COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

LEGAL AND CONSTITUTIONAL AFFAIRS REFERENCES COMMITTEE

Reference: Donor conception in Australia

TUESDAY, 2 NOVEMBER 2010

SYDNEY

BY AUTHORITY OF THE SENATE

SENATE LEGAL AND CONSTITUTIONAL AFFAIRS
REFERENCES COMMITTEE
Tuesday, 2 November 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 9.05 am

CHAIR (Senator Barnett)—Good morning, everybody. Welcome to the inquiry today. This is the third 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.

[9.07 am]

CEFAI, Ms Michelle, Treasurer, Donor Conception Support Group of Australia Inc.

HEWITT, Mrs Leonie, Secretary, Donor Conception Support Group of Australia Inc.

HEWITT, Mr Warren, Committee Member, Donor Conception Support Group of Australia Inc.

LORBACH, Mrs Caroline, National Consumer Advocate, Donor Conception Support Group of Australia Inc.

LORBACH, Mr Patrice, Committee Member, Donor Conception Support Group of Australia Inc.

CHAIR—I welcome representatives from the Donor Conception Support Group. The Donor Conception Support Group of Australia Inc. has lodged a submission which we have designated as submission No. 122. Do you wish to make any amendments or alterations to that submission?

Mrs Lorbach—No.

CHAIR—We invite you to make an opening statement, after which we will have some questions.

Mrs Lorbach—We thank the committee for this inquiry and for giving us the opportunity to speak to you. We are blessed that we have been able to have children even though we, as couples, were infertile. Raising our donor conceived children has taught us a lot. We have made realisations that never entered our minds before we had these children. We are here today to speak out for our children. Within the DCSG we have a wealth of life experience in donor conception and it is from the experiences of those of us sitting here and the thousands of people that have been part of our group over the years that we speak to you today.

Our government has sanctioned the practice of donor conception through Medicare, and this has helped to create an estimated 60,000-plus donor conceived people. The self-regulating system of the past and that currently in place do not provide fully for the needs of donor conceived families. To try to compensate for this, a small group of parents formed the Donor Conception Support Group in 1993. We were the first group in the world devoted to supporting families created from donor sperm, eggs and embryos, and we are the only group of its type operating in Australia.

At our very first meeting, all of us agreed that we wanted to tell our children the truth about their conception. Truthfulness is one of the first important ethical lessons that most parents teach their children, because we as a society understand the significance of honesty in the building of good relationships. However, up until the 1990s, most of the families in our group had been told by their doctors that they should withhold the truth from their children. Even though our group has always advocated openness and worked towards this, we still have many parents in our group who feel that they cannot make public how they conceived their children. We also have adult donor conceived people who will never admit outside the group how they came into the world. Donor conception will always be a subject that is not openly spoken about while the country as a whole refuses to deal with the long-term effects of the withholding of donor information by clinics. When secrecy is operating, there is a high chance of family relationships being damaged. Secrets prevent family closeness and open communication.

Australia has ratified a number of important international conventions. The two most important ones that apply to donor conceived people are the United Nations Convention on the Rights of the Child and the International Covenant on Civil and Political Rights. It is clear that donor conceived people who are actively being denied access to information on their biological parents are the victims of discrimination. Some may argue that many people in today's society do not know a part of their heritage for a variety of reasons. However, their right to seek information is not denied to them through any legislative or regulatory framework. The donor conception legislation in those states that have it applies only to children born after the acts have been put in place. Those born before are refused access to information. The implementation checklist of the Convention on the Rights of the Child asks:

- Do all children, including adopted children and children conceived by artificial forms of conception, have the right to know, as far as possible, who their genetic parents are?
- Is refusal of this right limited only to the grounds that refusal of information is necessary to protect the child from a likelihood of harm or is necessary to protect the child's parent from a likelihood of harm?

The National Health and Medical Research Council guidelines on assisted reproductive technology, which all clinics are supposed to follow, state that the welfare of those born from reproductive technology is paramount. This is stating that the welfare of donor conceived people should be considered as more important than that of all others involved. If the welfare of donor conceived people is paramount then there are no competing rights.

Since the release of the 2004 NHMRC guidelines, clinics in Australia have supposedly moved towards a system whereby anonymous donors are no longer accepted. Children born after that date should be able to access identifying information on their donors. But, because of the system of accreditation, we have no way of knowing if clinics are complying with these guidelines, and the system is not retrospective. Clinics are only accredited every three years. The DCSG firmly believes that to withhold information about identity, medical histories and relationships from people conceived by donated gametes is not treating their interests as a primary consideration. In fact, it is treating them in quite the opposite way, withholding from them rights that the rest of us accept as our due.

The denial of such rights of access to one group can have severe adverse effects on their perception of themselves and their position in the world. We are concerned that denial of rights purely on the basis of their date of birth has produced a minority group afforded fewer rights than their younger counterparts. The federal government has a responsibility to store and protect the existing records before they are lost or destroyed forever and to ensure that donor conceived people have the same rights that everyone else in the population has, regardless of when they were born and what state they were conceived in.

CHAIR—If no-one else wishes to make an opening statement we will go to questions.

Senator CROSSIN—It is good to have you all here at this inquiry. I know a number of us at this table appreciate the journey that you have been on in getting the Senate to have a look at this situation. I hope we can deliver for you the outcome that you are expecting. I want to touch on your own support group. Do you have a membership? How do people get on your books to be contacted by you?

Mrs Lorbach—People contact us and become members of the group. We charge a yearly fee, which is the only finance for our group. Currently we charge a yearly fee of $40.

Senator CROSSIN—How many members would you have?

Mrs Lorbach—It is hard for us to list the number of members, because we have family memberships, and a family can be anyone from two to five people, as in our family of five. Our list at the moment would probably be around about 1,000.

CHAIR—One thousand families?

Mrs Lorbach—One thousand people.

Senator CROSSIN—I notice that you get no government funding or support. Have you ever applied for funding to service your group?

Mrs Lorbach—Yes, we have tried a number of avenues for getting funding, both federal and state. We have the problem that legislation that does exist is under the health portfolio but the issues that we are primarily dealing with are more in the community services area. So we tend to fall between the cracks between two different departments. We have tried getting funding through health departments and through community services departments and we have not been successful either way because they keep telling us, ‘Oh, no, you are covered by the health portfolio,’ or the health department will tell us, ‘No, your issues are community services issues.’ So we have never actually been able to get funding.

Mrs Hewitt—We did get a loan from the department of community services in New South Wales to produce a book called *Let the Offspring Speak*, but we had to pay back the money to them.

Mrs Lorbach—We could say the same of a whole lot of groups, like the national support group for victims of child abuse. It could be either mental health or community services. So there are a whole lot of groups that I know of that get funding and are covered by both.

Senator CROSSIN—Do you feel that there has not been recognition by government of the need for your group and that is why you have not had funding?

Mrs Lorbach—I think so. A lot of it has to do with the secrecy surrounding donor conception, the fact that families will not come forward and speak openly about it because they are afraid for a variety of reasons. In some cases they are afraid of being judged because they are using donor conception. If you do not have the loud voice of a lot of people coming forward often you will not attract funding.

Senator CROSSIN—So it is a bit of catch-22, in a sense.

Mrs Lorbach—Yes.

Senator CROSSIN—We have had a spreadsheet done for us of people who can access information and we know the Victorian government changed their legislation. As I see it now we currently have two groups of donor conceived people in this country: those who can access information after a certain date and prior to that they cannot access information. Is that correct?

Mrs Lorbach—That is correct, but the date will change from state to state for those states that have legislation, depending on when their legislation came in. In New South Wales our legislation came in only at the beginning of this year, so only children conceived from the beginning of this year will have a guaranteed right to know the name of their donor.

Senator CROSSIN—Prior to this year, is it that clinics were collecting the same information five years ago as they are collecting now or is it that five years ago someone who was going to donate did not have to give consent to be identified? What are the variations and the differences here?

