COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

LEGAL AND CONSTITUTIONAL AFFAIRS REFERENCES COMMITTEE

Reference: Donor conception in Australia

FRIDAY, 29 OCTOBER 2010

CANBERRA

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SENATE LEGAL AND CONSTITUTIONAL AFFAIRS
REFERENCES COMMITTEE
Friday, 29 October 2010

Members: Senator Barnett *(Chair)*, Senator Crossin *(Deputy Chair)* and Senators Furner, Ludlam, Parry and Trood

Participating members: Senators Abetz, Adams, Back, Bernardi, Bilyk, Birmingham, Mark Bishop, Boswell, Boyce, Brandis, Bob Brown, Carol Brown, Bushby, Cameron, Cash, Colbeck, Coonan, Cormann, Eggleston, Faulkner, Ferguson, Fielding, Fierravanti-Wells, Fifield, Fisher, Forshaw, Hanson-Young, Heffernan, Humphries, Hurley, Hutchins, Johnston, Joyce, Kroger, Ian Macdonald, McEwen, McGauran, Marshall, Mason, Milne, Minchin, Moore, Nash, O'Brien, Payne, Polley, Pratt, Ronaldson, Ryan, Scullion, Siewert, Stephens, Sterle, Troeth, Williams, Wortley and Xenophon

Senators in attendance: Senators Barnett, Crossin, Pratt and Trood

Terms of reference for the inquiry:

To inquire into and report on:

The past and present practices of donor conception in Australia, with particular reference to:

(a) donor conception regulation and legislation across federal and state jurisdictions;

(b) the conduct of clinics and medical services, including:

  (i) payments for donors,

  (ii) management of data relating to donor conception, and

  (iii) provision of appropriate counselling and support services;

(c) the number of offspring born from each donor with reference to the risk of consanguine relationships; and

(d) the rights of donor conceived individuals.

WITNESSES

Committee met at 9.15 am

CHAIR (Senator Barnett)—Good morning, everybody. This is the first hearing for the Senate Legal and Constitutional Affairs References Committee inquiry into past and present practices of donor conception in Australia. This inquiry was referred to the committee by the Senate on 23 June 2010. In conducting the inquiry, the committee is required to have particular reference to:

(a) donor conception regulation and legislation across federal and state jurisdictions;
(b) the conduct of clinics and medical services, including:
  (i) payments for donors,
  (ii) management of data relating to donor conception, and
  (iii) provision of appropriate counselling and support services;
(c) the number of offspring born from each donor with reference to the risk of consanguine relationships; and
(d) the rights of donor conceived individuals.

On 30 September 2010 the Senate decided to re-adopt the inquiry with a new reporting date of 24 November 2010.

I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to the committee. Such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to the committee. The committee prefers all evidence to be given in public, but under the Senate's resolutions witnesses have the right to request to be heard in private session. It is important that witnesses give the committee notice if they intend to ask to give evidence in camera. If a witness objects to answering a question, the witness should state the ground upon which the objection is taken and the committee will determine whether it will insist on an answer, having regard to the ground which is claimed. If the committee determines to insist on an answer, a witness may request that the answer be given in camera. Such a request may, of course, also be made at any other time.

[9.17 am]

STAFFORD-BELL, Dr Martyn Anthony, Medical Director, Canberra Fertility Centre

CHAIR—I welcome Dr Martyn Stafford-Bell from the Canberra Fertility Centre. Thank you very much for being here today. The Canberra Fertility Centre has lodged a submission, which we have designated submission No. 48. Do you wish to make any amendments or alterations to that submission?

Dr Stafford-Bell—No.

CHAIR—That being the case, I invite you to make some opening statements, at the conclusion of which we will have questions from members of the committee.

Dr Stafford-Bell—I would like to draw your attention to an area of particular concern to us, and this is the area of state or federal registries. There are already registries in place. They are run by the individual ART units. They are run by experts and they are run to the dictates of RTAC and the NHMRC, without which we cannot get registration or accreditation or run our clinics. The concept of state or federal registries means that we therefore have duplication or even triplication, which is a blueprint for chaos and confusion and the reporting of inaccurate data, which of course could have potentially disastrous results.

The public have a horror of having their intimate details on a government computer, to which they believe any public servant can get access. This fear is exacerbated by the regular reporting in the news media of leaks from government departments. In Western Australia, where there is legislation, the supply of donors—if you will pardon the expression—has almost completely dried up. I am quite sure that federal or continuing state legislation will result in the loss of almost all of the very few donors that we still have in this country, with the resultant effect on the patients who need their help.

The reasons that people put forward for a register are, firstly, that it will prevent somebody donating in multiple clinics. In Australia, where we have the greatest possible difficulty in getting anybody to donate anywhere, this mythical being has yet to be recognised or demonstrated. We believe he does not exist, but if he does and he is that determined, he will get around any restrictions that you care to impose. The second area which is always raised is the risk of consanguinity, and there is no adjective which accurately describes just how tiny this chance really is. If you consider for a moment the number of people at any one time aged between, say, 20 and 38 in the community who are donor conceived as a percentage of the total number of people of that age group in the community, you can see just how tiny it is, and the chance of two of those people meeting even tinier, and the chance of them both coming from the same donor even more remote. Parents do not always tell their children that they are donor conceived, so they would have no indication in their minds to access such a registry. Therefore, a registry is not going to reduce the risk of consanguinity. This is kept to an almost irreducible minimum, if indeed it exists, by the clinics, which put a limit on the number of families a particular donor is allowed to produce.

Finally, we are completely opposed to a register of donor conceived children. The situation in Western Australia, for example, is that the register informs the child at the age of 16 of their donor origins and the identity of the donor. Are you able to imagine, for example, a girl who has not been told that she is donor conceived, who, along with her birthday cards on her 16th birthday, receives a notification from the registry that says that the man she has called dad for 16 years is not her father; it is a man called John Smith from somewhere else. That anguish would be with her for life, reinforced on every single birthday. Together with the pain and loss of trust in that family, who is going to come forward and be accountable for that particular family disaster? Therefore, these are our concerns on a registry. I draw your attention to the famous Hippocratic statement of primum non nocere, which is, ‘firstly, do no harm’. We believe that state and federal registries would do a great amount of demonstrable harm on the basis that I have just alluded to. They will do no appreciable good and certainly no good over and above that which is presently being done by the registries kept by the clinics. So my advice, and indeed my request to you, would be that you leave the maintenance of donor registries to the experts, who have been doing it very successfully for years to the satisfaction of all concerned. Thank you.

CHAIR—Thank you very much, Dr Stafford-Bell, for your opening remarks and for your submission. We will now move to questions.

Senator CROSSIN—Dr Stafford-Bell, thank you for your submission and your time today. The issue of the registration—leave it alone in the interests of those concerned. The very reason we are having this inquiry is that we have been lobbied very heavily from parents who have used the donor conception technology and the children of those parents to say that the situation in this country is not satisfactory at all. That is why they want the Senate to have a long, hard look at what is happening. Can I ask you, in terms of registration, when you get somebody who is actually providing you with a donation, what information goes on your register?

Dr Stafford-Bell—There is a list of information which is required by RTAC and the NHMRC. It is a very extensive one: name, address, date of birth, name of wife, date of birth—

Senator CROSSIN—And if you are not married, then?

Dr Stafford-Bell—Then you have not got a wife.

Senator CROSSIN—Okay.

Dr Stafford-Bell—We take a past medical history and then there is a list of questions which the doctor goes through with the donor, looking for conditions which may be transmissible down the family line. There is a standard proforma that we all use—family history in addition to that, educational background and personal interests.

His height, weight, hair colour, eye colour, general build, blood group, complexion and race go on the form for identification-matching purposes. Following that he has the screening tests, which are recommended by RTAC and the NHMRC, and which also go on his record.

Senator CROSSIN—That is what you do in Canberra, under the guidelines. Do you believe those guidelines are adequate?

Dr Stafford-Bell—Yes, I do.

Senator CROSSIN—We have got evidence in submissions that have come before us that the information you record is not consistent across the country. Even though there are guidelines, state based registers vary, and therefore there is a very strong call to have a national register and national consistency.

Dr Stafford-Bell—Could I ask you to help me: what are the complaints that your constituents raise? What are their concerns?

Senator CROSSIN—Inadequacy in accessing those records, and data that may be recorded in some places but not in other places. You say that you take a past medical history of the donor, but it seems that in some places people cannot access that. People believe they have got an entitlement to that.

Dr Stafford-Bell—They do. My first comment to that is that if you phoned up a government registry and said, ‘I want access to data,’ I wonder just how many months it would be before that data was actually produced and by whom?

Secondly, it is a requirement of RTAC and the NHMRC that we do record these things. I would suggest that if you have any problems in that particular area you should be talking to RTAC.

Senator CROSSIN—We will subsequently do that in this inquiry. But you are not aware then, from the Canberra clinic’s point of view, of any inconsistencies that operate across the country?

Dr Stafford-Bell—No, I am not. But, obviously, I have not looked at other people’s registers. I do know that they are all supposed to keep the same information. Therefore, since we cannot operate unless we have RTAC accreditation, I would think that the simplest way around the problem that you describe is not to set up a very expensive government registry, of which the public would have a horror, but to go to RTAC and say, ‘Here are the complaints that we have. You accredit these clinics and it is up to you to sort this out.’ One of the requirements of RTAC is that we conform to the requirements of the NHMRC, into which government has a considerable input.

Senator CROSSIN—They are guidelines at this point in time. I suppose we will explore the power that they have to actually enforce those guidelines and whether there should be legislation rather than guidelines that do make it consistent. Is there any national organisation, peak body or means by which your clinic can interact and network with other clinics around this country? Is there a national body? Do you come together yearly or monthly? Do you look at the kind of registers that are kept in Melbourne and Victoria and compare them with what you keep?

Dr Stafford-Bell—No, I do not. We are all members of the Fertility Society of Australia. But you said that these are just guidelines. Yes, but if we do not conform to the guidelines, then RTAC will not accredit us. And if we do not show evidence of conforming to the guidelines then RTAC has the option of recommending to the government that our patients do not receive Medicare benefits until we do conform.

That is a real sting that RTAC carries and it is agreed with government. If you have any problems such as you describe, I repeat that I think that the setting-up of an extremely unwieldy and expensive government registry is really not the way around it. It is to say to RTAC, ‘Here is a problem that we have: some of these clinics are clearly not conforming, we believe—and it is only patients’ words; documents have not been produced—to the NHMRC guidelines and we would like you to sort this out.’ And you could also put a very nasty little sting in the tail and say, ‘If you don’t sort it out, we will set up a federal register’—which nobody wants.

Senator CROSSIN—I am sure there are a whole range of options that the committee will consider in the course of this inquiry.

Dr Stafford-Bell—That is the option I would use.

Senator CROSSIN—Do you pay your donors?

Dr Stafford-Bell—No, only out-of-pocket expenses.

Senator CROSSIN—So a taxi fare or—?

Dr Stafford-Bell—Correct.

Senator CROSSIN—You do not actually give them a cash payment each time they donate?

Dr Stafford-Bell—No.

Senator CROSSIN—Finally, how many donor conceived people have come to your registry seeking information about their donor?

Dr Stafford-Bell—None.

Senator CROSSIN—Are you aware that any have tried to do that?

Dr Stafford-Bell—That is a double question. Yes, I am aware, and I am aware that nobody has.

Senator CROSSIN—Can I go to your clinic and seek information about the person I believe is my donor?

Dr Stafford-Bell—Yes.

Senator CROSSIN—What is the process for doing that?

Dr Stafford-Bell—You contact the clinic and say, ‘I’m So-and-so. My date of birth is such and such. I was a donor conceived child and I would like information on my genetic father.’ You have to be 18 before you can do that. We would then say, ‘Right, there is now a 30-day cooling-off period in which you can reconsider this, but in the meantime we will contact the donor.’ In that time we contact the donor and we let him know that the child is 18 and has requested identifying information about him and that we are going to release the information, because these days of course donors sign consent for that information to be released to an 18-year-old. This gives the donor and his family time to prepare for the potential contact and visit from the child, and after 30 days we release the identifying information to the child.

