction Generale de la Sante, Ministere de l’Emploi et de la Solidarite</td>
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**Tuesday, 21 July 1998**

<table>
<thead>
<tr>
<th>Meeting 1</th>
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<tbody>
<tr>
<td>Professor Rene Frydman</td>
<td>Obstetrician and Gynaecologist, Hopital Antoin e Beclere</td>
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<table>
<thead>
<tr>
<th>Meeting 2</th>
<th>PARIS</th>
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</thead>
<tbody>
<tr>
<td>Professor Jean-Pierre Changeux</td>
<td>President, Comite Consultatif Nationale D’Ethiques.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Meeting 3</th>
<th>PARIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Jean-Marie Kunstmann</td>
<td>Biologist, Centre d’Etudes et Conservation des Oeufs et du Sperme Humains (CECOS) Cochin</td>
</tr>
<tr>
<td>Mme Simone Bateman Novaes</td>
<td>Member of the Executive Committee of the Federation Francaise des CECOS</td>
</tr>
<tr>
<td>Dr Francois Thepot</td>
<td>Director of CECOS Amiens</td>
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**Wednesday, 22 July 1998**

<table>
<thead>
<tr>
<th>Meeting 1</th>
<th>LONDON</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Josephine Quintavalle</td>
<td>Co-Founder, CORE (Comment on Reproductive Ethics)</td>
</tr>
<tr>
<td>Dr Helen Watt</td>
<td>Linacre Centre</td>
</tr>
<tr>
<td>Mr Chris Moore</td>
<td>Centre for Bioethics and Public Policy</td>
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<table>
<thead>
<tr>
<th>Meeting 2</th>
<th>LONDON</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs Kim Cotton</td>
<td>Chairperson, COTS (Childlessness Overcome Through Surrogacy)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Meeting 3</th>
<th>LONDON</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>
Thursday, 23 July 1998

Meeting 1
Ms Marcia Fry Head of Health Policy Branch, Department of Health.
Mr Nick Dean Policy maker and Team Leader - assisted conception, surrogacy, Department of Health
Mr Mike Evans Senior Policy Manager in the area of assisted conception and infertility, Department of Health
Ms Sue Ryan Legal adviser on human fertilisation, embryology and surrogacy
Dr Elaine Gadden Senior Medical Officer, Department of Health

Meeting 2
Mrs Suzanne McCarthy Chief Executive Officer, Human Fertilisation and Embryology Authority (HFEA)
Mrs Jane Denton Deputy Chairman, HFEA
Dr David Thorne HFEA Senior Manager - (Licensing)
Ms Beatrice Heales Policy Manager, HFEA

Meeting 3
Professor Sheila McLean International Bar Association Professor of Law and Ethics in Medicine, Director of the Institute of Law and Ethics in Medicine, University of Glasgow

Friday, 24 July 1998

Meeting 1
Ms Juliet Tizzard Administrator, The Progress Educational Trust

Meeting 2
Ms Susan Rice Chief Executive, ISSUE The National Fertility Association

Meeting 3
Ms Clare Brown Executive Director, CHILD

Meeting 4
Professor Susan Golombok Director, Family and Child Psychology Research Centre, City University of London
Monday, 27 July 1998

**Meeting 1**
Professor Ian Cooke
Clinician and Chairman of British Fertility Society

**Meeting 2**
Ms Jennifer Hunt
Chair, British Infertility Counselling Association
Mr Eric Blyth
Principal Lecturer in Social Work, University of Huddersfield

**Meeting 3**
Dr Peter Brinsden
Medical Director, Bourn Hall Clinic, Cambridge

Wednesday, 29 July 1998

**Meeting 1**
Dr Suzanne Scorsone
Anthropologist and former Commissioner with the Royal Commission on New Reproductive Technologies

**Meeting 2**
Ms Diane Allen
Executive Director, Infertility Network
Ms Sherry Franz
Social Worker and Co-founder of Infertility Network
Ms Jean Haase
Social Worker, Reproductive Medicine, London Health Sciences Centre
Mrs Shirley Pratten
New Reproductive Alternatives Society

**Meeting 3**
Ms Jan Silverman
Coordinator, Infertility Support and Education Program

Thursday, 30 July 1998

**Meeting 1**
Mr Bernard Starkman
Senior Counsel, Department of Justice
Dr Phyllis Colvin
Director of Health Policy, Health Canada
Ms Doris Cooke
Senior Policy Analyst, Health Canada
Ms Christine Aubry
Health Canada

Monday, 3 August 1998

**Meeting 1**
Mr Bill Handel
Director, Centre for Surrogate Parenting and Egg Donation (CSP)
Dr Karen Synesiou
Director, CSP
Ms Hilary Hanfin
Counsellor, CSP
Mr Andrew Vorzimer
Lawyer
Meeting 2
Professor Michael Shapiro
Professor of Law and Medicine, University of Southern California

Meeting 3
Mrs Barbara Ely
President, Greater Los Angeles Chapter of RESOLVE
APPENDIX F

CONSENT FORMS
APPENDIX G

STATEMENT OF ACTUAL (OR ESTIMATED) COSTS OF THE OPERATION OF THE COMMITTEE IN ACCORDANCE WITH STANDING ORDER 378(b)

<table>
<thead>
<tr>
<th>Travel Expenses</th>
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<tbody>
<tr>
<td>Interstate Investigative Tour - Melbourne/Sydney/Canberra - 22 March - 26 March</td>
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<tr>
<td>Allowances Members</td>
<td>$ 7 400</td>
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<tr>
<td>Allowances Staff</td>
<td>$ 3 000</td>
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<tr>
<td>Airfares Members</td>
<td>$ 9 400</td>
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<tr>
<td>Airfares Staff</td>
<td>$ 4 100</td>
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<tr>
<td>Incidental expenses</td>
<td>$ 1 400</td>
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<tr>
<td>Overseas Investigative Tour - France/London/Canada/USA - 17 July - 6 August 1998</td>
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<tr>
<td>Allowances Members</td>
<td>$21 700</td>
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<tr>
<td>Allowances Staff</td>
<td>$15 600</td>
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<tr>
<td>Airfares Members</td>
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<tr>
<td>Airfares Staff</td>
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<tr>
<td>Incidental expenses</td>
<td>$ 8 700</td>
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<table>
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<tbody>
<tr>
<td>Consultants (Research Officer)</td>
<td>$41 100</td>
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<tr>
<td>Advertising</td>
<td>$ 9 900</td>
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<tr>
<td>Postage, couriers</td>
<td>$ 700</td>
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<tr>
<td>Reference books and materials</td>
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<td>Refreshments</td>
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<td>Stationery and photocopying</td>
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<tr>
<td>Miscellaneous</td>
<td>$ 400</td>
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<td>Provision for Printing of Report</td>
<td>$10 000</td>
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<tr>
<td>Provision for Postage of Report</td>
<td>$ 5 000</td>
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**TOTAL** | $172 600 |

Please note that amounts are rounded to the nearest $100.