Mrs Lorbach—Some clinics have been asking their donors if they are willing to be identified probably for over 10 years; some did not ask that question until the NHMRC guidelines of 2004 started coming in. It took well over a year or so before most clinics started to adopt those guidelines. Today we still do not know whether they are following those guidelines—we have no way of knowing. I would ask the government: do you have an away of knowing whether clinics are following those guidelines? All we have is the word of RTAC, which accredits clinics, that yes the clinics are following the guidelines.

Mr Hewitt—There is a third group of offspring who will never be able to get access to records because their records have been destroyed.

Senator CROSSIN—How did that happen? Tell us about that scenario.

Mr Hewitt—The third group of people, whose records were destroyed, came about because clinics had made guarantees to donors that their identity would never be revealed and clinics became afraid that they mean be in a position of conflict, so they destroyed the records. That is why it is really important that a central register is established so that these records are preserved for future offspring, so that they will not be in the same situation as our daughter.

Senator CROSSIN—If a clinic gets to a point where it might close down shut, what happens to those records currently?

Mrs Lorbach—According to the Fertility Society code of practice, they are so supposed to be taken up by another clinic. That is not helping those records which are being held perhaps in garages, in storage from doctors who have retired or doctors who have died. Their children are probably holding on to some records. So we have a lot a very valuable records being held outside clinics. Some of our son’s records are being held by a pharmaceutical company.

Senator CROSSIN—How did that come to be?

Mrs Lorbach—Because of the clinic being bought and sold a number of times.

Senator CROSSIN—So there is no national approach to handling the records of this nature?

Mrs Lorbach—No.

CHAIR—Is your son able to obtain that information from the pharmaceutical company or are you? Who can access it?

Mrs Lorbach—I would like to go quickly over our eldest son's story. When we first approached the clinic where we conceived him, we wanted to write a letter to the donor to say thank you and we wanted to ask whether in future he might be willing to answer any questions. The clinic said they would contact the donor for us but we got a reply sometime later saying that they could not find him, that he was not at the address he had registered. So we left it for a while. The clinic had some changes made so we approach them again. We then spoke to a counsellor and asked again could she try to find the donor and could she use other means of finding him, perhaps electoral rolls. She said yes, that they would do that. She got back to us quite quickly and said that she had found the donor at the address the clinic had—he had never moved. Our only conclusion was that the clinic had lied to us when they told us that they had tried to contact him. What happened then was that the donor did not want to have any contact with us but he was willing to give the counsellor a good amount of information which we could pass on to our son. To get the basic information, to contact that donor the counsellor had to then go to the pharmaceutical company to get the contact information which was in storage there.

CHAIR—Did they get it?

Mrs Lorbach—Yes they got it and that is how they found where he was and the fact that he had never moved.

Senator CROSSIN—Some of the submissions we have received have suggested that donors should be able to donate only five times, 10 times, six times or perhaps one donor for one family. Do any of you have a view about that issue?

Mrs Hewitt—One of our children has 31 half-siblings. I have this letter here that was written to us in 2006 from Repromed in South Australia, where they informed us that our son's donor had donated in South Australia as well as New South Wales and there were 20 children in 10 families conceived from this donor in South Australia between 1990 and 1997. I would like to submit this letter as part of my submission. I forgot to send it in.

CHAIR—There being no objections, that is so approved. Mrs Hewitt, you will table that letter when you have finished discussing that?

Mrs Hewitt—Yes. For our children to have 31 half-siblings—I cannot even put it into words how I feel about that. We have told our son that. He has been to Adelaide for work and at least he has been informed. But what about those other 20 children in South Australia?

CHAIR—Just for the record, you are shaking your head. You do not approve?

Mrs Hewitt—No, I do not approve. I think there should be a limit. If a donor only wants to donate to one family then they should only do that. You should not be able to go interstate or overseas and donate. There should be a national register for donors and, when a donor—a male or a female—goes to donate, we must check that they are not serial donors.

Senator CROSSIN—So you think it should be one donor, one family?

Mrs Hewitt—I think we could do a little bit more but, if a donor only wants to donate to one family, then we should listen to his feelings about this. But there should be a limit of five families, I think, or even fewer. How does everybody else feel?

Ms Cefai—As a maximum, I would think it should be five families, and it should be at the discretion of the donor if he or she chooses for it to be a smaller number. That certainly should be on.

Senator CROSSIN—If you had a national register and someone moved interstate then that register would pick that up, I take it.

Mrs Lorbach—Yes. There have been suggestions that donors do not donate at more than one clinic. In our submission to the committee, you would have seen the handwritten notes that one donor made where he donated at multiple clinics across Sydney. We have had other donors come to us and tell us that they have donated in more than one clinic and were never asked about donating at other clinics or, if asked, it was still okay for them to continue donating. Our eldest son has 18 half-siblings from the same donor. We do not know how many families they are in, because the clinic has not told us.

Senator CROSSIN—They will not tell you?

Mrs Lorbach—It just was not part of the information they gave us. We have not yet approached them again to ask that question. That is another issue that we need to raise with the committee. Clinics will often say, ‘We don’t get people coming back to us complaining or asking for a lot of information.’ It is because there is a fear involved in that. Our families here are very, very outspoken about donor conception, but the minute we set foot inside the clinics where we conceived our children we are nervous. It worries us. I have come to the conclusion for myself that is because they are holding information that is like a birth certificate to our children. There are no rules written down for how we approach the clinics. There are no rules written down for what they can and cannot give us. What happens if we step over some imaginary line and they decide to shut down and not give us anything? What happens if they destroy the records, which in some cases they can legally do? I think that is why a lot of parents do not go back to clinics or they do it in a way where they ask the minimum of questions—because they are afraid.

Senator TROOD—Thank you for coming this morning. We appreciate your evidence very much. I have a couple of issues that I want to explore with you. It has been suggested to us that whilst the idea of a national register is superficially very attractive—and you make a compelling case for that—some people would be troubled by the fact that all this data is held by a government agency and that for some people all that information in the hands of a government agency is undesirable, that people are naturally uneasy about governments holding this kind of very personal, private, confidential information. Do you have a view on that?

Mrs Lorbach—I would trust the government to look after this information more than I would trust a company to look after it. I do not think a company, a place of business, is the appropriate place for what is in effect birth certificate type information. I think it would be much easier for a clinic to be broken into and have information taken from it than for a government department.

Senator TROOD—Your submission is that there be an authority established—is that right?

Mrs Lorbach—Yes.

Senator TROOD—It would be held not necessarily within a government department but in a specific authority which would have an independent status with particular responsibility in this area. Is that your position?

Mrs Lorbach—Yes, because we feel we need expert people to be running it. We look to the model of the Victorian government and the way the Infertility Treatment Authority was run before they made their changes. That was world leading in the way it was being run.

Senator TROOD—I see. You have made a couple of references to the behaviour of clinics, but I wonder whether or not you can give us some idea of whether or not your support group's experience is that for the most part fertility clinics behave well in dealing with people. Do you have a kind of litany of experiences, all of which suggest the clinics with which you are required to deal either are not keeping to the guidelines which are available or are particularly difficult to deal with? I am trying to get a sense of how well the clinics interact with those people who come to them for assistance.

Mrs Lorbach—It is a real mixture. It has improved over time. The Victorian clinics in particular are, from the reports we are getting, doing very well these days in helping people with information. But we are still getting people coming to us today saying: 'The clinic will not give us this information. They will give us this basic information. We think they've got more but they're not giving it to us.' The problem is, as we said before, we have no way of knowing whether clinics are following the guidelines, because how they are accredited is a closed book to us.

The only thing that we have been able to say, as we said in our submission, is that there is one guideline that they are supposed to be following that we know they are definitely not. Part of the NHMRC guidelines says that all clinics are supposed to be approaching past donors to encourage them to come forward. They are not doing that. They are supposed to be using the media or appropriate organisations to do that. We have never been approached to help them with that. They have never gone to the media to do that. If they are not following that guideline, what else aren't they following? We have no way of knowing.