Senator CROSSIN—So if the donor does not consent?

Dr Stafford-Bell—But he already has.

Senator CROSSIN—He has to consent when he donates?

Dr Stafford-Bell—Yes.

Senator CROSSIN—We might question whether that is the same in each state or territory, I guess.

CHAIR—The law changed on that, of course.

Senator CROSSIN—Can I at any stage come to your clinic and say, ‘I don’t want to meet my donor, but I want to know his medical history.’

Dr Stafford-Bell—Yes, absolutely, and we have a right to release it. There are of course, as you would be well aware, two types of donors: those who donated before the recommendations came in that donor conceived children have a right to know their genetic origins—there are people around who are now 20 or 30 years old who came from that sort of donor—and we have the latest situation, which has been around for eight to 10 years, I suppose, now—do not quote me—that donor conceived children have a right to know the identity of their genetic father. Yes, you can access all of that, and we have a very clear protocol—as, I believe, do all the clinics, because if anybody does not then they are not conforming to the NHMRC guidelines and they should not be accredited by RTAC. So I come back to the comment that I have just made: your first port of call should not be an expensive government registry; it should be a telephone call to RTAC.

Senator CROSSIN—Again, they are only guidelines.

Dr Stafford-Bell—Yes, they are, but without—

Senator CROSSIN—They are not enforceable, you see.

Dr Stafford-Bell—Yes, they are, because we cannot work unless we comply.

Senator CROSSIN—With all of them?

Dr Stafford-Bell—With all of them.

Senator CROSSIN—And how often does RTAC ensure you are complying with all of the guidelines?

Dr Stafford-Bell—Every year. We are accredited every year.

CHAIR—That is something I think we could come back to as well. It is a very important point. Now Senator Pratt has some questions.

Senator PRATT—You have argued that in states like Western Australia there are not a lot of donors anymore, but it strikes me that, even in the ACT, clearly people have to be prepared when they donate to be a known donor in some context. I do not quite understand what the difference is. Could you explain to me what you think it is.

Dr Stafford-Bell—Sure. People feel that if their data is kept on a register run by professionals in the field with vast experience then it is handled sensitively and in confidence. It is like going to see your doctor. They are very afraid, rightly or wrongly, of having their intimate details on a government register to which they believe any Tom, Dick or Harry living around the corner can log in and gain access. Whether or not that is true I do not know, but it is the perception of the general public.

Senator PRATT—Do you have any views about the historical problem we have, which is those people—largely adults now, although I think the practices here changed some 10 years ago—who feel a lot of parallels with past adoption practices in that they are unable to find information about their biological parents? Clearly you have been involved in creating many of these children, which is a terrific thing. How do you think we as legislators need to deal with these past practices?

Dr Stafford-Bell—There are two answers to your question. No. 1 is legislation. I really believe that you cannot legislate to force previous donors to have their identity revealed. Thirty years ago people donated on the strict understanding that their donation was anonymous, and I do not think you can have retrospective legislation. That would be a total betrayal of people’s trust. If somebody came to us—and let me emphasise that nobody has—

Senator PRATT—Well, they know they cannot.

Dr Stafford-Bell—The oldest child from our donor program was born in 1979. If that 31-year-old came to us tomorrow and said, ‘I would like to know the identity of my genetic father,’ then we would make every possible effort to contact the donor. Let us accept that, whether you have a government registry or our registry, contacting somebody who donated 30 years ago might be difficult, but we would make every possible effort to trace this donor. We would contact the donor and say, ‘This request has been made.’

Senator PRATT—That is certainly something that takes place now in relation to past adoption practices in states like Western Australia, as I understand it. But that depends on the goodwill of your practice. Perhaps someone should have the right to say, ‘There is a process mandated by law and the best endeavours will be made to make contact,’ and that information would be coordinated on a national basis with the very important imperative that someone who wants to find their genetic parent has the best possible chance of doing so.

Dr Stafford-Bell—I come back to my previous comment as to just how long it would take for a government-run register to turn out that information.

Senator PRATT—I am not necessarily saying it would be government run but that there would be protocols that could exist, if you like, across the sector.

Dr Stafford-Bell—You said firstly it was up to the goodwill of the clinic to do it. I believe every clinic would but I take your point. It is then up to the goodwill of the donor as to whether he is prepared to be identified, and I do not think I have indicated that it is appropriate to have retrospective legislation, which is a ghastly concept.

Senator PRATT—We have done it with adoption in many cases. There are protocols in place where you have skilled counsellors who are mandated to make contact. Even if someone declines a number of times, their privacy is never breached, but the opportunity is offered through a third party to relay the circumstances under which someone would like to make contact with their parent. There are a range of those protocols in place, which in many instances have led to very worthwhile connections being made and which I believe people are probably being denied under the current circumstances.

Dr Stafford-Bell—I think you would get a very much better outcome if the contact were from the clinic. If, for example, a man has not been contacted for 30 years, he is not going to respond terribly well to a government bureaucrat saying, ‘We want you to let the donor know who you are.’ On the other hand, if somebody phoned up and said, ‘Hey, John, this is Pam from Canberra Fertility Centre. You won’t remember me but you donated,’ you might get, ‘Of course, I remember you.’ If Pam then says, ‘John, you are not obliged, but we’ve had this request. What do you think?’ John is much more likely to respond to that sort of personal contact.

Senator PRATT—I do not disagree but some clinics may no longer exist. That is why you need a very firm protocol. The government cannot help, if you are going to consider these things, but have involvement, to make sure that records are kept, that they are handed over, that they are consistent et cetera. Those processes definitely need to be in place and there needs to be a fallback for someone who does not have access to a clinic but is offering a decent service.

Dr Stafford-Bell—Well, then why don’t you go back to the organisation that you support, which is RTAC, and say, ‘This is what we want; fix it.’ I assure you that RTAC would fix it, because the last RTAC or a fertility society, of which it is a branch, want is a central government, bureaucratic, impersonal registry.

Senator PRATT—That is why we are here talking to you about the issues, so we know what questions to ask.

Senator TROOD—Dr Stafford-Bell, your submissions says that you are not totally opposed to a central state or national donor registry if it acted in the best interests of all parties involved. What does the last part of that mean—‘in the best interests of all parties involved’?

Dr Stafford-Bell—I think that any sort of central registry has to be run by experts. It has to be run with sensitivity and it has to provide the information which is required, but in a sensitive fashion. That is almost a contradiction in terms. We have said this, and I will make a comment at the end if I may. The difficulty with a central registry is the experience of the people likely to be running it and the sensitivity of the people running it, who are dealing with people they do not know and with whom they have never had any contact. The opposite to that is the clinics, which are quite the reverse of that situation.

Senator TROOD—I see the point you were making to Senator Pratt, but 'in the best interests of all parties involved' is not just a matter of courtesies and manners, as I understand it; it is a matter of the interests and rights of the donors and the conceived child. I assume that is what you mean.

Dr Stafford-Bell—Yes, it is.

Senator TROOD—Is that right?

Dr Stafford-Bell—Absolutely.

Senator TROOD—Would your view be that the kinds of protocols that are in place reflect those best interests?

Dr Stafford-Bell—Yes.

Senator TROOD—Do you see any need for the guidelines by which you act at the moment to be expanded in any way? Do you think there are any weaknesses or limitations in those guidelines?

Dr Stafford-Bell—I personally think the guidelines are perfectly adequate. It is a question of enforcing them, as I have indicated. RTAC has the real power to enforce them. I have no problem whatsoever with you sitting down with RTAC or the NHMRC. Basically, on the question of donors, RTAC says, 'You will follow the guidelines of the NHMRC,' so I have no problem with you sitting down with the NHMRC, to which government has a very considerable input anyway, and saying, 'Here are your guidelines; we have concerns that don't seem to be met by your guidelines (1), (2), (3), (4) and (5), and we would like you to include those in your guidelines.' They are then issued in a revised set of guidelines—and the guidelines are revised with great regularity—and then it is up to RTAC to enforce it.

Senator TROOD—There may be ways of doing that, but I am interested in whether you regard the guidelines as adequate or perhaps even overbearing in some respects. As a practitioner in this field for a long period of time, do you think the guidelines provide for, in your words, 'the best interests of all parties involved'?

Dr Stafford-Bell—I think the NHMRC guidelines at this present moment are perfectly adequate. That is my view. I really do believe that clinics will act in the best interests of patients. The issue has been raised that this is up to the goodwill of the clinic. Well, I think the clinics are all going to act in the best interests of the patient, so it does not present a problem. In that sense, I think that the guidelines are adequate. If, however, there are things which you really feel must be spelt out in the guidelines—contact with donors of time past, for example, as Senator Pratt was raising—then the thing to do is to talk to the NHMRC. It is simple.

Senator TROOD—Do you know of any instances where a clinic has either had its accreditation withdrawn or been in any way sanctioned as a result of its failure to meet guidelines?

Dr Stafford-Bell—Yes, I do.

Senator TROOD—There have been instances of that?

Dr Stafford-Bell—I know exactly which clinic it was, but I am not going to tell you.

Senator TROOD—We can perhaps ask the authorities for that information. Is there only one instance of which you are aware?

Dr Stafford-Bell—No. There are two actually.

Senator TROOD—Without revealing the detail, was the result of that sanction that the clinic was closed down or was it required to change its practices?

Dr Stafford-Bell—In the case of the first clinic, it was required to change its practice and it duly did. In the case of the second clinic, the owner of the clinic retired and the clinic was closed down.

Senator TROOD—In your submission you say that you perform annually various treatments using sperm imported from overseas. Is that a large part of your practice?

Dr Stafford-Bell—Yes. It is a large part of most people's practice, because of the lack of sperm donors.

Senator TROOD—I am interested in the extent to which the importation is adequately regulated under the guidelines.

Dr Stafford-Bell—Again without going into detail, I am at this moment being asked to provide an expert opinion on sperm importation from a particular source to a particular clinic. The second question that I have been asked is: 'That particular source isn't adequate; are there any other sources which are more adequate?' I am still working on my answer, but the data that I have at this present moment suggests that the sperm that is imported from overseas—and it is almost entirely exported from America; there is some from Europe but it is almost entirely from America—really meets the guidelines very strictly. In fact, the American clinics have stricter guidelines than we have here. The reason for that is that medical litigation is the national sport in America. It is almost bigger than baseball. The clinics therefore go to quite extraordinary lengths—when I talk about clinics, I am talking about laboratories as well—to utterly minimise the risk of litigation in what they are doing. So I am perfectly happy at this moment that sperm that is being imported from overseas more than meets the NHMRC guidelines.

Senator TROOD—So most of the imported sperm comes from the United States?

Dr Stafford-Bell—Yes.

Senator TROOD—There are obviously costs involved in that importation. Where are those costs borne?

Dr Stafford-Bell—What we do and what I believe most people do it is we have a list—let me make it as brief as possible. We have a female patient and we want a donor of the same blood group to avoid any possible clash of blood groups. Let us say she is A positive. We email the clinic and they send us a list of their A positive donors. The patient then selects a donor from the list and she sees all the characteristics that I referred to earlier on. She selects a donor from the list. We email the clinic in America and say that Mrs Kafoops is going to make contact with them. Mrs Kafoops emails them, she buys the sperm from them and she pays the cost of the importation of the sperm, which is addressed to her care of Canberra Fertility Centre.

Senator TROOD—I see. So you become the agent of the recipient.

Dr Stafford-Bell—Yes.

Senator TROOD—Is that right?

Dr Stafford-Bell—Yes, but there is no financial consideration attached to it.

Senator TROOD—From your perspective?

Dr Stafford-Bell—Correct.

Senator TROOD—Is that typical of the way overseas donations take place?

Dr Stafford-Bell—Yes.

Senator TROOD—Is that transaction covered adequately in the guidelines, do you think?

Dr Stafford-Bell—The guidelines do not say anything at all about the importation of overseas sperm, but the New South Wales legislation is very clear on the acquisition of sperm. The New South Wales legislation is very clear that you must not deal in sperm—in other words, you must not pass on sperm for a financial consideration.

Senator TROOD—No, I understand that. But, if your answer is not the central registers and things of that kind and you see merit in the regulations through RTAC et cetera and through those kinds of guidelines, then it is an obvious question as to whether or not those guidelines need in some way to be strengthened, given that apparently so many donations come from overseas and that they ought to be strengthened in ways which reflect that part of the practice.

Dr Stafford-Bell—I would answer it in two ways. Firstly, in almost all cases, whichever company in America we wish to talk about will provide to sperm to only one clinic per state in Australia. In other words, they will not supply all the ART units in New South Wales, of which there are a good number; they will supply one. This makes it very easy to control the number of families that that donor produces in Australia, which is the way we deal with our local donors. We do not swap sperm from donors from one state to another; it is confined to the state in which they donate. So that is easy.

Should guidelines be updated to deal with the importation of overseas sperm? I would have no problem in updating the guidelines to emphasise that there must be no financial transaction—in other words, we should not import sperm at $500 a straw and sell it to the patient for $1,000 a straw. That contravenes the idea of altruism, I believe—no, it does not; sorry. I have no problem with updating the guidelines from that point of view. But the work that I am doing at the moment—and it is not complete—suggests that, if you make a list of every single requirement and guideline of RTAC, NHMRC and the New South Wales legislation and send it to a clinic in America, they will meet every one of those guidelines.

CHAIR—Thank you very much. We are nearly out of time, Dr Stafford-Bell. I have two very quick questions. How do you track the identity of those overseas? Is it problematic? Have you found it to be problematic? And what is your response to that?

Dr Stafford-Bell—No, because the overseas clinics maintain a very careful register of their donors and very close and ongoing contact with their donors. Once again, this is necessary for good practice, but in the American perspective it is necessary to avoid litigation.

CHAIR—I guess it depends where the donor comes from and on different circumstances. Anyway, thank you for that feedback. Finally, how many donor conceived individuals are there in Australia in your view? What is your estimate?

Dr Stafford-Bell—I have no idea.

CHAIR—What is your best estimate?

Dr Stafford-Bell—No, I am not going to make an estimate, because I really do not know.

CHAIR—You do not know?

Dr Stafford-Bell—I honestly do not know.

CHAIR—Okay, thank you. Senator Pratt, very swiftly.

Senator PRATT—I have a quick question. You said in your opening statement how alarming it would be for a child to find out that they were donor conceived. It is my understanding with adoption practices that people now counsel families to tell their children when they are quite young about their origins and that that is now an emerging practice with donor conception, so I wanted your views about counselling around those issues.

Dr Stafford-Bell—It is not an emerging practice at all; it has been standard for years. I have been telling patients that they need to tell their children since we opened the sperm bank here in 1978.

Senator PRATT—So you tell them that a child should know from the outset?

Dr Stafford-Bell—Absolutely. But it is ultimately up to the parents to decide, because they may feel that it is not in the best interests of the child to know. You could think of several reasons why you should not tell a 15-year-old that they are donor conceived—or an eight-year-old.

Senator PRATT—But if they have always known then it is not so much of an issue.

Dr Stafford-Bell—Correct. I would agree with you. But we do counsel people.

Senator PRATT—Okay, thank you.

Dr Stafford-Bell—Since we are drawing to a close, could I make one suggestion to you—and you would be very wrong to assume that this represents a backdown from the position that I have adopted in opposition to a central registry. If, at the end of your deliberations, you decide for whatever reason that there must be some sort of central register, could I suggest that you discuss this with the FSA and ask them to run a central register. There are certain advantages from this that I would see. No. 1 is that the patients would not be afraid or have any horror of a register run by the FSA. No. 2 is that it would be run by people with great experience in the field. No. 3 is that it would be run with great sensitivity, and No. 4 is that it would be very, very much cheaper than a government run central registry.

CHAIR—Thanks very much for your concluding comments, Dr Stafford-Bell. I was checking whether we had received a submission from the FSA, and I do not believe we have at this stage. I was interested in that. Thank you very much for your submission.

Senator CROSSIN—Chair, could I just ask Dr Stafford-Bell to take on notice your view about nationally consistent legislation. I do not think we covered that. There is legislation in a couple of states, but there is no legislation in other states.

Dr Stafford-Bell—Correct.

Senator CROSSIN—We are out of time, but, if you could just provide us with your thoughts on that in due course, that would be useful.

Dr Stafford-Bell—That is easy. I would like to see two things. No. 1, I would like to see some sort of consistent guidelines on the number of children to be born in Australia from each donor. Some states make it five; some states make it 10; some people do it on a pretty arbitrary basis roughly based on the population of the state. Sorry, my mind has gone blank. What was the second part?

Senator CROSSIN—It was whether there should be consistent national legislation. I am not saying a national piece of legislation but consistency across the country. Some states have no legislation; some do, and for those that do it is inconsistent.

Dr Stafford-Bell—I am sorry. Yes, I agree with you absolutely. I think it is crazy that we have nine separate governments, all of them producing their own legislation, in a nation of 22 million people. I would like to see consistent legislation across the country on all subjects. As you know, my big thing over the years has been surrogacy. I would like to see consistent legislation. But the concept of a central Big Brother registry really frightens me.

CHAIR—I will have to call this time to a close. Dr Stafford-Bell, thanks for that, and I thank you for your presentation today.

[9.58 am]

EGAN, Mr Richard John, FamilyVoice Australia, National Policy Officer

CHAIR—Good morning, Mr Egan. I welcome you as a representative of FamilyVoice Australia. FamilyVoice Australia has lodged submission No. 17 with the committee. Do you wish to make any amendments or alterations to the submission?

Mr Egan—No.

CHAIR—That being the case, I invite you to make a short opening statement, after which we will have questions from members of the committee.

Mr Egan—Thanks, Chair. I first became aware of donor conception, I suppose, a decade and a half ago. I recall vividly attending a seminar on the topic in Perth where I was impressed by the stories of Joanna Rose, who shared her experience of growing up as a donor conceived child and the identity bewilderment that she experienced, with some friends saying, ‘You look like you’re Swedish,’ and some saying, ‘You look like you’re Chinese,’ and poor Joanna having no idea because—as she found out when her father, a little drunk one night, blurted out, ‘You’re not my kid’—there was this whole mystery in her background. Donor conceived children seem to report this sense of identity bewilderment even before being told the facts.

After hearing Joanna’s story, I kept an eye on this over the years. I have seen some of the websites run by donor conceived children—TangledWebs and some of the other groups—and have certainly been very moved by their stories, thinking: something has to be done about this; it is not right how these children are being treated. What has happened is that we have moved from the anecdotal, where we have a collection of stories. Those who are saying there is no problem say, ‘They’re only a small sample of all the donor conceived children.’ But now, with the study by Elizabeth Marquardt—and I understand the committee will be hearing evidence from her, so I will not attempt to speak to her research in a comprehensive way—I was certainly impressed that she was able to get a good representative sample of donor conceived children and compared that with controlled groups of both adopted children and children raised by their biological parents to demonstrate, on a whole range of indicators, that donor conceived children are not doing well. I think her evidence shifts things from an anecdotal situation, where we have a number of donor conceived children raising concerns, to where we now have some reasonably robust research evidence to say that this is not just a handful but is representative of donor conceived children as a whole.

The other story I heard at the first seminar I went to was from a man who became a donor as a med student and happened to be working somewhere where this was simply expected of them. He donated semen and said it did not bother him at all until later when he married and had children. He then went through quite a turbulent time of being concerned about these unknown children—where they were, were they okay, did they need him? For me that raised the issue of whether it is right to entice men to become anonymous fathers. There is question of payment. Monash IVF is paying $90 per semen donation, up to a total of 10 donations from a donor. That is 900 bucks, which for some of us may not be too much, but if you are a cash-strapped student it is fairly enticing. If you are reasonably young and thinking that someone might be popping up in 18 years time, you could probably put that off into the distant future. I am quite concerned about any payments under the guise of reasonable reimbursement of expenses, which this 90 bucks is supposed to be. In terms of overseas donors, and it was not quite clear from the testimony that I had the advantage of hearing earlier, it seems to me that no-one is donating for nothing in the United States. There is a cash market in semen and there is ova donation. I cannot imagine that the donors we are talking about are donating for nothing. As far as I could follow the account, it seems that the woman herself is making a fairly substantial payment for the import of semen, which probably includes a payment to the donor, but the clinics are saying, ‘We’re not giving any valuable consideration, so it complies with the guidelines.’ That seems a bit inappropriate to me, to say the least. There is something about the right to know and a number of families being treated from one donor. I had better conclude my remarks.

On the right to know, our organisation had more reluctance about breaching the undertaking essentially given to women surrendering children for adoption under past regimes. I will not go into our reasons for that now; that is for another occasion. We do not have those reservations at all with regard to men who have donated semen. We simply do not think that anyone ever had the right to promise a bloke that he could become a dad with no consequences. We just do not think anyone had that right. If anyone made that offer it is quite appropriate for legislation to nullify that offer that should never have been made. The right of a child to know their genetic origin and the identity of their biological father should trump the guarantee of confidentiality that in our view no-one had the right to make. There are reasons we do not quite think the same about a woman surrendering a child for adoption. I probably do not need to go into that.

In terms of the number of donations, if donor conception is allowed to continue then we honestly think it should be limited to one family. It is not just the issue of consanguineous relationships, which are statistically unlikely; it is the psychological impact on the child who, for a fellow, will be wondering about every girl he sees, ‘Is she my half-sister?’ You do not know where your siblings are. There is not just the possibility of mistakenly entering into a romantic or sexual relationship with one of them, but also, if you decide to reconnect all the pieces of the jigsaw puzzle of your family—we know how hard that is for adopted children where there are only two families involved—and we are allowing five different families to have children from the same father, try connecting that. It is more than a life’s project to try to bring that together. It just seems unjust to me to be imposing that fracturing of family on children.

CHAIR—Thank you very much for that, Mr Egan.

Senator TROOD—I am just looking at recommendation 1 in your submission, which calls for a moratorium on all forms of donor conception, which seems to be a very absolutist position.

Mr Egan—It is and—

Senator TROOD—You can respond to that observation if you choose to, but what I am particularly interested in is that moratoriums suggest that you suspend whatever activity is subject to the moratorium until such time as certain things have occurred. I suppose my question is really: are you calling for a moratorium on donor conception of all kinds in perpetuity or are you calling for a moratorium until such time as certain things have happened that you think better meet the needs of the people involved?

Mr Egan—The word moratorium in this context originally came from Elizabeth Marquardt two or three years ago, before the research that I have just referred to had been completed. She and a group of colleagues asserted at that point that there were sufficient indicators that this donor conception was not in the best interests of children and she called for a moratorium. We have adopted that call and made it in various submissions and comments on this issue. It could be said that perhaps the research she has done now is sufficient to say it is no longer appropriate to call for a moratorium but just for a permanent prohibition, but it is after all one piece of research, even though I think it is a very robust piece of research, so we have stuck with the term moratorium. I guess we are implying there that, if it turns out to be different and donor conceived children are really actually doing very well, let’s hear about that. But the evidence at the moment is that they are not doing very well at all, so essentially donor conception is a failed social experiment that ought to be brought to a halt. Just as past practices of closed adoption have been brought to a halt or removing Aboriginal children from certain situations have been brought to a halt, donor conceived children should be seen as something where we have made children the subject of an experiment that is not in their best interest.

Senator TROOD—I am keen to clarify this because, having called for a moratorium in recommendation 1, you then make a series of subsequent recommendations that seem to assume that will not take place. Do I take it that your group’s position is that the subsequent recommendations are the things you think need to be attended to if this process should continue?

Mr Egan—Absolutely. We are realists. We have been in the political game for a long time, so we know that many of the things that we call for are not going to be adopted by parliament the first time we call for them, but we keep hammering away. We are always keen to state upfront what our ultimate preferred position is; we are very honest about our positions. But I am quite realistic. I certainly do not expect this committee to recommend a permanent ban right now on donor conception and, in the light of that, think a number of other things ought to be done.