Senator TROOD—We do have, in the NHMRC rules, a fairly comprehensive set of guidelines and rules. Do you think they are a satisfactory foundation for regulating this area? If those rules, for example, were to be the foundation upon which a national register were to operate, is it your group's view that they would be an adequate foundation, or would you like to see them extended in some way?

Mrs Lorbach—They need to be extended because of the fact that they do not cover information being given to children born before a certain date. There is no retrospectivity included in the guidelines, and we feel that that is a necessity.

Senator TROOD—We are going to take evidence from a professor in the United States who has done a study of donor conceived children. The study points to a series of difficulties that they experience compared to other control groups. I am just wondering whether or not you can tell us of your own experience about donor conceived children. None of you may have natural children, but you probably interact with them. I am interested to know whether or not being a donor conceived child has particular challenges for parents, or are there particular behavioural challenges that you confront as a result of that?

Mrs Lorbach—On challenges for parents, firstly: yes, we do have challenges that are different to those of other families. They are probably more similar to the challenges faced by adoptive parents, in that we have to make decisions about how to tell our children how they came into the world, how to answer their questions as they grow, which is not a challenge that most families have. There is no organisation apart from ours, really, for people to go to to get help in that. If you adopt a child, there are a lot of organisations you can go to. In New South Wales, there is the Post Adoption Resource Centre, which is heavily government funded and funded through the Benevolent Society. They have trained counsellors; we do not have trained counsellors in our group. We have parents with experience; that is all we have. So we do face a lot of challenges as our children grow, including the big challenge: how do we get information to answer our children’s questions? In the case of Leonie and Warren, they could not get information to answer their child’s questions because it did not exist any longer.

Mrs Hewitt—I think it is quite challenging to raise three children, two who have access to information and one who has not got it. It breaks our heart that we were in some way complicit in this, causing harm to our eldest child. When our middle child got his records, he said to us one night: ‘Gee, mum, I didn’t even really want this. Geraldine should have this, and she hasn’t got the right to have it.’ So even the children struggle between each other.

Mrs Lorbach—I do not think we can generalise as to how donor conceived children will fare as they grow. Some have absolutely no interest in finding information; some have a burning need to know, and there is everything in between. One thing I would say is that I have never met a donor conceived person who said they should not have the right to know—and, within our group, we have met thousands of donor conceived people over the years since we have been working. I think one of the most troubled people that I have met is a young man who went to the extent of having a bar code tattooed on the back of his neck because he felt like he was a product. He talked about the fact that the clinics were making money out of producing him and he felt like a product, so he had a bar code tattooed on the back of his neck. He is a very troubled young man.

Senator TROOD—As I understand it, the legislation in Western Australia is rather different to that in other states where there is legislation, in that—I have not looked at the legislation myself, but perhaps you can explain this to me—in fact the government advises children when they become 16 about their status. Do you know whether that is the case or not?

Mrs Lorbach—I do not know exactly what they are going to be doing about that because the children are not old enough for that yet, so we do not really know how that is going to come about, but I doubt whether it will actually mean that they will automatically advise all children. I would say that that is if there is a person wanting to contact them, be it a half-sibling or a donor.

Senator TROOD—Do you have a view on the desirability of that course of action?

Mrs Lorbach—We feel that all children should be told the truth because it is part of their identity. In the Victorian legislation, they will be making a notation on birth certificates in future so that it will become the same as adoption in most states—that is, where when a person applies for a birth certificate they will be told that further information is available and asked if they want to access that information.

Senator TROOD—I am inclined to agree with you that they certainly have a right to know. The question is whether or not that information is information that should be provided by a government as a matter of law, or whether it should be left to the parents to decide at which time this information is provided to the child. Developmental rates are all very different; some people can handle it at different times than others. It seems to me rather brutal that parents who may never have been able to have a conversation with their child about this know that at 16 the child is going to receive a birthday present and a letter from the government saying, ‘Here’s a bit of information you might not have been aware of.’

Mrs Lorbach—Of course there are better ways of doing it. What needs to happen is we need to have very good education campaigns and support for parents in how to tell their children. People have often said, ‘Most children through donor conception in the past were not told, parents did not want to tell.’ Our experience is that they do want to tell, it is just they do not know how to. There is no help really, apart from our group, in how to tell these children. We need so much more support. And if you give parents advice on how to tell their children, they will tell, for the most part, just like in adoption. If you adopt a child in this country, if you even hint that you are not going to tell your child the truth, they are not going to allow you to adopt a child.

Senator PRATT—We have had some comparisons this morning with adoption, and I want to ask you about the kinds of things that you would like to see put in place that provide appropriate supports. You have talked about identifying information about donors. In many places there are still contact vetoes in place between adoptees and birth parents. Can you tell us what in an ideal world you would like to see in place—open information, open contact? Could it be a better national register where all donors are put on a register and then you have, for example, a voluntary process of making contact that the donor could then veto but the identifying information would be provided. There is a range of different thresholds of the kinds of processes you could put in place, and I am wondering if you have discussed those issues.

Ms Cefai—It would be good to have a tiered system because personally I think that giving the offspring the identifying information without any support or counselling is obviously going to be detrimental. And in some cases people may not want personal contact but they may be prepared to exchange information, so there should be a tiered system as to how much information both sides are prepared to give and also an understanding that it is not always going to be their decision. They may decide that they only want written contact at the moment, and in a few years time they might be prepared for personal contact. To be able to have the options there all the time and to review them—

Senator PRATT—And that seems quite similar to how adoption is managed in many states, including past adoptions where privacy previously had been assumed but now identifying information is provided with the contact vetoes in place. That is certainly how it is in Western Australia.

Mrs Lorbach—It is in most states.

Senator PRATT—You are advocating that something similar for donor conception, at the very least, should be in place?

Mrs Lorbach—Yes, similar to adoption in most states.

Senator PRATT—In relation to where records have been destroyed, you have talked about how clinics are supposed to encourage previous donors to come forward. How would that happen when they are not really making contact with anyone other than those who walk through their door, I am not quite sure. Are you looking at a DNA type register for people who have previously donated to put those records back together again in some way? What have you looked at there?

Mrs Hewitt—I would like to bring up the fact that the Royal Hospital for Women did go to extraordinary lengths to find Geraldine Stoner, and they need to be commended for that. They have set up their own voluntary register—sadly, it is hidden on their website. We did some publicity for that years ago. They did electoral checks. They did an internet search Sydney-wide and Australia-wide. They sent letters out to people with the same surname. They have his surname but no date of birth. So they did an awful lot, and I think this letter should be submitted as well.

CHAIR—Mrs Hewitt, are you asking for that letter to be tabled?

Mrs Hewitt—Yes, please.

CHAIR—If the committee are happy for the letter to be tabled, it is so ordered. I do not think we have received the first letter either. Could you give that to the secretary?

Mrs Hewitt—Okay. We talk a lot about the donors and making contact with them, but in the case of our eldest child there is no donor to contact. For her there needs to be register for the half-siblings to make contact. There is nothing in place for them to meet those half-siblings.

Senator PRATT—Even in the absence of the donor being found, the biological children of those gametes should have the opportunity to make contact with each other. That is something they are currently denied. That is also the case with adoption, as I understand it.

CHAIR—Is it the view of the group that you should be able to access the identity of not just the donor but the siblings?

Mrs Hewitt—Yes.

Senator PRATT—As we understand it, many families are accessing gametes from overseas. We are interested in your views in that regard. For example, you could have a scenario where a sperm has been used from a donor who has created many families, and suddenly a limit is put on that. Yet there might be an Australian family who wants to add another child to their family. There could be any number of different scenarios that could cause difficulties if you put arbitrary limits in place, while you are working towards limiting the number of families that donors might create. Should there be limits on overseas sperm? Should there be a paper trail that ensures that a limited number of families are also being created overseas, or are we just talking about Australian families here?