Senator TROOD—You are FamilyVoice. Your submission and your remarks this morning seem to place a lot of emphasis on the interests of the child rather than the parents—those who have for various reasons not been able to conceive a child in a natural way and desperately want a child. That seems to me to be a good family conviction, so I am interested to know how you strike this balance between those couples who want to be part of a family but are unable to do so and the interests of the child.

Mr Egan—Yes. As a group that strongly values parenthood, we sympathise with the desire of people in all kinds of situations to have a child. But, from examining the evidence of the outcomes in many of the situations where various means are then used to achieve that desire, we have come to the conclusion in a number of areas that certain ways of achieving the desire to have a child are not in anyone’s best interest—neither the children nor, in the long run, the adults. There is not much of this in the submission, I think, but some of the things donor children have said have raised some serious questions about this idea of acting on adult desires to have a child at all costs. In particular, a number of the donor-conceived children say things like, ‘We’re told to stop complaining because our mother must have wanted us a lot to go through what she went through to have us.’ I say: yes, but sometimes love and adult desire to have a child are not enough. They do not mean that it is going to work out well.

Also, in terms of the relationships, the bringing of a child into a couple relationship where the father is unable to father a child can actually be quite damaging. Some of the social indicators, from the evidence, seem to reflect a connection with internal family dynamics: the woman essentially getting herself pregnant by bringing in semen from outside the marital relationship has actually been quite a damaging dynamic within the marriage.

Senator TROOD—I am wondering whether that is in fact not the heart of the problem here. Those children and the evidence around their experience may well be related to the fact of their birth, but it may also be a reflection of some rather poor parenting skills in the way in which they deal with the reality of their situation.

Mr Egan—I am interested in the Marquardt research, and if you get a chance you may want to ask Ms Marquardt about the explanation for why adopted kids are doing better than donor-conceived kids, because you would think there would be some of the same problems but the gap seems to be quite significant. That would suggest, I think, that there is something in the family dynamics that is not working well for everybody concerned.

Senator TROOD—I think my colleagues have some questions.

CHAIR—Thank you. Before I pass to Senator Crossin, I am advised by the secretariat that the Fertility Society of Australia has put in a submission, so I just want to clarify that for the record.

Senator CROSSIN—Mr Egan, good morning. Thanks for coming to our inquiry; it is appreciated. Do you know if there are any other countries that have banned donor conception, or is it a pretty common practice right around the globe?

Mr Egan—It is a fairly universal practice. I know the call by Ms Marquardt and her colleagues for a moratorium was an international call. I think many of them are US based, but it did have some international support. I know that—contrary to the Australian trend, which is moving towards legalising surrogacy all around the country—France has a new bioethics law being considered by the National Assembly at the moment which would ban surrogacy. It is interesting there because it is mainly from the left and from a feminist critique that surrogacy is being seen as not the appropriate way to go. They are talking about fractured identity, women as incubators and so on. But I do not think anyone has moved directly against artificial conception. Of course, one cannot directly prohibit all artificial conception; you cannot make it a criminal offence for parties to arrange this informally. You could only ban the role of medical clinics and so on. Of course, that then raises the safety issues surrounding semen testing for HIV and other diseases. So I am quite conscious that talk of prohibiting these things is problematic. It is difficult to know exactly how to do it.

Senator CROSSIN—So you would have the same view about egg donation?

Mr Egan—I think egg donation raises some serious questions about women’s health because of the mortality risk and the morbidity risk. I think, a man can supply semen quite readily, whereas for a woman to be asked to provide ova where there is payment for strangers donating eggs—in Australia it is only a known woman who will donate for a friend, normally a sister or a very close friend, undergoing that procedure.

Senator CROSSIN—In my reading of your submission, I am trying to—I am assuming you are not saying that there should be a moratorium on adoption.

Mr Egan—No, not at all.

Senator CROSSIN—I am trying to balance this up: you have got a couple who are married, in love with each other and for some reason one of the partners cannot reproduce, therefore they would look for assistance—that is, through, say, sperm donation. Are you suggesting that couple should adopt a child rather than at least use an egg or sperm from a donor?

Mr Egan—Yes, for a number of reasons. One, adoption is always a solution to a child that is already there. The woman is pregnant for whatever reason, whatever the story is that has led to that situation. She and the birth father together for whatever reason think they are not able to raise that child and then they make a decision to ask the state: can you find parents to take care of this child? That matches up, where possible, with a couple who are ready to provide parenting. So the interest of the child is always upfront and the second interest is the interest of the relinquishing parents: you are serving them.

When we look at a donor conceived child in all the different combinations, there is no existing child. We are talking about bringing a child into existence from the start fracturing its identity and its origin, bringing in a third party, so this is very different to adoption.

Senator CROSSIN—But half of those genes—

Mr Egan—Half of those genes—that is an interesting point because the donor conceived kid says, ‘My mother insisted that it be genetically her child even though it was not going to be her husband’s or her partner’s child, but what about me? What about my genetic connection, the other half of me, that comes from this stranger?’ There is a lack of parity. In Dr Joanna Rose’s very profound and exhaustive PhD thesis on this, which is readily available, she talks about how there are two different paradigms being used: one for the woman and her interest in conceiving a child that she has a genetic link to; and a different paradigm that tells the donor conceived child: ‘It does not matter where you came from. We love you and here you are and stop asking questions.’ So there are these two paradigms in conflict with one another.

Senator CROSSIN—I think the reality of actually having a moratorium on this practice is probably not going to exist. What issues do you think this committee should look at at minimising some of the challenges you have raised?

Mr Egan—The right to know first, and we would absolutely support retrospective legislation that said that every donor conceived child at the age of 18 has the right to identifying information. That legislation would require a national register because you need to collect the data before clinics go out of business. Some of it will be very patchy going back to the 1970s and so on, but we need to get that information into a central registry before it is too late. Some people may not start looking for their donor father until they are 30 or 40, so these things come up at different times in people’s lives. So: an absolute right to know.

Obviously you should prefer the evidence of the donor conceived children’s groups on some of these questions, but I think some of them suggest that they would accept the contact veto that some of the adoption legislation has. No-one wants to force themselves on someone else, but they do have a right to know where they come from, who they are, who their relatives are and so on. That should include the ability to track donor siblings so you know who your brothers and sisters are. That seems to me a fundamental human right. That is the ‘right to know’ stuff.

There should be a complete ban on any payment at all. I cannot see how a bloke has any expenses for turning up at a clinic and making a semen donation. Maybe he caught a taxi there, but if you are going to be altruistic you can spare 30 bucks for the taxi fare. Give me a break! If you stop all payment then there is no incentive, except someone is choosing to do it knowing they are going to be identified as the dad when the child is 18, and there are absolutely no questions about that.

In terms of importation from overseas, I think that has got to be stopped. It is unjust to the child to have this dad in some foreign country who in 18 years time they are going to have the alleged right to track down. How is that going to work, realistically, especially if there are children all over the place from this fellow? They say they have a matching system with a clinic in Australia, but are they having children in the United States as well? Are they also providing semen for five more families or 10 more families in the US? How many donor siblings are you ending up with? So I think restricting donations to one family is the only fair thing. If you think about adoption, if you are trying to put your jigsaw together, you just have to find your birth mother and maybe the birth father; maybe he married someone else. But even with human stories you might end up with two or three families to track down—things get complicated these days—but a donor child may have five siblings in different families. To track them down would be an incredible nightmare to put on somebody trying to find themselves.

So if all of those things are done that I think they are big steps forward. If the result is there are no donations in Australia, that is just how it is. If no-one is willing to undertake this, then that is fine.

Senator PRATT—Many of the things you have raised today are slightly contradictory, only in that I think you have expressed a general objection to donor conception—

Mr Egan—Yes.

Senator PRATT—but say that there are circumstances under which you think it could be more ideally realised.

Mr Egan—There would be fewer things wrong with it. That is all I would say. Our organisation’s position on children’s fundamental right to a mum and a dad is well known. That is not directly before the committee today, so I do not want to labour that point. We have addressed it in other issues. Clearly here we think that donor conception that involves a single woman or a same-sex couple, as well as imposing the genetic bewilderment and all the other factors, deprives a child of any paternal figure in their life. We would see that as a double-whammy against the poor kid.

Senator PRATT—If I were to ask you whether there were any circumstances under which you would support gamete donation, the answer is?

Mr Egan—No.

CHAIR—Perhaps I could ask you a few questions, Mr Egan. Thanks for your submission. On this issue of five different families—and you have indicated your view that if donation is to be then it should be limited to one family—can you set out the arguments for that and the problems that would exist if there were five families, 10 families or three? Secondly, I would like you to outline this to the committee. In your opening statements you talked about identity bewilderment. Why is this so important? Why is this such an important issue for kids?

Mr Egan—On the number of families, it seems the rule in Australia is five in some places and 10 in others. But of course—

CHAIR—In the four states that have legislation, as I understand it, it is five. Is that right?

Mr Egan—It is five. I am not across the details.

CHAIR—We can clarify that.

Mr Egan—Yes. I think there are a number of issues. The question of a donor conceived child meeting and developing a romantic attraction to someone who turns out to be a donor half-sibling may be statistically unlikely, but this plays on the mind of donor conceived children. Many of them talk about it in their personal stories. That simply is not an issue if the donor is only allowed to donate to one family—except perhaps their children from a relationship. Certainly, if you limited donations to one family you would remove that particular worry from the donor conceived children.

The second thing is, whether we love them or hate them, we all have some kind of relationship with our brothers and sisters. And, if we are from a family where either our father or mother has been in more than one relationship and there are half-brothers and -sisters—my father was married twice so I had seven half-brothers and -sisters from his first marriage—tracking them down at some point, getting to know them, is part of who we are. That can be complicated enough in all kinds of situations; but, if a donor has given semen to five different women, trying to put your family back together is just an incredible burden on top of everything else the donor conceived child is dealing with, and I think it is an unfair burden and it is being done, basically, on economic principles: ‘We’ve got only a few donors and so many people wanting treatments, so we’re going to try to spread it around.’ So they would be my arguments for donation to one family only.

CHAIR—And this issue of identity?

Mr Egan—The truth is we are embodied persons. Whatever our particular metaphysical idea of the human person is, we all acknowledge we have got bodies, and every cell of our body has DNA in it and that DNA is derived, for every single one of us, no matter how we were conceived, from a human male and a human female. It connects us in very direct, embodied ways with other people—our genetic mother and father, other children that they have had, grandparents and so on. It is deep in the human psyche to want to know where you came from. It develops at different stages as the child grows, particularly during adolescence, but also at some other points—perhaps when you are marrying and having children yourself. But this issue, where you come from, is very deep in our understanding of ourselves. When you read Marquardt’s research, quote after quote from donor conceived children is along the lines of ‘I don’t know where half of me comes from’, ‘I look in the mirror and wonder which bits are reflecting my unknown father’ and so on. This is a fundamental right, to know one’s father and one’s mother.

CHAIR—It appears from the evidence we have received that most of the imported donor sperm is coming from the USA. Do you have a view as to why that is? Secondly, you expressed some concerns about importation. Can you outline your concerns.

Mr Egan—The US, unlike Australia, have never prohibited payments at market value for semen and for eggs for the purposes of conception. I think they have some restrictions on payment for eggs for research but not for conception. You can get books with photos of people, the university degrees they have, their sporting qualifications et cetera, and you can pay market value for the sperm or the eggs you want. So it seems that, if we are allowing the importation of sperm from overseas, we are hooking into that market trade. I stand to be corrected on that if that is not the case, but I do not understand how there would be altruistic sperm donors in the US.

CHAIR—The earlier witness indicated that supply and demand in Australia is problematic because there is the demand but not the supply. Do you know how much is being imported into Australia at the moment in terms of percentages or numbers or anything?

Mr Egan—I do not know the percentages but I know that in the submission from the previous witness they said the majority of semen is coming from overseas. They may have had an adjective in front of ‘majority’, like ‘large’ or something, but I am not sure without checking. I do know that IVF in Albury paid Canadians—or offered to pay; I am not sure if it ever actually happened—$7,000 in travel reimbursement to come out to Australia, have a skiing holiday and make a few sperm donations while they were here. They claimed that fitted within ‘reimbursement of reasonable expenses’. So there are a few things going on here.