Mrs Lorbach—We have a problem with semen being imported—full stop. Children have enough problems trying to find donors within this country let alone having to cope with contacting another country. It just adds yet another level of difficulty to an already serious problem.

Senator PRATT—What if an Australian family conceives a family overseas with sperm from, say, Europe and an Australian couple conceives in the UK because they happen to be living there and the sperm is from the Netherlands and the family move to Australia?

Mrs Lorbach—That is a different scenario because they obviously want to create a sibling for one they already have. We are concerned about the wholesale importing. Clinics are saying they are importing because they cannot get enough donors here. But how often do clinics actually advertise for donors?

The last major campaign was done by the Albury clinic where they had a big story about getting donors to come from Canada, about how they were paying them thousands and thousands of dollars of expenses. But what happened in the end is that they never had to get anyone to come from Canada. Because of that story being in the media, they got plenty of donors in Australia approaching them. You have a good advertising campaign and you explain to people how the system works, you give them some rights within the system and you will get donors.

Senator PRATT—Who makes a good donor? I am sure there is a very diverse range of people who might, but what kinds of things might they have in common?

Mrs Hewitt—Are you talking about sperm donors or egg donors? I am concerned about the importation of eggs from Albania and Greece.

Senator PRATT—Both.

Mrs Hewitt—I think somebody who has completed their family, who has their own biological children and knows the joy that children bring and somebody who understands the needs of our children to know the person who helped create them.

Mr Hewitt—I think it is for altruistic reasons as well because in the past there have been university students who were almost forced into being donors—they were paid for it.

CHAIR—Can you finish your answer regarding Albania, your concerns about eggs from places like that?

Mrs Hewitt—I am aware that Australians are going to Greece for eggs and going to—was it Romania or Albania? I cannot remember.

Mrs Lorbach—It is being facilitated by doctors here in Australia.

CHAIR—What is your concern?

Mrs Hewitt—As Caroline stated before, it is hard enough to trace Australian donors. How difficult is it going to be to trace people in those countries. I am worried about the exploitation of people from poor countries.

CHAIR—You think they may be doing it for financial gain.

Senator TROOD—Are your group opposed to overseas donor conception?

Mrs Lorbach—Apart from the exceptions Senator Pratt mentioned, yes, because it becomes almost an international trade in human beings. We govern very seriously overseas adoption, how that is done, but it seems that because a person has not quite been created, we do not think that this area needs any governance, but it does.

Senator TROOD—Can you tell us how widespread the phenomenon is of people bringing in eggs, embryos or sperm from overseas?

Mrs Lorbach—Because we do not have access to what clinics are doing in this country, we could not give you figures of what is happening but it appears that international trade between countries is getting bigger and bigger. There is a lot of money being made in it.

CHAIR—Thank you for your submission. It is very substantial and very compelling. Many of the arguments are obviously heartfelt. On the importation side, we were advised in evidence on Friday last week that the majority of donor conception is from overseas at the moment, mostly from USA. Would that be consistent with your view or your evidence?

Mrs Lorbach—I do not think that is happening in every clinic, no.

CHAIR—Do you think there might be a majority from overseas at the moment?

Mrs Lorbach—Again, because we do not have access to that sort of information from clinics, we could not say that.

CHAIR—The figure of 60,000 donor conceived individuals in Australia—that is in your submission and you mention it in your opening statement—is obviously an estimate. We asked questions on Friday and were not able to get an answer as to estimates from the other witnesses because they were not aware. How sure are you of that estimate? Would you have a view as to whether donor conception is growing? I would be interested in the yearly figures. What would it be each year in Australia? Do you think it is growing or reducing in size?

Mrs Lorbach—We made an estimate of 60,000 and we based that on a book by two very well respected researchers in South Australia who in 1982 estimated that 10,000 had been born at that stage. We know that donor conception has been happening in this country since at least the 1940s. The first official clinic operating in Australia opened in 1970 in Victoria. In the 1990s we kept asking doctors how many children were being born from donor insemination, just by itself, at that time. We were told by different doctors that there were about 2,000 a year. So, if there are 2,000 a year from 1990 to 2010, we are looking at another 40,000. Then there was the gap between 1982 and 1990. We came up with an approximate figure of 60,000. That is as close as we can get because, until the last couple of years, no records were kept within clinics of how many children were being conceived through donor insemination. Since IVF started, they were keeping records on how many children were conceived through IVF but not through donor insemination.

CHAIR—Do you think we should?

Mrs Lorbach—We definitely should because you cannot quantify a problem if you do not have a figure. You cannot research a problem if you do not have a figure. But, unfortunately, we do not have a figure for the past.

CHAIR—I will move on. Mr Hewitt mentioned the view that the donor should be altruistic and be motivated in that way. My question is: how concerned are you as a group with respect to the cost and the financial gain that may flow through to the donor? We were advised in evidence on Friday that a clinic in Melbourne paid $90 per donation. That was purportedly to meet the reasonable costs of the donation. What are your views with respect to financial gain and the costs incurred—whether they are reasonable or whether there should be any payment at all? One witness on Friday said that there should not be any remuneration at all. What is your view as a group on the cost side of it?

Mr Hewitt—I think that, if the donor is doing it for altruistic reasons, there should be no monetary compensation for them. It is like blood donors—you get tea and biscuits. You are doing it because you are trying to help someone, not because you want to get money out of it.

Mrs Hewitt—Having spoken to 1,000 donors in 17 years, I would say that most of them do it for altruistic reasons. I know one donor who still cannot cash the cheque that he was given in Adelaide 28 years ago. He told me he would feel like a prostitute if he cashed it.

CHAIR—We have talked a lot about the clinics and the guidelines, but what about other situations where there is donor conception? Do you think that should be regulated in the same way, outside of clinics, perhaps in other circumstances?

Mrs Lorbach—Do you mean private donations?

CHAIR—Yes.

Mrs Lorbach—That is not an area that our group has explored at all.

Mr Hewitt—Private donations would be very hard to regulate.

CHAIR—Let’s move on. You mentioned two international conventions—rights of the child and the International Covenant on Civil and Political Rights—and bestowing obligations on Australians and Australian law to protect the donor recipient individual and ensuring their right to know. I want to get on the record that they have a right to know and that you have the view that it should be retrospective, going back however many years.

Mrs Lorbach—Yes.

CHAIR—Do you think that there should not only be a right to know but that they should be compelled to know? If so, how should that information be imparted?

Mrs Lorbach—Could you explain what you mean by ‘compelled to know’.

CHAIR—They have a right to know but should they be compelled to know? I mean, do you think the donor recipient individuals should all be advised of who their donor parent was in whichever case?

Mrs Lorbach—No, I think our view would be that they have the right to access that information if they so desire.

CHAIR—Mr Hewitt, do you want to add to that?

Mr Hewitt—I was just going to say that the ideal situation from my point of view is that the child grows up knowing their identity and how they were conceived and not reach a certain age and then you get with that bombshell. Hopefully that can be done through education and counselling of the parents as they are going through the process of donor conception.

CHAIR—This is a bit of an issue as to the timing, and I think Ms Cefai talked about it on a graduated process during the child’s growth through the years up to the age of 16 or 18. Have you worked that out as a donor group as to when this information is imparted to the child, or would you leave that information and that decision in the hands of the parents to decide?

Ms Cefai—If the information of their conception is provided to the child early on and they grow up knowing the information—

CHAIR—What does ‘early on’ mean?

Ms Cefai—From birth, basically. The experts suggest that they should never not know, that it should not be an announcement, that it should be part of their day-to-day conversation and it should start off when they are very, very young. That is how you are going to—

Senator PRATT—Sorry to interrupt. As their language skills develop it is just part of the day-to-day conversation with the child.

Ms Cefai—The language is in conversation on a day-to-day basis, not overloading them with information but just providing the information and including its in your conversation. If the offspring have been advised of their conception then the decision to access the information should come from them. They should decide when they want to access the information. If that is at a younger age then they would need assistance from their parents to make contact and maybe just get information and so they go through the process.

CHAIR—Moving to the issue of identity for the donor conceived individual and the issues around that, the psychological concerns flowing through to that, you have all expressed the view of having some sort of limit up to a maximum of five families. What about for the kids who have all these half brothers and sisters? Firstly, do you agree that they should have access to know who they are, and, secondly, what sort of psychological impact does this have on the children when they grow up, whether they are going to fall in love with somebody they are related to. We are advised that there is a very low level of risk of that happening but psychologically it must have some impact. What is your view on that impact of how serious is that psychologically on the donor conceived individual?

Mrs Lorbach—A donor conceived person as they grow up has to make a decision: do they, and if they do when, ask a partner or potential partner whether they were also conceived through donor insemination? It is an added thing. I think if society understood the issues better, if all donor conceived people knew the truth, it would be so much easier for them.

CHAIR—We know that is not the case at the moment, so how significant are these questions for donor conceived persons?

Mrs Lorbach—For some very serious. I think there are an awful lot who actually ignore the question and hope that issues are not going to surface later.

CHAIR—We are about to hear from Elizabeth Marquardt from the USA and her experience and research, which demonstrates, from her perspective, that there is a real issue with identity and psychological flowthrough negative effects. I am just asking your views on that and on her research, if you are aware of it.

Mrs Hewitt—I have not read her research, but as a mother of a 27-year-old, I know that our eldest raises this when she gets involved with somebody from the opposite sex. I do not think our middle one does at all. I think he puts it in the bottom of his heart. He has a steady girlfriend and he knows that that girl has not been created from donor conception so it is not an issue. But I think the youngest one has sent you a submission, and she has talked about genetic sexual attraction in her submission. That is a fear for her.

CHAIR—We often compare this with adoption from interstate and overseas and it is difficult. You can only adopt into the one family. You have said a maximum of up to five families, but that is a decision—I think you indicated—for the donor. We had evidence from some people on Friday that there should be a maximum of one family. What is your argument to say that it should be a maximum of up to five families? Why is that appropriate and not the one family or 10 families? What are your arguments to support that view?

Ms Cefai—There is an assortment of donors and how many donors we have on file, as opposed to how many families are looking for treatment. It is also balancing it out with the risk of meeting somebody who is your half-sibling and establishing a relationship. It is not an ideal number but it is a kind of balance between the two issues. That is where we sit on it.

Mrs Lorbach—It has also been based on discussions we have had with donors who have approached the group and with adult donor conceived people over the years who have also come to the conclusion that that would be the upper limit of what they think they could cope with. The five families include the donor's own family.

CHAIR—Thank you for that.

Senator CROSSIN—I am aware that there are a couple of publications that people have been made aware of. I think it would be very useful if you draw those to the committee's attention, because I think both of them highlight some very significant issues we have talked about today.

Mrs Hewitt—I do not buy this magazine normally but, on Sunday when I was doing the grocery shopping, I found an article in *That's Life* titled 'I ordered my baby online.' The gynaecologist suggested that the lady had imported the donor sperm from overseas, so that little baby has an American father. I do not know whose *Sydney Morning Herald* this is but it was sitting there on the chair—and I read anything. There is a huge ad in the *Sydney Morning Herald* today, which would cost thousands and thousands of dollars.

Senator CROSSIN—For the *Hansard* record can you tell us what the ad is about.

Mrs Hewitt—The ad is about what sets Sydney IVF apart. The ad says that there are lots of little things. It says that infertility is not a choice but that your IVF clinic is. It lists quite a lot of clinics all around the country—Tamworth, Port Macquarie, Perth. There is obviously a lot of money in IVF. We could not afford to pay for an ad advising donor families that we exist.

Senator CROSSIN—The other thing I want to ask you is: what was the name of the *Four Corners* program in, I think, 2005?

Mrs Lorbach—I think it was 'Secret of the Fathers'.

Senator CROSSIN—When it was aired, what was the public or government response at that time? Did you get any reaction or feedback from that *Four Corners* show?

Mrs Hewitt—We got a lot of donors and recipient families ringing the group after that show. There were a lot of adults in their late 30s. I remember one woman rang me who was a lawyer in Sydney. Her parents had gone to the same clinic as the twins that were featured in that show.

Senator CROSSIN—So it raised awareness amongst parents and donor conceived persons rather than reaction from governments or authorities.

Mrs Hewitt—It did, yes. I think it was shown at the end of the year—around December. Everyone in this country goes to sleep around December and wakes up in February.

Senator CROSSIN—It might be something we would have a look at ourselves to refresh our memories.

CHAIR—Thank you very much indeed for your group and your representatives appearing today. It is obviously a personal and heartfelt response from you all, and we thank you for that and for your submission.

Mrs Hewitt—Thank you.

Mrs Lorbach—Thank you for the opportunity.

[10.17 am]

BOURROUGHS, Ms Kimberly, Attorney, Schiff Hardin law firm

MARQUARDT, Ms Elizabeth, Director, Centre for Marriage and Families, Institute for American Values

Evidence was taken via videoconference—

CHAIR—Welcome to Ms Elizabeth Marquardt by videoconference from Chicago. I am Senator Guy Barnett, Chair of the Senate Legal and Constitutional Affairs References Committee. I am joined by Senator Trish Crossin, who is the Deputy Chair, and also by Senator Louise Pratt, who is a Labor senator from Western Australia, and by Senator Russell Trood, who is a Liberal senator from Queensland. It is great to catch up with you from Chicago. We know you have a big day coming up tomorrow, as in Tuesday. We have been hearing a lot about your elections over there—Super Tuesday. I understand it is around 6 pm your time, on Monday night.

Ms Marquardt—That is right. I am joined by my colleague, Kimberly Bourroughs, from the Atlanta office of the Schiff Hardin law firm.

CHAIR—We have a copy of your paper *My daddy's name is donor*, which the committee has designated as additional information. We would very much appreciate it if you could make an opening statement, at the conclusion of which committee members will ask some questions.

Ms Marquardt—Thank you so much for having me today. It is a real honour to be able to participate in this discussion in your country. I hope to visit your neck of the woods some day as well. The study was released in June this year. It was co-investigated by me, a professor at the University of Texas Austin, Norval Glenn, and Karen Clark, an author, who was herself donor conceived in the United States. The study took advantage of a web based panel of households—that is, people who had signed up to receive surveys on anything, not necessarily to do with reproductive technologies or even families. There were 1.1 million people on the panel, and we surveyed them through a web based survey. Through that method we were able to gather 485 adults who had sperm donor biological fathers and compare some groups of 562 persons who were raised by their adoptive parents and 563 persons raised by their biological parents. So the data that I can share with you—and which you can see in the report—is based on those samples.

The biggest thing I would like to put across is that there was a substantial report of identity loss and kinship confusion among young persons who were conceived through sperm donation. This kind of confusion that I allude to has impacted on their wellbeing in measurable ways. We looked at the indicators of substance abuse, depression and delinquency—that is, being in trouble with the law before age 25. In all three cases—and I can tell you more about it—those who were conceived through sperm donation had elevated risks of these negative outcomes compared with those raised by their biological parents. In two of the cases, they even had elevated risks compared to those who were adopted.

With the issue of substance abuse, those conceived through sperm donation were more than twice as likely as those raised by their biological parents to say that they had struggled with substance abuse or alcohol issues. Related to delinquency or trouble with the law before age 25, they were twice as likely as those raised by their biological parents to say that they had had these problems. Related to mental health or diagnosis of depression or other mental health issues, they were 1.5 times as likely to say that they had struggled with these problems.

This was important because, while other studies have alluded to some of these kinds of concerns, it is unusual to be able to have a comparison group of young persons who were conceived this way who were not recruited from an online panel that has to do with the topic of donor conception, where you could that perhaps people who were more troubled were more likely to show up in that place, and to be able to have this comparison group of those who were adopted and those raised by the biological parents is also a unique feature of this study. Figure 1, which I shared with you and I believe might be before you, shows in a graph the breakdowns of mental health, substance abuse and delinquency outcomes for these three groups.