But, certainly, to claim you are bypassing payment of valuable consideration by having the woman directly pay the sperm donor in the US—otherwise, why would US donors be willing to give and Australian donors not if they are also going to be faced with a child turning up on the doorstep in 18 years time? It is because they pay them in the US.

CHAIR—We have got a bit of an issue if the majority or a significant proportion of the donor sperm is coming from overseas and it appears to be unregulated at this stage by the NHMRC; there is no reference to it, apparently, in the guidelines we have received. We can clarify that. Frankly, I see there is a bit of a gap there, if that is the case. What about other places, like Europe? Are you familiar with what happens in Europe?

Mr Egan—I know that Scandinavians for some reason are keen donors. I do not have a theory as to why. But I know that the UK are importing most of the semen from Denmark at the moment. I think I did hear about Danish donors in connection with Australia as well at one point, but I am not across the details of why that would be the case. Certainly, with surrogacy, we have got a big trade going on in India, where girls are being paid to carry children, and I think that is a huge concern. There is possibly an egg market from some of those places as well.

CHAIR—Thanks for that. That is an area where the committee can try and access further information and research. We thank you for your submission and for your time today.

Mr Egan—Thanks very much, Senator.

Proceedings suspended from 10.32 am to 10.47 am

DEVEREUX, Dr Annemarie, Assistant Secretary, Office of International Law, Attorney-General's Department

PIRANI, Ms Toni, Assistant Secretary, Family Law Branch, Attorney-General's Department

CHAIR—Before we begin our next session, I remind senators that the Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of them to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. Officers of the department are reminded that any claim that it would be contrary to the public interest to answer a question must be made by a minister and should be accompanied by a statement setting out the basis for the claim. I welcome officers from the Attorney-General's Department. I invite you to make a short opening statement and then we will have some questions.

Ms Pirani—I will make a brief statement. My statement has been prepared in response to the letter dated 30 September 2010, sent by the committee to the Secretary to the Attorney-General's Department, Mr Roger Wilkins AO. In the letter the committee asked for the department's input on the progress of the Standing Committee of Attorneys-General, SCAG, discussion paper, the Council of Australian Government's, COAG's, indication about moving towards national legislation, the international human rights aspects of donor conception and whether the Commonwealth has constitutional power to make national legislation about donor conception.

I will deal with each of those issues in turn. SCAG has recognised the need to develop a national approach for the registration of donors. Ministers have discussed the importance of all persons born as a result of assisted conception procedures to have the means to access information concerning their genetic heritage. In April 2009, SCAG ministers agreed to an officer-level working group developing a discussion paper on a national model for registration of donors in consultation with health and community services ministers. The work of that working group is ongoing. Due to the subject matter and the complex issues involved, it has become apparent that significant involvement will be required from health and community service ministers and officials to progress the initiative. The regulation of assisted reproductive technology, ART, including donor conception, is primarily the responsibilities of the states and territories. New South Wales, Victoria, Western Australia and South Australia have enacted legislation governing donor conception. This legislation is the responsibility of the respective state health ministers.

All clinics across Australia providing assisted reproductive technology services are subject to the Reproductive Technology Accreditation Committee's certification scheme issues by the Fertility Society of Australia. Clinics must also comply with the National Health and Medical Research Council's ethical guidelines on the use of assisted reproductive technology in clinical practice and research.

I understand that at the COAG meeting of 5 April 2002, COAG agreed to work towards a nationally consistent approach to assisted productive technology. In particular, COAG agreed that accreditation by the Reproduction Technology Accreditation Committee—RTAC—of the Fertility Society of Australia should provide the basis for a nationally consistent approach to the oversight of assisted reproductive technology clinical practice in Australia. Accordingly, from the COAG perspective, the matter has been dealt with, and the further work around donor conception is being progressed through other fora.

In relation to the question about the Commonwealth's power under the Constitution, I am unable to provide legal advice to the committee about whether the Commonwealth has power under the Constitution to make national legislation for the regulation of assisted reproductive technology or the creation of a national donor register.

The Convention on the Rights of the Child includes a number of articles that may be relevant in the context of donor conception. In particular, the best interests of the child as recognised in article 3 of the convention is a guiding principle in the development of domestic legislation and policy. Any legislative or policy developments in this area would need to comply with Australia's obligations under international law. This concludes my opening statement. I would like to thank the committee for the opportunity to appear this morning.

CHAIR—Thank you, Ms Pirani. You have referred to my letter on behalf of the committee on 30 September to Mr Wilkins. You have responded to that. You have indicated that you cannot provide constitutional advice as to whether legally we are able to legislate in this area or have a national register. Why is that?

Ms Pirani—The department has not sought any legal advice on that issue. So it is just not something that we have looked at.

CHAIR—We have a problem. We have a concern here because we are a Senate committee. We are looking at this very issue. This is critical to our committee work. So we asked the department verbally, through the secretariat, and I wrote personally on 30 September, for that contribution. I know that you are not a constitutional lawyer so I am not having a go at you but I am saying that we have made a request verbally and we followed it up in writing. Now we are sitting here and we are not able to receive that contribution. I understand that that advice was put through the secretariat in the last couple of days. So we have a problem; we have a concern. Frankly, it is not good enough.

Ms Pirani—All I can do is raise the matter with the Attorney-General and see if it is a matter on which he would wish to seek advice and go from there. That is really all that is within—

CHAIR—Are you saying that there is nobody within the department who could provide advice on this matter?

Ms Pirani—I have consulted with the relevant area of the department and their response was transmitted to the secretariat yesterday.

CHAIR—Is their response that they cannot provide the advice because they are too busy doing other things, or they just cannot provide the advice because they are not across the issue?

Ms Pirani—I think the issue is that they have not had the advice sought by the department or by the Attorney-General and, accordingly, are not in a position to provide that advice.

CHAIR—Senator Crossin, do you want to add to that?

Senator CROSSIN—I do; absolutely. This Senate committee is asking the responsible department whether or not the federal parliament can legislate in this area. I do not think that is an unreasonable question for this committee to ask the department. We are not asking you whether you have legal advice about it or what that legal advice is; we are just asking a pre-eminent question as to whether or not the department has a view that this parliament is able to enact national legislation when it comes to donor conception or people who actually donate in this area, essentially.

Ms Pirani—All I can say is that the department has not formed a view on that.

Senator CROSSIN—This committee is now asking the department to form that view and to try to inform this committee so that we can conduct this inquiry and come to some conclusion. There is no point us coming to the conclusion that we need nationally consistent legislation or that there should in fact be a national piece of legislation if, at the end of the day, it is not possible under the Constitution. We are just asking for a view from the department about whether or not there exists a power under the Constitution to have national legislation that addresses the issues.

Ms Pirani—All I can do is take that back to the secretary of the department and take it on notice and raise the matter with the Attorney-General.

Senator CROSSIN—Has somebody in the department read the submissions to our inquiry?

Ms Pirani—Yes.

Senator CROSSIN—I take it that, because there has been no submission from the Attorney-General’s Department, there is absolutely nothing raised in any of these submissions that the department feel they need to respond to.

Ms Pirani—The department’s approach is that we are working as hard as we can on trying to progress the issue through SCAG and that the issues that have been raised are, as the committee would know, very complex issues that cut across legal and medical and health issues. We certainly find the submissions that have been made very informative and things that we would take into account in moving forward through the SCAG process and informing ministers, both Attorneys-General and health ministers, about options that might be available in terms of developing a national approach.

Senator CROSSIN—So what are you saying to me—that the SCAG process is pre-eminent in your thinking and deliberations about the legal issues raised here and, as to the Senate committee, well, you have them but you cannot, will not or should not provide a review or a response to the issues raised here?

Ms Pirani—Not at all. We certainly have found the information very useful, but I am not sure that the department is really in a position to be able to respond to the types of issues that have been raised with the committee, because a policy position has not yet been formed in relation to those.

Senator CROSSIN—All right. I am then going to go to—

CHAIR—Senator Crossin, I have a question before you go through your various questions for the department. The other matter that you raised was the UN Convention on the Rights of the Child. You responded to that in your opening statement that this has direct implications for the rights of donor conceived children to access information. As set out in the letter of 30 September, we wanted you to provide advice to this committee as to whether it does have implications for the law in Australia. Are you telling me that you cannot provide that advice, that it is same answer as the constitutional advice that you are unable to provide, or are you giving us an answer to that question today?

Ms Pirani—I might hand over to my colleague Dr Devereux to address that.

Dr Devereux—If I could perhaps answer the question in two ways, I think fundamentally in terms of detailed advice on the question the answer is the same as in relation to the constitutional law. I am here today and I am happy to address in general terms the relevant articles of the convention that would be of relevance. But in terms of providing a particular view that constitutes legal advice, I am not in a position to do that with the committee.

CHAIR—All right. Just to conclude in terms of the process and the procedure here, let me say on behalf of the committee we are extremely disappointed and concerned that the department has not acceded to our requests for advice with respect to specifically the constitutional advice and, secondly, the UN Rights of the Child Convention and its implications for Australia. So we will consider that as a committee as to what course we take, but if you take that back and take on notice the concerns we have as a committee and the disappointment that we have that we are sitting here and we have written letters requesting it and that advice is not with the committee today. We will continue. Senator Crossin.

Senator CROSSIN—Whether or not there should be national legislation is a policy decision of government. Whether or not the parliament can actually enact national legislation under the Constitution would be just a matter of fact, I would have thought. And that is the question we are asking the department. We could ask the same question of the federal Parliamentary Library really but we do not get the Parliamentary Library to appear before us as witnesses. That is the question we wanted to know from you. Can I go to April 2009 when SCAG agreed to convene a working group of officials to prepare a draft discussion paper that explores options to harmonise the collection and recording of and access to donor information. Can you tell me which officials are on that working group?

Ms Pirani—The Commonwealth is leading that working group. I cannot recall off the top of my head exactly which states are involved but I do expect it would be most of them.

Senator CROSSIN—Who is actually leading that? Is it A-G’s or Health?

Ms Pirani—It is A-G's at the moment because it is in SCAG, so it is being led by Attorney-General's.

Senator CROSSIN—Where is that draft discussion paper at? We are 18 months away from that date now and when will that draft discussion paper be finalised and be made public?

Ms Pirani—It has not yet been presented to ministers. As you may know, the SCAG meeting that was due to occur in July this year was cancelled because of the federal election. The next SCAG meeting is due to happen in December this year.

Senator CROSSIN—So the paper is finished and it is ready to go back to SCAG, is it?

Ms Pirani—We need to go back to SCAG ministers in relation to the paper, yes.

Senator CROSSIN—So that meeting will also determine whether or not there will be public consultation on this paper?

Ms Pirani—I really could not say what that meeting will decide in relation to moving forward—

Senator CROSSIN—I am not asking you to pre-empt that; I am asking whether or not there is a proposal to suggest that document goes to public consultation.

Ms Pirani—The difficulty that we find ourselves in with this discussion paper is that we have done quite a bit of work to try and look at what is happening around donor registration in each of the jurisdictions. In looking at this issues from a legal perspective, as I am sure the committee has itself found in looking at this issue, the interaction between the legal issue and the health and medical issues is such that you really cannot deal with one without the other.

Senator CROSSIN—Why can you not give some of that work to this committee to help us inform our inquiry? If it was simply a fact-finding mission where you have looked at each state and territory's legislation and what is there and what is not—in fact, four of them do not have legislation, for starters—and the intersection between the health issues and legal issues, surely they are just matters of fact that you could provide to us.

Ms Pirani—We are still exploring the interaction between the legal and the health issues.

Senator CROSSIN—Have you at least done a spreadsheet of the legal issues?

Ms Pirani—We have, yes.

Senator CROSSIN—I am going to request that you look at providing that information to the committee.

Ms Pirani—We could look at providing that. As with some other things that have been dealt with by SCAG, because of the way they are developed, we would have to consult with the states and territories before we would be in a position to do that. But I am happy to take that on notice.

CHAIR—Can you take on notice to provide to this committee all and any relevant information and research on the health, legal and other aspects of the SCAG process that you think would be of merit for this committee to review and consider in its deliberations.

Ms Pirani—Yes.