Overall, about two-thirds of young persons conceived through sperm donation say, ‘My sperm donor is half of who I am,’ and approximately two-thirds of them affirmed the right to know their identities. Depending on which question we asked them, around two-thirds—sometimes a little less and sometimes a little more—would say that they felt that they had the right to know the identity of their sperm donor and to know the number of and identity of their half-siblings. They felt they had the right as children to have a relationship with those half-siblings and a right as adults to have a relationship, if they wished, with their sperm donor biological fathers. So a clear majority of those in the sample of young persons conceived this way who were recruited from a web based panel of households are deeply concerned about anonymous conception and the right to know their origins.

One feature I would like to make clear, though, is that openness alone does not seem to absolve all the risks. Table 4 of the full report—and the full report is 135 pages and has all the data available in it is available at familyscholars.org—makes clear that, even those young persons who were conceived this way whose parents were always open with them about their conception still have an elevated risk of negative outcomes related to substance abuse, in particular, and also mental health and delinquency. Certainly if were counselling a parent who asked my advice and said, ‘I’m having a child this way; do you think I should tell them the truth?’ I would say, ‘Absolutely, yes—tell them the truth,’ but it is clear that, even if the young people know the truth of their origins, they can still struggle with significant problems compared with those raised by their biological parents.

Our study also indicated that there are higher levels of stress or conflict in families that use these technologies. We asked about family structure at the time of the birth and at age 16 and those who were conceived with sperm donation were twice as likely, compared with those who were adopted, to have experienced the divorce of their parents. That is, if they were conceived through sperm donation to heterosexual married parents by the time they were 16 they were twice as likely as those who were adopted to see the divorce of their parents. The adoption/donor conception comparison is useful here because most people have babies in what you might say the old-fashioned way, which tends to be early in marriages. Marriages are also more likely to end in divorce early in the marriage. So if people are using donor conception or adoption to build their families that tends to be later in marriages when marriages on average are more stable. Yet it is clear that those who use adoption have more stable marriages than those who use donor conception. We could talk about possible reasons why, but it is an interesting finding for parents and policy makers to be aware of.

Another striking feature to come out of our study was that we asked all three groups of these young adults—18 to 45 year olds—who had been conceived this way if they themselves had been sperm or egg donors or surrogate mothers. Of those who were raised by their biological parents only one per cent told us that they themselves had been a sperm or egg donor or a surrogate mother. Of those who were adopted zero per cent, no-one, told us that they themselves had been a sperm or egg donor or a surrogate mother. Of those who were conceived through sperm donation, as adults 20 per cent—one in five—told us that they themselves had been a sperm or egg donor or a surrogate mother. It is striking. It certainly begs for more research and exploration of this issue, but I think one of the things it really points to is that we are looking right now at the year 2010 and how many young people and children and babies are impacted by this issue. If, as our study indicates, it is the case that people who are conceived through these technologies are more likely to grow up and become donors themselves, we also have to look forward to the year 2025 and the year 2040 at those people. Even if they have the right to know where they come from, if they find their sperm donor and the donor himself may have no idea where he came from, or at least where half of him came from. So, we have to look not only at how these technologies impact people who are alive right now but also how they are changing cultural attitudes in ways that could perhaps be making those conceived this way more likely to separate sex from reproduction in ways that can impact the next generation of children.

So there is a lot here. You asked for five minutes and I wanted to put some of that on the table. I am happy to answer questions and I appreciate your having me today.

CHAIR—Would you like to make an opening statement, Kimberly?

Ms Bourroughs—No, thank you. I would like to defer to Elizabeth's comments. She is the expert scholar at the Institute for American Values.

Ms Marquardt—Kimberly Bourroughs is the chief of staff for Chief Justice Leah Ward Sears of the state of Georgia, retired now, who is a board member with me, and they have kindly provided me with the space today.

Senator CROSSIN—I live in the Northern Territory and my home base is Darwin, if you get a chance to picture Australia. We are right up north, about an hour south from East Timor. I find your research very interesting. It highlights some of the issues that have been presented to us in submissions to our inquiry about the impact of how people are donor conceived grapple with the news. In some instances they come to terms with it quite well and sometimes they do not. One of the issues that we are looking at here is whether or not there should be a national register and how donors have information about themselves recorded—what sort of information and how accessible should it be to offspring in the future. I would appreciate your view about that, and perhaps you could tell us a little bit about what happens in the United States in relation to information about donors.

Ms Marquardt—All I can say is that in my country we are not having an inquiry like you are having right now. I think that you are leading the world on this. In the US it is much more privatised. We have a privatised healthcare system. There are some registries that are voluntary. You may be talking to Wendy Kramer, of the Donor Sibling Registry, who has been a real leader in this area. There are voluntary registries but of course it is very difficult because the donors and others may not know about them and the clinics are—sadly, unfortunately—not very supportive of these registries for the most part. I certainly think that a national registry is a great idea. Particularly as a nation that has a national healthcare system, you have a real advantage in establishing something like that—the sooner the better, in my opinion, because as we are debating whether these children should be told the truth and what kind of information they should know, more of them are being conceived and born each day. I believe we do have an obligation to keep the information and as soon as possible so that it will be available if and when the law comes into effect that gives them a right to know.

Senator CROSSIN—Also in your research you make the observation that 'adoption is a rigorous process; donor conception is not'.

Ms Marquardt—Yes.

Senator CROSSIN—We have had a lot of evidence about the way in which this country treats imports of donations—in fact, the way we do not treat them, to be honest with you. Certainly if you want to adopt in this country, or if you want to adopt a child from overseas, the process is extremely rigorous. Welfare agencies look at the status of your background, your ability to raise a child, the condition of your home—it is quite an extensive and intrusive assessment program, and if you want to adopt from overseas it is even more so. I do not get the feeling that, if you want to have a child by donor conception, the same rigorous process exists. Do you have any views as to why that is the case and whether or not they should be treated in a similar manner?

Ms Marquardt—I do believe they should be treated in a similar manner. In my own country right now they are not. I know more about the US than I do about Australia, but it sounds similar. I believe that right now we see adoption operating as an institution. Adoption operates with a series of norms and practices, supported by law but also by social norms that are oriented around the best interests of the child. This comes out of more than a century of adoption practice, because adoption has also had errors in the past, and adoptees will be the first to tell you about these. It was through a process of learning, and adoptees becoming activists and coming to committees like yours to tell their stories, that adoption law moved forward and oriented itself around the best interests of the child. It functions like an institution.

Donor conception in my country—and I believe also in yours—functions much more like a market. Rather than being an institution or centred on the best interests of the child, donor conception operates more as a market oriented around the desires and rights of parents to acquire children. There is a very different set of ethics and practices involved. Sometimes people say to me, 'Aren't donor conception and adoption the same thing?' I say, 'No, they're not, and if you think that they are, then fine, let's treat donor conception like we treat adoption. Let's have studies, screenings and inquiries about whether people are a fit parent, and let's have the state say, "No, I'm sorry, you cannot do this", as they say to adoptive parents sometimes.' People are horrified by that.

I think there is a real lesson here about how differently we treat these practices and yet, in the end, we have a similar outcome. We have a child denied the opportunity to be in a relationship with, or possibly even have knowledge about, a biological parent.

Senator CROSSIN—The other debate is whether or not there should be a limit to the number of times a donor can provide assistance to families—whether it should be one donor and one family, or five families. Pick a number, any number. Certainly we have heard in submissions that you have got one donor who has been able to contribute to 30 or more children being born, and there is a view that that is too many. Do you have a view about limiting the number and what are the benefits to donor conceived people if that number is limited?