CHAIR—Thank you.

Senator CROSSIN—For consistency in access to information for those who are donor-concedes, it has been a requirement in Victoria since the late 1980s for gamete donor details to be recorded and those details to be passed on to any of their genetic offspring after they turn 18. But those conceived with donor sperm are unable to trace their biological fathers in that state. If you have done that scoping study about the legislation across the board, can A-Gs provide us with a comparison between an adopted person's legal rights to access information about their biological mother or father and the legal rights of a person conceived by donor conception?

Ms Pirani—That is not an analysis that we have done for the purposes of this exercise, but—

Senator CROSSIN—No, I am asking you to do it for the purposes of this committee.

Ms Pirani—I can certainly take that back to the department, because I know that there is work that happens in other parts of the department in relation to adoption.

Senator CROSSIN—I am asking you to take on notice—

Ms Pirani—I can take that on notice

Senator CROSSIN—a comparison between the rights of a donor conceived person versus a person who has been adopted in accessing knowledge about their biological mother and/or father.

Ms Pirani—We can certainly look into that.

Senator PRATT—We have had a discussion about the incapacity to provide legal advice. In looking at the need for national consistency, is SCAG only considering achieving that through consistent legislation state by state or has SCAG itself looked at a combination of both? Is it too early to say? I find it a little remarkable that you do not have such advice when SCAG is clearly actively considering these issues.

Ms Pirani—SCAG has asked the officers working group to look at a national model for donor registration. That has been the focus. We have been looking at standard approaches that could be used around Australia rather than necessarily focusing on the mechanisms that might be used for that.

Senator PRATT—You are looking at standard approaches, so the question of whether that is uniform or Commonwealth or a combination of both has not yet been finalised?

Ms Pirani—That is correct.

Senator PRATT—It strikes me that it probably would be a combination of both in any case. So it is just a model of the ideal scenarios that should be created that is yet in question and not the mechanism at all?

Ms Pirani—At this stage of the project, yes, that is where it is at.

Senator PRATT—In relation to public consultation and engagement, you are probably aware that one of the reasons that this inquiry has come up is that members of the public have lobbied parliamentarians quite hard because they have been affected by the issues in how reproductive technology is regulated in Australia. One of the reasons, I think, that this inquiry has come up is that they have not had a lot of engagement from SCAG and the government as they have sought to move through these issues. Whilst the department is working on its papers and moving through those issues, there are a huge number of affected people who are wondering what is going on. Can you report to us what the public engagement for SCAG is going to be in terms of consultation?

Ms Pirani—As I said in relation to a previous question, I have no certainty around that. However, we have been asked to prepare a discussion paper. In previous SCAG projects, I am aware that discussion papers have certainly gone for public consultation. That was certainly the case with surrogacy. I know that ministers found that valuable. But no decision has been made on that.

CHAIR—Last question, Senator Pratt.

Senator PRATT—I do not think that this committee would necessarily want to duplicate a process if it were confident that there was an effective process going on, but it is hard to avoid creating a two-stream process when the engagement has been so limited with outside stakeholders, I suppose. That is more by way of comment. Thank you, Chair.

Senator TROOD—Ms Pirani, lest you are under any illusions about this, let me just state my view and add my voice to the views expressed by other members of the committee about the need for the Attorney-General’s Department to consider again the request we made for constitutional advice. I think it is entirely unsatisfactory that you have not responded to that and you have not provided anybody to the committee this morning who can address that question on our behalf. I would not want it to be thought that it is a minority view on the committee. In fact, I think it is a view shared by all members of the committee.

You did not actually say that this paper that is going to SCAG in December had been completed. Is it complete at the moment or not?

Ms Pirani—No, it is not, because we need to do more engagement on the health issues arising.

Senator TROOD—Are you confident that a completed paper will be taken to SCAG in December or are you just going along and giving an interim report, saying, ‘We’re still working on it and we’ll bring it to you the next time we meet’?

Ms Pirani—We are very keen to progress the issue. I am confident that it is a matter that will be receiving consideration by SCAG in December to determine a clear way forward with it.

Senator TROOD—Can you tell me whether or not you have turned your mind to how the matter might proceed after SCAG or is that premature?

Ms Pirani—That is probably premature.

Senator TROOD—Dr Devereux, can you provide us with some advice as to how the international conventions that are relevant here play into this field from your perspective?

Dr Devereux—As I stated at the outset, I am not able to provide detailed advice on this question. What I can do is identify several articles of particular relevance in the Convention on the Rights of the Child and indicate some of the considerations that would need to be looked at in relation to an advice. Ms Pirani has already mentioned article 3 of the convention which states:

> 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—

obviously as an overarching theme of the entire Convention on the Rights of the Child. In this field, you would also be wanting to look at a couple of other provisions in the Convention on the Rights of the Child, the first being article 7.1 providing that:

> The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents.

In outlining that article, I stress the term ‘as far as possible’ indicating that there is a qualifying phrase within article 7 in terms of the circumstances, as opposed to being an absolute right to know and be cared for by his or her parents. The article has a much wider application than potentially to the situations your committee is looking at, but the breadth of that as far as possible would need to be looked at in detail were advice to be given on it. I also note that a number of states have made declarations at the time of ratifying the convention, outlining their understanding that article 7.1 does not preclude anonymous adoptions or donation of reproductive material.

Senator TROOD—Have we made a reservation in that respect?

Dr Devereux—No, Australia has no reservation or declaration to article 7. The other article that would be of particular interest to this committee would be article 8.1 which provides:

> States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognised by law without unlawful interference.

Much of the impetus for this particular article in the Convention on the Rights of the Child related to concern over enforced disappearances of children during the 1970s and the involuntary abduction and abduction of children to indicate why in particular there was mention of the right to know family relations. I would also point out in relation to this article that it is phrase in terms of the right to preserve his or her identity, including family relations, as recognised by the law, without unlawful interference. Again there is another phrase within that article and so in understanding the full impact of those articles, it is necessary to see them in context of the right and the qualifying phrases placed within those articles.

Senator TROOD—Have you given any consideration to the extent to which the practices that exist in Australia at the moment, whether they are legislated or not, are in compliance with the articles of the convention?

Dr Devereux—No, we have not been asked for advice on that matter and have not looked at the schemes in relation to compliance with these standards.

Senator TROOD—Presumably, with any program of work or proposal that might go to SCAG you would see in Australia's interests that we are in compliance with the international convention—would that be the case?

Dr Devereux—As Ms Pirani indicated in her opening statement, the Commonwealth obviously would be committed that any legislative or policy developments would be consistent with Australia's international obligations.

Senator TROOD—At some point, you are going to have to do that assessment, are you not?

Dr Devereux—If there is a legislative or policy proposal being developed through the SCAG process with the involvement of the family law branch, if we are requested for that advice we would give it.

Senator TROOD—I just do not understand how you can set in place a process which involves the attorneys-general of the Commonwealth, states and territories for a broad policy which is coherent across the country and not give consideration to the importance of any international conventions that may apply to the circumstances. It seems to me elemental that you would be doing that.

Dr Devereux—I think perhaps the question would be best answered by Ms Pirani in terms of how they see the process going forward and what input they would have. Obviously, if we were requested for that advice we would give that advice.

Senator TROOD—It is a different question as to whether I think we should comply with the conventions, but I assume that since we are party to the conventions you, as the Attorney-General's Department, think that we probably should uphold these conventions in some fashion or other. Reading those conventions into, or ensuring that our obligations under them are acknowledged in, the policy that is being developed seems to me to be a rather fundamental proposition. Is that true, Ms Pirani?

Ms Pirani—We will certainly be taking international obligations into account. In answer to your earlier question as to whether we have done any analysis of the extent to which the current state laws comply with those international obligations: no, we have not. We would be using the current laws to inform a national approach, but a national approach would not necessarily be based on or follow what is currently legislated. I am not sure—and Dr Devereux might correct me if I am wrong—that we generally play a role in checking whether state legislation meets international obligations. We certainly do in relation to Commonwealth legislation.

Senator TROOD—The Attorney-General’s Department of the Commonwealth surely could not be orchestrating a process of integrating or coordinating a set of complicated laws that does not involve the responsibility to ensure that Australia’s obligations under international conventions are complied with, could it? Isn’t it a central proposition that we would want to comply with these conventions and that you, if anybody—that is to say the Attorney-General’s Department—are the body which is responsible for ensuring that compliance takes place? Is that right?

Ms Pirani—Indeed, yes. As I said, we have had a look at what the states that have enacted laws have done in order to inform a national approach and a national model, and we would certainly ensure that any national model is compliant with our international obligations.

Senator TROOD—So you are going to do that analysis at some point?

Ms Pirani—At some point, yes.

Senator TROOD—Perhaps you could take on notice for me, Ms Pirani, the need to provide the committee with advice as to the extent to which the legislation in the states and territories, where it exists, is in fact in compliance with our international obligations.

CHAIR—Will you take that on notice, Ms Pirani?

Ms Pirani—Yes.

CHAIR—Thank you. We are out of time. There are many other questions that we have for you.

Senator PRATT—Senator Crossin and I have one quick question. We could put it on notice.

CHAIR—All right, one quick one to be put on notice.

Senator CROSSIN—Ms Pirani, in your opening statement, which I do not have a copy of, you mentioned something about a COAG issue that has now been dealt with. Could you remind me what you were referring to?

Ms Pirani—There was a reference in the letter that was sent by the committee to Mr Wilkins about the COAG issue.

Senator CROSSIN—What COAG issue?

Ms Pirani—Sorry, I do not have the letter.

Senator CROSSIN—Was it a SCAG issue?

Ms Pirani—No. There was reference to an earlier COAG meeting, as early as 2002, where COAG agreed to work towards a nationally consistent approach to assisted reproductive technology. I think there was perhaps—

Senator CROSSIN—That was eight years ago.

Ms Pirani—Yes. The outcome of that process, as I understand it, was that COAG agreed that accreditation by the Reproductive Technology Accreditation Committee of the Fertility Society of Australia should provide the basis for a nationally consistent approach to the oversight of assisted reproductive technology. That was the outcome of that earlier process.

Senator CROSSIN—So you are saying to us that it has been dealt with?

Ms Pirani—That particular issue, which had been raised in COAG, was dealt with and that was the outcome.

Senator CROSSIN—Has there been any assessment about whether that is an adequate outcome, or whether it is working?

Ms Pirani—I could not answer that.

Senator PRATT—You could put this in writing to us. It is difficult for us to know what is within the scope of what SCAG is considering. If there is something that you could outline to us with respect to that, that would be great—that is, the extent to which it covers surrogacy, the extent to which it is going to cover information about donors and people’s rights to access that information, the number of families that donors can contribute to, the importation of sperm from overseas, and perhaps whether people can access sperm from the same donor interstate. Could you tell us, in general terms, the scope of the issues that SCAG is considering.

Ms Pirani—Certainly.

CHAIR—I advise that I am going to table the letter that I wrote to Mr Wilkins on 30 September 2010. With leave of the committee, I do so now so that you have a copy and it is available on the public record. Thank you.

[11.26 am]

DYKE, Dr Timothy, Acting General Manager, National Health and Medical Research Council

MORRIS, Dr Clive, Deputy Head, National Health and Medical Research Council

CHAIR—Thanks very much to the NHMRC for being represented here today. I invite you to make a short opening statement after which we will have questions from the committee.

Dr Morris—I would like to thank the committee for the opportunity to make an opening statement, which will be brief. Firstly, the NHMRC is established under the National Health and Medical Research Council Act 1992. The act charges the NHMRC with a number of responsibilities: firstly, inquiring into and issuing guidelines and advice on a range of matters relating to individual and public health, including health ethics; secondly, advising the minister in relation to the funding of health and medical research across Australia; and, thirdly, advising the states in relation to its advice on matters relating to individual and public health. Under the NHMRC Act the Australian Health Ethics Committee is established as a principal committee of the NHMRC, and through the Australian Health Ethics Committee the NHMRC issues guidelines and advice on ethical matters relating to health and on the ethical conduct of health and medical research. In addition to this, the NHMRC has responsibilities under two acts of the Commonwealth: the Prohibition of Human Cloning for Reproduction Act and the Research Involving Human Embryos Act.