Ms Marquardt—What you see right now in the absence of limits is the ability for these technologies to create young people who must grapple with family structures that have never been heard of before in history. If you are adopted, you know that you may have some siblings out there—maybe as many as 10 and 12 but probably far fewer. If your father abandoned the family, you know that you may have some half-siblings out there—maybe a handful. This in itself can be disturbing. With donor conception and the full severing of sex from reproduction, you have young people who have to figure out on the back of a napkin how many siblings they might have. They think, ‘If one donor donated this many times over this number of months and it was successful half the time, then I could have 300 half-siblings anywhere in the world.’ This is psychologically untenable, I think, for any of us. For any of us who were not conceived this way, it is hard to imagine how that would feel.

By not having limits, we are asking people to struggle with making sense of their own identities amid kinship networks in a way that no-one in human history has ever had to do before. And, of course, you are vastly raising the dangers of consanguinity—that is, the chance that young persons conceived this way could accidentally have sexual relations with someone who is their close relation, which is a real fear among donor conceived persons. In our study we asked about that, and donor conceived persons were far more likely, even than those who were adopted, to say that they have worried that they could be unknowingly attracted to someone who is their sibling or that their children could date someone who is the child of one of their siblings.

You could say, ‘How often does that happen?’ Anecdotally it appears that it has happened before. It speaks to the fact that, in the absence of any knowledge at all, anything could be true. So persons conceived this way who have no knowledge have to grapple with: ‘Who is my sperm donor biological father? Is he alive or dead? How many siblings could I have? I may have two. I may have 300. I may have none. They could live down the street. They could live on the other side of the world.’ It is this sort of psychological reality that they have to swim in. If we are going to have these practices, it needs to be open about who your sperm donor is and there should certainly be limits on how many families can conceive children with the same donor.

Senator CROSSIN—Is there any legislation in the United States or in individual states in the US or in other countries that you know of that sets a benchmark about how some of these issues can be handled? We have legislation in Victoria here that was introduced in the last year or so that starts to grapple with these ideas, but my research tells me that there is actually a lack of good legislation around the world that starts to come to terms with some of these issues.

Ms Marquardt—I believe you are correct. I believe you and New Zealand are leading the way. Even in the UK, where they banned anonymity several years ago and they have a much more public and open debate about these issues than, for instance, in my own country, I believe they are not as far ahead as you all are in trying to come to terms legislatively with this. As you know, in Canada this is being dealt with right now in the courts. We do not know what the outcome will be. There are people trying to get better legislation in Canada to respect the child's right to know their progenitor and for the wellbeing of a child to be paramount, which is what their current law says, but it seems to be in contradiction—some of us would argue—with their actual practice of anonymous conception there. While a few nations in the world—Scandinavian countries, the UK, New Zealand and parts of Australia—have said that anonymous conception can no longer happen, there really is a paucity of legislation. I think you are correct on that.

Senator CROSSIN—Have countries legislated to stop donor conception?

Ms Marquardt—No, just anonymity. Anonymous donor conception is not tolerated in some parts of the Middle East. I know Turkey tried to pass legislation recently saying that women would be prosecuted for going abroad to obtain donor sperm. That is not the way I would want to approach these issues. That is more draconian than I would want. But in terms of Western or European nations, or nations that come out of the British Commonwealth model, I am not aware of any that have banned donor conception.

Senator TROOD—Thank you for joining us today. We really appreciate your giving us the time. Are there any states in the United States where there is legislation covering this area?

Ms Marquardt—In a state of Arizona there was a bill put forward to try to limit anonymity for egg donors. When this issue comes up in the US it has been dealt with in courts in various jurisdictions, but it is really the wild west with regard to reproductive technologies. In fact, people from other countries with more stringent laws come here to get sperm and eggs and surrogate mothers.

Senator TROOD—And there is no federal legislation, obviously.

Ms Marquardt—Right.

Senator TROOD—For this whole area of activity and behaviour there is no legislative framework anywhere in the United States.

Ms Marquardt—There may be some case law and there certainly could be others who are better informed on this than I am. But it is not something that has been pursued that way. When it becomes a real mess it ends up in the laps of judges, who make their way through it the best they can.

Senator TROOD—Can I take it from that that there are no clear guidelines as to how fertility clinics, for example, must operate, or are there some nominal guidelines provided by some medical organisations? I am interested in whether or not there are any guidelines that operate here and whether there is any obligation for those guidelines to be followed by fertility clinics, for example.

Ms Marquardt—There are professional guidelines. The American Society for Reproductive Medicine, ASRM, has its own set of guidelines. For instance, they recommend that not more than 25 offspring are created from the sperm of one donor. That is one example of a guideline. I personally think 25 is too high and even then because our clinics operate independently from one another there is no regulation or reporting of sperm donor of births. Egg donor births and embryo transfer births are reported that the CDC, our Centre for Disease Control, does have those numbers. But sperm donor offspring births are not reported, which is difficult for researchers. We do not even know how many people we are talking about in this country. So the fertility industry seeks to regulate itself in this country and until now and for the foreseeable future legislators and regulators have allowed that to occur. There are also healthcare clinics that are regulated and have to screen the sperm for HIV and STDs, for instance. The FDA put a ban on European sperm a while back because of the fear of mad cow disease. So in various areas it is regulated, but not in any of the significant issues we are talking about here.

Senator TROOD—In relation to your study, did you control for different ethnicities or socioeconomic groups or not?

Ms Marquardt—We have that information. It was interesting for us that the sperm donor offspring in our study were actually the most ethnically diverse. A number were Hispanic and a number of them were African-American, so our range of minorities or ethnic populations in this country were well represented among them. We also asked about mother’s education as a marker of family wellbeing or affluence, and the sperm donor offspring in our group actually have the highest level of mother’s education compared with those who are raised by adoptive or biological parents. Yet they have the worst outcomes related to the wellbeing measures I was telling you about, mental health and depression and such.

I think sometimes there has been the attitude, we all know that social science is showing us that single motherhood, for instance, can be risky for children but people have assumed, I think, that if you use these technologies, if you have money and you do it on purpose then that is different and the kids are fine. We were able to break out of our 485 young people conceived this way those who were conceived with single mums, those who were conceived in heterosexual married couples and those conceived to lesbian couples. First of all, all three of them were showing on average the kinds of negative outcomes and I am telling you about and mother’s education did not seem to be a protective factor. Indeed, the single mums by choice, women who would have had enough money to get treatment from a fertility clinic and who clearly got pregnant on purpose, were struggling the most with these negative outcomes. So I do think that this study underlines that when you are talking about alternative family structures perhaps how you create that alternative family structure does not matter as much as the structure itself. And perhaps children need to know where they come from, even when technologies are used.

Senator TROOD—This behavioural finding is obviously very striking in your study. I understood from your evidence a little earlier that you are saying that being open is not the solution to this problem. I am just wondering whether you have been able to dig a little deeper and determine whether or not there are any significant variables that make the difference in behavioural outcomes in families where children are donor conceived.

Ms Marquardt—Certainly openness is a key factor there. I told you about table 4. Those persons in our studies who said that their parents had kept it a secret, leaving them to find out the truth about their conception in an accidental and unplanned way, were far, far more likely to be struggling with these serious negative outcomes. I do want to make clear that if donor conception is happening, mandating or encouraging openness—or however you want to put it—rather than secrecy is the way to go. But I also want to make clear that even with openness the problems do not completely go away. There seems to be something else about knowing that the person who raised you also deliberately denied you your other parent before you were even born. I believe that is part of what is going on here.

Senator TROOD—But could it also be that there are some distinctive factors in the United States that do not necessarily apply here? For example, as I understand it, people receive payments for donations. That is generally not the case in Australia. The idea that they are being conceived for a payment might be a psychological factor that plays into someone's behaviour or activity. Another factor is that there do not seem to be any limits on the numbers, so you can be a half-sibling to a large number of people rather than perhaps a smaller group. Could there be, in your view, factors like that that are significant behavioural influences?