In relation to assisted reproductive technology and the issue that your committee is looking at—donor consent—the NHMRC has been issuing guidelines since 1982. I understand that the first guidelines were issued as a supplementary note—supplementary note 4—to the national statement in 1982 and that following the passage of the NHMRC Act in 1992 the Australian Health Ethics Committee revised and released updated guidelines on ART in 1996. It is worth noting that in the 1996 guidelines appendix 11 prohibited unacceptable practices. It listed 11 different practices which AHEC at the time considered to be unacceptable and which should be prohibited, including commercial trading in gametes or embryos or paying donors of gametes or embryos beyond reasonable expenses.

When it released its 1996 guidelines the Australian Heath Ethics Committee also noted that only three states at the time had legislation that regulated ART in those states and, as an independent body, it commented on the need for national legislation. It also noted the same matter when it updated its guidelines in 2004. In relation to its 2004 guidelines, AHEC started a process in 2001 and went through two rounds of public consultation before releasing new guidelines in 2004. Those guidelines also took account of the passage of Commonwealth legislation relating to human cloning and other matters. AHEC then released another update of its guidelines, in 2007, to take account of further updates in national legislation.

The NHMRC has a policy of updating its guidelines every five years, or sooner if there are developments in technology, social or ethical issues or government policy which require a more rapid update. That concludes my statement to the committee. We are happy to answer questions.

CHAIR—Thanks very much. Dr Dyke, are you happy with that?

Dr Dyke—Yes.

CHAIR—Senator Trood, we will pass to you.

Senator TROOD—Dr Morris, just to clarify: the latest iteration of the guidelines completed is which date?

Dr Morris—2007.

Senator TROOD—What is the relationship between the guidelines and the body that registers or oversees—in other words, RTAC?

Dr Morris—RTAC, the Reproductive Technology Accreditation Committee, is an independent committee of the Fertility Society of Australia. It essentially accredits all IVF clinics on behalf of the Fertility Society and it incorporates a requirement that IVF clinics comply with the NHMRC's guidelines as a condition of accreditation. That is my understanding.

Senator TROOD—Do those guidelines apply to other than clinics—in other words, do they apply to individuals who might be medical practitioners who engage in this kind of activity?

Dr Morris—A guideline is a guideline. Unless it is incorporated in a piece of legislation or by a national body it stays a guideline. It has a moral weight, but there is no—

Senator TROOD—That could be argued to be part of the problem, if indeed we have a problem—the fact that these are voluntary guidelines for which there is no particular obligation for compliance other than in relation to RTAC and registration, where obviously compliance is desirable. What do the guidelines say in relation to sanctions and things of that kind where individuals or clinics act inconsistently with the guidelines? Where does the sanction lie: is it with the committee or is it with RTAC, if anywhere?

Dr Morris—The guidelines as written contain a range of requirements which are worded as 'should' or 'must', but they do not contain sanctions. It would be up to whichever body was responsible for regulation to apply sanctions.

Senator TROOD—Dr Dyke, is there anything more you could add?

Dr Dyke—The only other comment, and this is not related to the guidelines but to the Prohibition of Human Cloning for Reproduction Act, is that there is an offence in that act to conduct commercial trade related to gametes. That is section 21, and I can refer specifically to that if you would like to hear that. So there is an offence there and it has a penalty associated with it.

Senator TROOD—The behaviour we are talking about and that the committee is clearly concerned with is a bit wider. There is 'shall' or 'must', as you say, but there are no particular sanctions provided for in the guidelines where RTAC or anybody else discovers that there is behaviour inconsistent with the guidelines—is that right?

Dr Morris—That is correct. The NHMRC provide advice for bodies doing IVF. We also provide advice for human research ethics committees which are constituted by universities and medical research institutes on how to conduct research. We provide the advice and the guidelines; other bodies implement them.

Senator TROOD—You presumably go through a process of consultation before you develop iterations of guidelines? Is that a formal process or a process by which the committee just decides: ‘We’ll talk to a few people and see whether or not there is a need for review or otherwise’?

Dr Morris—There are formal requirements under the National Health and Medical Research Council Act 1992 that the NHMRC engage in public consultation whenever it is developing guidelines. The Australian Health Ethics Committee historically has often undertaken two rounds of public consultation in addition to what is required by the legislation on issues which are seen as particularly emotive or controversial to ensure that the advice it provides has a good grounding in full consultation.

CHAIR—The guidelines for clarity purposes are the *Ethical guidelines on the use of assisted reproductive technology in clinical practice and research* 2007. Is that correct?

Dr Morris—Yes, that is correct. The title on the front of the guidelines is: ‘2004 (as revised in 2007 to take into account the changes in legislation)’ and then says ‘June 2007’, and so they are referred to as the 2007 guidelines.

Senator TROOD—I gather the committee has a copy of these but unfortunately I do not have them before me, so I apologise for these things that I could perfectly read for myself. Could you just provide me with some information about whether or not the guidelines say anything about the importation of donor sperm or other elements which are required for reproductive technology.

Dr Morris—I will pass over to Dr Dyke to talk about what the guidelines require. They generally relate to the use of donor sperm—not the origin—whether it is imported or donated directly.

Dr Dyke—I do not believe there is a reference to the importation in the guidelines.

Senator TROOD—Has it occurred to you that that may be a weakness in the guidelines or do you regard that as not being within your area of responsibilities? I ask this because it transpires that part of this behaviour and activity in Australia involves the importation of sperm at least and for some clinics it is a significant part of their activity. I am slightly concerned that it may not be a well regulated part of the activity. It may well be, but I am asking this: are you aware of it being a significant part of this behaviour in Australia; and do you think it is an area which requires your attention?

Dr Morris—There are probably a number of answers to that question. Firstly, when the Australian Health Ethics Committee goes through a process of revision and out to public consultation, it takes account of a whole range of emerging technical and social issues, so each iteration of a guidelines tends to get more comprehensive on certain issues. There is quite a good section in the guidelines on the use of donor gametes in relation to limiting the use of gametes to restrict consanguineous relationships et cetera. I understand that the issue of availability of donor gametes has been one that has been receiving increasing attention and I would imagine that, when the NHMRC starts the next revision of a guidelines, it will be an issue which is incorporated more comprehensively than it has been in the past.

Senator TROOD—Do you have a revision scheduled at this stage?

Dr Morris—As I said in my opening statement, we have a policy of revising every five years or sooner if there are particular issues of concern which need to be addressed.

Senator TROOD—We have got 2007. Are you planning to undertake a revision soon?

Dr Morris—Yes we are, most probably before 2012 because the 2007 guidelines were not really a full review. They were a very minor review of the 2004 guidelines. So we are looking to do a review fairly soon.

Senator PRATT—Can you tell me the extent to which NHMRC's guidelines cover records and govern the relationships in terms of patients' access to records?

Dr Dyke—There is a specific section on record keeping and data reporting. I can provide further detail on notice as far as the access to records goes. Importantly, there is also part of a chapter on upholding the right to knowledge of genetic parents and siblings. So, as an ethical principle, that is in the guidance.

Senator PRATT—So that is a guideline, but it is not enforceable. To what extent do you police that to ensure that people are consistently meeting the requirements of those guidelines?

Dr Dyke—As Dr Morris said, this is a guideline and it is taken up through the RTAC process. The RTAC process may consider this. We do not do active policing of this; we do active policing of the laws related to cloning and embryo research.

Senator PRATT—Some states have their own regulations. Are they relying on these guidelines for their own enforcement? Clearly to some extent they are probably informing across to make sure their own laws are consistent. So in some states there would be some enforcement of the issues within the guidelines but in others there is not. Is that what you are saying?

Dr Dyke—I think the enforcement would be through the state law and regulations. We have not done an analysis of whether they are consistent with the guidelines. This is certainly the national ethical framework for assisted reproductive technology.

Senator PRATT—Except that it does not seem to be enforced. Thank you.

Senator CROSSIN—Can I just ask what measures are actually in place to enforce the guidelines?

Dr Morris—As we have said, there is legislation in at least three states and there is the Reproductive Technology Accreditation Committee of the FSA. In both cases there is implementation of the guidelines.

Senator CROSSIN—It is pretty inadequate, isn't it? There is legislation in three states, so what happens in the states where there is no legislation?

Dr Morris—The NHMRC's role is to produce national guidelines, not to police the guidelines.

Senator CROSSIN—What role do you play in the states where there is no legislation?

Dr Morris—We provide the guidelines. We answer questions on the guidelines. Should an IVF clinic or RTAC or a human research ethics committee have questions, we are able to answer through the advice of our Health Ethics Committee. Sometimes particular questions arise in relation to any of our ethical guidelines and we often provide supplementary notes to the guidelines to provide further advice. Essentially our role is as an advisory body.

Senator CROSSIN—We had someone this morning from the Canberra Fertility Centre who thought the guidelines were enforceable. Would it concern you that a fertility clinic would have that view?

Dr Morris—The role of RTAC is seen by some as a strong role. I know it is an industry body. Again, it is not really the NHMRC's role to comment on how the guidelines are being enforced.

Senator CROSSIN—They are not enforceable under law, are they? Strictly speaking they are guidelines; they are not enforceable.

Dr Morris—That is correct and that has been noted by the Australian Health Ethics Committee on a number of occasions. It is an independent body and it does not determine policy, but AHEC has on a number of occasions noted that there is inconsistent legislation across Australia.

Senator CROSSIN—So in that respect is it the role of the NHMRC to have a view about whether or not there should be a national register? Do you do an analysis of whether the guidelines are impacting on this call for a national register?

Dr Morris—We have not to date but if that is an issue on which we are asked then we would be happy to provide that question to the Australian Health Ethics Committee.

Senator CROSSIN—So at this stage do you just provide guidelines to ensure there is consistency in the way the donations are received, essentially?

Dr Morris—We provide the guidelines on the basis that ART clinics are going to use the guidelines to dictate their clinical practice.

Senator CROSSIN—Okay, but not so much perhaps the legal practice of identifying whether or not donor conceived persons can access that record?

Dr Morris—At this stage no.

Senator CROSSIN—That is not in your role to do that.

Dr Morris—Not at this stage.

Senator CROSSIN—Who would have that role to ensure there is national consistency in that area?

Dr Morris—I am afraid I cannot tell you. I know that there is legislation at the state level covering certain aspects of this but I cannot tell you who specifically is responsible.

Senator CROSSIN—I see. I will leave it there. I think it has been covered by the other questions.

CHAIR—Thank you. A number of areas have been covered but in the time available a few quick questions. Firstly, your best estimate of the number of donor conceived individuals in Australia and the number brought into being each year.

Dr Morris—We do not have numbers on that. It might be that the Australian Institute of Health and Welfare collects that data. We could take it notice to see if there is such a publication.

CHAIR—If you could take it on notice. We have got one estimate of 60,000 from somebody and we need to find that out. If you can either answer it or point us in the direction of where we can obtain that it would be appreciated. Secondly, we have been advised this morning that the majority of donor sperm comes from overseas. Is that your understanding?

Dr Morris—Again, I know no more than what you have been told.

CHAIR—Is that something you could again take on notice and advise us the answer or direct us to where we might be able to obtain that information?

Dr Morris—Yes, Senator.

CHAIR—Thank you. In the guidelines what do they say about data conceived individuals' access to information and right to know family members and so on? I am looking at them here. Where does that come up? Is it under point 9, page 41, information given counselling and consent? If not, where?

Dr Dyke—The right to knowledge is in chapter 6. I was suggesting to Senator Pratt that we may have to take on notice what the guidelines say about the access to records that are being kept. The record-keeping parts are in chapter 10, but I do not have that level of detail as far as access is concerned.

CHAIR—If you could take that on notice. These guidelines relate more to IVF practices. Is that correct?

Dr Dyke—It is the whole gamut of assisted reproductive technology practices.

CHAIR—But there is not a dedicated focus on donor conceived individual rights and so on, it is not focused on that area in particular?

Dr Dyke—There are various references to donor conception throughout the guidelines. We could draw your attention to those.

CHAIR—If you could on notice. Senator Crossin has asked questions about the unenforceability of these guidelines which I wanted to just confirm, which you have already confirmed on the record. If we have further questions, we will send those to you in writing. Thank you for being here today.

[11.50 am]

SHELTON, Mr Lyle, National Chief of Staff, Australian Christian Lobby

WILLIAMS, Mr Ben, Research Officer, Australian Christian Lobby

CHAIR—I welcome representatives of the Australian Christian Lobby. Thanks for being here. You have no submission, so I do not need to go through that. I invite you to make a short opening statement, at the conclusion of which we will have questions.

Mr Shelton—Thanks very much to the committee for this opportunity. This inquiry has been convened because of the pain and hurt that has been caused to donor-conceived children, now adults finding their voices, as a result of social experimentation with human gametes in recent decades. This experimentation is creating even more complex situations as we continue to avail ourselves of new reproductive technologies. The voices we are hearing are rightly causing us as a society to take stock and consider whether or not this experiment is working. It is also apparent that the voices of donor-conceived children, unlike those of another large class of conceptions which briefly exist in our society, will continue to be heard and will not go away.

ACL has been very concerned to see state governments rushing headlong into surrogacy legislation in particular without properly considering the rights of the child. It is worrying that Queensland, Victoria, Western Australia and now New South Wales have recently created different surrogacy laws at a time when SCAG is going through a process of considering nationally consistent surrogacy laws. We note our concern, and I think there have been concerns in evidence given today by previous witnesses about the processes of SCAG. We have concerns over the transparency of SCAG and the ability to know exactly how its processes work and how we as the public can follow those and have input into them. We have called on state governments to wait and ensure that Australia has consistent laws that put the interests of children first. We are disappointed that these calls have been ignored and fear that SCAG will be forced to agree to a national approach with the bar set at a very low level for donor-conceived children.

Of particular concern has been the passing of surrogacy legislation in Queensland and Victoria which allows a single man, two women or two men the ability to acquire a baby through surrogacy, thus denying this child the right to at least begin life with a mother and a father. While children find themselves motherless or fatherless, mainly due to tragic or undesirable events in their lives or the lives of their parents, this does not mean that we as a society should not strive to ensure that they are afforded every opportunity to have a mother and a father.

Where the state must provide a regulatory framework—which it must around issues of new reproductive technologies—it is incumbent upon the state to ensure that kids' rights come first. ACL agrees with the many groups submitting to this inquiry who say that no-one has an automatic right to a child. We have said before that children are not pets. Parenting is a privilege and it involves enormous self-sacrifice, a concept which is now almost foreign to the prevailing ethos of the 21st century consumer society, where it seems life is all about 'me'. The voices of another stolen generation and forgotten generation are beginning to stir. They are not happy that adults, because of their often legitimate desires, took decisions to sever them from their natural biological heritage and experiment with their conception.

In New South Wales, Victoria, Queensland and Tasmania we have seen legislation pass which lies to a child on its birth certificate, mandating the biological fiction that two mothers are its parents. ACL believes that ART or NRT should be limited to circumstances where the biological parents are able to supply the gametes. If this is not the case then ideally close family members should be involved. In all cases, a child should not be deliberately denied the human right to begin life with a mother and a father. A child should never be denied the right to know who its natural parents are. Just because technology allows us to do things to defy nature, this does not mean we should do them. We certainly should not be experimenting with the lives of children.

Submissions to this inquiry estimate that there are anywhere between 20,000 and 60,000 donor conceived children living in Australia. Given the passing of liberal laws governing NRT in some states, this number will only grow, and along with it the risks of siblings unwittingly engaging in sexual relations, further compounding the ethical minefield of donor conception. ACL believes the Commonwealth, through SCAG, should urgently reframe laws around NRT to ensure the best interests of the child—that is, to minimise the incidence of genetic bewilderment.

The problems that have led to the formation of this inquiry are the result of the breaking of the natural biological family, which has historically been protected through marriage between a man and a woman. This is why the marriage debate matters. The evidence of the first few decades of experimentation with NRT is in, and the voices of donor conceived children the committee is hearing will only amplify in the future. There is time for government to act before further damage is done. However, this will require courage by politicians to stand against a powerful but numerically small political lobby that does not accept that natural biological ties are important to the wellbeing of children. It requires us to make hard choices between the rights and often legitimate desires of adults and the human rights of children. A compassionate and selfless society will err on the side of the latter. Thank you very much for the opportunity to make these opening remarks.

CHAIR—Thank you, Mr Shelton. We will go to questions.

Senator CROSSIN—Thank you for your submission. I want to ask you a question I asked this morning of FamilyVoice. In a situation where, for some reason, either a husband or a wife is not able to assist in the production of a child, what is the solution for those people? Do you believe that they should not be able to access a donation from a sperm donor? Should they only rely on adoption?

Mr Shelton—It is a very tricky issue, obviously, Senator. As I said in my opening remarks, we would prefer wherever possible—and I realise the substance of your question is where it is not possible for the gametes to come from within the biological mother and father—that circumstances that would allow outside gametes should be very tightly controlled, preferably from a close family member or someone very closely known to the family. We realise that this is occurring, that this is something that has been a longstanding practice and that remedying it involves difficult policy prescriptions. I guess our appeal to the committee today really is around rethinking all of this—I know this is what the work of the committee is about—but doing so in the best interests of the child, and that is in the context of at least ensuring that children have a mother and a father.

Senator CROSSIN—I suppose that is why the inquiry was generated. I am not sure you can go to a close family member if we are actually talking about trying to create another human being. I guess there are issues—major issues—there, which is why people go to somebody who is a donor, someone who is not known. Even if that were a very limited number, there are still huge consistencies in the way this whole area is approached in this country. We have heard even this morning that consistencies across states and territories do not exist, and the rights of people who are actually born in this situation do not exist. So I suppose I am interested to know, even if that number were really scaled down and there were very limited numbers, do you have a view about the rights of those people or what should exist?

Mr Shelton—I would not want to be prescriptive and say it should never occur. I do have some sympathy with the view that FamilyVoice have expressed this morning. We realise this is a very complicated issue. It creates immense issues for children because of the entanglements, the many adults that can have a biological and emotional stake in a child. I think this opportunity which the committee has before it gives us an opportunity as a society to take stock of that. I would not want to be prescriptive and say yes or no at this stage. I think it needs a lot more work and consideration by society. But our preference is as I stated in my opening remarks.

Senator CROSSIN—There are some people who can get access to the information about who that donor is, but prior to the 1980s they cannot. Do you think that that legislation should be changed so that anybody in this country who is donor conceived can access that information?

Mr Shelton—Yes, I think that would be a just outcome for donor conceived children.

Senator CROSSIN—Do you think the number of donations a person can make should be limited?

Mr Shelton—Yes, I think that would be a wise thing.

Senator CROSSIN—We have had submissions that have stated that there are instances where many, many donations have been made from one person. But you have a feeling that donations should be limited in number?

Mr Shelton—Yes, absolutely.

Senator CROSSIN—Does ACL have a view about payment for donations?

Mr Shelton—We would not support any payment. We think that is fraught with all sorts of—that it compounds the ethical dilemma that is already inherent in this practice.

Senator CROSSIN—Yes, okay.

Senator TROOD—I have just the one question. Do you have a view on the right of a child who may have been born in this way to have access to information about a possible sibling, or half-sibling, as the case may be.

Mr Shelton—Yes, I would absolutely support that right. I think that has been mentioned this morning. I would agree that that is a fundamental human right of anyone who has been conceived in this way and it just underscores the ethical dilemma which I know the committee is grappling with.

Senator TROOD—You may not have thought through this but do you think that that right should obtain when the child becomes 18?

Mr Shelton—My personal view is that it should be a right prior to that. I think a child should have the right to know as much about its genetic heritage at whatever time that child wishes to explore that.

Senator TROOD—I see; thank you.

CHAIR—You say, in answer to Senator Crossin's question about limits, that you want to limit the numbers. My understanding is that currently there are laws in New South Wales, Victoria, South Australia and WA. I think it was indicated there might be three but I understand there is four—

Mr Shelton—Yes, that is probably right, Senator.

CHAIR—And I understand that there are limits of up to five families. Now I stand to be corrected in terms of donor practices, but what is your limit? Would you want to limit it to one family, or should it be up to two or three families?

Mr Shelton—We do not have a firm view on that. As I have stated, our preference is for the gametes to come from the biological parents wherever possible. We realise this is a difficult issue and we understand and empathise with the deep pain that goes with childlessness so we do not want to strike a hard and fast rule. But we would prefer that to be someone who is close to the family so that you limit the entanglement—the sense of genetic bewilderment—that occurs as a result of these sorts of arrangements. So I cannot answer your question with a fixed answer.

CHAIR—Okay, but when the donated sperm is granted do you think it should be granted and allowed to proceed to a whole range of different families or just a limit of one?

Mr Shelton—Yes, I think it would be sensible to have it limited as much as possible.

CHAIR—Do you have a view on the importation of sperm? We were advised this morning on evidence that the majority of donated sperm comes from overseas—from the USA. We know that there are considerable funds expended for this purpose in the USA and that, no doubt, profit is obtained. Do you have a view with respect to this issue?

Mr Shelton—I have been learning about that here this morning. I do not know whether my colleague, Ben Williams, has considered that?

Mr Williams—We would be strongly opposed to the importation of sperm and other gametes because the regulatory system in the United States, in particular, is fairly loose. I understand that in California large payments can be made for the supply of gametes. We suggest that does not contribute to the apparent altruistic nature of donor conception or donation itself. We would be opposed to the importation of gametes.

CHAIR—You indicated the estimates for the number of donor-conceived individuals in Australia in your opening statement. Do you have an understanding of that or have you just looked at different advice—

Mr Shelton—No, just from what we have gathered from the submissions.

CHAIR—You also made a reference in your opening statement to surrogacy and the concerns that you have that some states have laws that are different to other states and there is a working group at SCAG that is looking through this. What you are really saying is that you have similar concerns that that is being replicated with regard to donor conception?

Mr Shelton—Absolutely. I was not aware of the SCAG process around donor conception. Obviously, we have been following the surrogacy one closely. With surrogacy, it has deeply concerned us that we have had states legislate in a way that does deliberately deny children the right to a mother and a father.

CHAIR—Hopefully, we can obtain clarity around this soon, but there is a view that they might be part of the same process at SCAG.

Senator CROSSIN—Yes.

Mr Shelton—As I said earlier, it is often difficult to chart SCAG's activities. I think that is a bit of a problem.

Mr Williams—If I can just add there: there was originally a discussion paper that was released by SCAG, I think in April 2009, on a consistent approach to surrogacy, and there was a consultation process. They reported that they have created 15 draft principles to model legislation on. We know that New South Wales is moving on the issue at the moment, and Queensland has already done so—allegedly based on these principles, which we have not seen publicly.

CHAIR—They are not public, to your knowledge?

Mr Williams—As I understand it, they have not been made public. We have requested them previously and they have not been released to us.

CHAIR—That is indeed a worry. The other overarching issue I have is about identity, and you have talked about the importance of that. Can you just reflect on that; the big picture as to the importance of why identity for kids is in the best interests of the child?

Mr Shelton—What has informed a lot of our thinking on this has been this excellent book by Tom Frame, who resides here in Canberra. He is an academic—I am not sure if the committee is aware of his work. He has written from experience as someone who was adopted himself, who has served on the ethics committees of major hospitals and who has seen the implementation of this sort of thing firsthand and has real ethical concerns. The title of the book is *Children on demand: the ethics of defying nature*.

That is where we first came across this phrase ‘genetic bewilderment’. He talks about the issues that not only some adopted people can feel but also, particularly as we move more into this area of donor conception, that is becoming a big issue for others, as I think you have seen in the instigation of this inquiry. I would highly recommend this to the committee’s consideration.

CHAIR—We appreciate that. Thank you again for being with us today and for your evidence to the committee.

Mr Shelton—Thank you very much.

CHAIR—I would like to thank all witnesses who have given evidence to the committee today. I declare that this meeting of the Senate Standing Committee on Legal and Constitutional Affairs is adjourned.

Committee adjourned at 12.08 pm