Ms Marquardt—I think there certainly could be, yes. I fully grant that this is a study based on the US population and that the United States is distinctive—as are all places—with some of our social concerns. I also think that there has been a more open public debate in Australia that has allowed more for the voices of young people conceived this way to be heard and I believe that has a psychological impact. I cannot prove that, but I do believe that some of the world leaders on this issue as far as activism goes arise from Australia. I believe they have given comfort to others who want to be able to tell their stories and be understood. We see that less in my country thus far. So I certainly grant that this can only tell us something about the US population who participated in the survey and Australia might be different.

Senator TROOD—Thank you for your assistance today. We are very appreciative of the work.

Senator PRATT—Who funds the Centre for Marriage and Family Studies at the Institute for American Values?

Ms Marquardt—We operate on private foundation and individual donor gifts, so it is a number of large family foundations in the US. We funded this survey ourselves from our general support, which we do not usually do, but it was tricky to get support for this work.

Senator PRATT—I think this might be a question for Kimberly. Sorry, I do not have your name in front of me. I am interested in information versus privacy laws. Clearly, it is well established that information should be widely available, but I am wondering if you have any examples of those legal conflicts and their implications.

Ms Bourroughs—I am sorry. I am not sure if I understand your question. Are you asking if there are any conflicts between the privacy right of the donors and the—

Senator PRATT—Yes. Clearly there are, and I am just interested in what kinds of examples you might have come across.

Ms Bourroughs—I personally did not participate in the study. Perhaps Elizabeth can shed some light on that.

Ms Marquardt—The debate about privacy is an important one, particularly in an era when all of our lives are lived on the internet. Some argue that we all have a right to privacy but perhaps not to confidentiality. We certainly have a right to say to someone who shows up on our doorstep, ‘No, I do not wish to speak to you. Please leave my property. If you don’t leave my property I’ll call the police.’ We have that right but perhaps we do not have the right to deliberately hide our names and identities from our biological children. That would be the distinction in this case.

CHAIR—To go to your study, I notice with mental health problems there seem to be fewer concerns compared to adopted children but with respect to substance abuse there seem to be more. Why would that be? Can you provide some analysis of that study?

Ms Marquardt—I can only speculate. It was interesting in our mental health outcomes measure that those who were adopted had the highest level of problems. I cannot prove but we do know from other studies that adopted parents are more likely to seek health care for their children and you are talking about a carefully selected group of people who have invested highly in their children. So I suspect that some of what is going on there is that the adopted persons are more likely to be getting treatment for problems they may be having. Why with donor conceived persons there would be a higher number on substance abuse than for those who were adopted I cannot say but it is a striking finding. I could only speculate.

CHAIR—That is fine. Moving on, we have had issues in Australian terms of reasonable costs. We have had evidence this morning to say that ideally it should be altruistic giving, that there should be no cost involved. Do you have a view with respect to cost?

Ms Marquardt—Sperm donation is not a physical risk for men. You might argue it is an emotional risk as he gets older and realises that he has biological children out there whom he does not know. Setting that aside, egg donation is quite risky for young women. They go through a hormonal procedure and a surgical extraction which may have long-term risks for their own fertility and health—it is not well studied. Surrogate mothers—I have been a mother myself twice and certainly pregnancy is no small matter. It changes your body forever and things can happen. It can kill you, actually. So I have some real conflicts myself. I think the involvement of money and the commercialisation of this practice, particularly in my own country, is abhorrent and hurtful to those conceived in this way, yet particularly when you are talking about women’s bodies the money which currently changes hands in no way compensates them for the risks they take. So I would have to admit that I do not have a good answer on this question. I am not sure what kind of society asks young women to donate parts of their bodies at risk to themselves for no compensation. Certainly we send men out to fight fires and to service oil wells where they face very high risks of potential physical danger and we offer them high insurance policies and good pay in order to help compensate for those risks but we do not treat egg donation and surrogacy in the same way.

CHAIR—I want to go back to the litigation you have had in the US, which you mentioned. Would you or Ms Burroughs like to respond? You said it ends up in the light of the judges. I can understand that, having worked in the US in mid-eighties with the Taft law firm, I know the litigious society you live in. What are some of the key outcomes in terms of the litigation and do they respect the right to know? We are aware of the Convention on the Rights of the Child which has implications for us in Australia and I assume in the US. We are unaware of the International Covenant on Civil and Political Rights. What have the judges said about the donor conceived individuals' right to know their parents and their other siblings?

Ms Marquardt—Most of the cases that have so far been tried have dealt with figuring out who the parents are in a given situation where there was contestation over that. The concept of intentional parenthood has become paramount in legal studies and often influential in the courts saying that persons who intended to be the parents are the parents. The issue of the offspring's right to know, I am not aware of a case in the US where that has come up. I could be wrong, there could have been one, but I am not aware of that having been even treated in the courts yet. Instead it is more around the parents deciding who among a host of actors appear before you are the parent, and whether a sperm donor is a father who should be held liable for child support or whether a surrogate mother is a legal mother. Those are the questions that are more often in the courts.

I believe the UN Convention on the Rights of the Child strongly affirms that we should not be deliberately separating children from biological progenitors without good reasons to do so. It is a very powerful convention, as you know. Unfortunately, my own country is one of two in the world that has not signed it and it is not as strong an arguing point here, but I believe it should be. It is very inspiring to those who are trying to make change on its behalf.

CHAIR—Due to our time constraints, we will need to conclude there. Do either of you have a wrap-up comment?

Ms Marquardt—I just wanted to thank you very much for taking this time today. I believe you received more than 150 submissions, and that really testifies to the deep passions and concerns that this issue raises, not only in Australia but also the world. The world really is watching what you are doing right now, and I commend you for taking on this very important issue.

CHAIR—I am advised that we have received about 1,500 submissions to date.

Ms Marquardt—Excuse me, I was looking at a website. I am sorry.

CHAIR—Anyway, that should be on the website shortly, if it is not there now, but that is my understanding. I introduced our senators earlier, but we are also professionally and wonderfully supported with a secretary, Julie Dennett, and her team and I want to acknowledge her and the team that give us support. Thank you very much for being there in Chicago and also in Atlanta, Georgia. It is great to talk to you. All the best for tomorrow. Big day for you guys and we will be watching closely.

Ms Marquardt—Thank you so much.

Proceedings suspended from 10.57 am to 11.12 am

RIGGS, Dr Damien Wayne, Lecturer, Department of Social Work and Social Policy, Flinders University

CHAIR—Welcome. We are very pleased that you have joined us from Flinders University in South Australia. You have lodged submission No. 19 with the committee. Do you wish to make any amendments or alterations to that submission?

Dr Riggs—No.

CHAIR—I invite you to make an opening statement, at the conclusion of which we will ask members of the committee to ask questions.

Dr Riggs—Other than to reiterate what I stated in my submission, I make clear that the findings that I have presented in my submission were based on two sets of research: one was an examination of 1,500 profiles on a sperm donor website and the other was a sample of interviews with 30 Australian men, examining their experience of acting as sperm donors. They were two distinct bodies of research but both intersected and certainly gave information about the characteristics of men who have the most desire to be donors, or are most willing to be donors, in the context of identity release legislation. There is some insight from the interviews about the complexities of acting as a donor and the relationship between donors and potentially donor conceived children.

CHAIR—Anything else?

Dr Riggs—No, I have nothing extra to add to what I have already put in my submission.

CHAIR—I will start with some questions. You made some reference in your submission to the need to regulate private arrangements involving donor conception. Can you outline your views with respect to private arrangements and how they could be best regulated?

Dr Riggs—That suggestion was on the basis of the interview research. Of the 30 men I spoke to, over 20 of them had donated in the context of private arrangements. That meant that the men were vulnerable, in the sense that their potential rights to have contact with the children, if that was part of the contract, were not protected, because the contracts are not legally enforceable, but also the recipients had no protection from the men potentially coming in and, as in cases in Australia before, saying, ‘Actually, no, we want access, we want custody and we want involvement.’

So at the moment the private sector, as far as I am aware, is unregulated. I do not think it necessarily has to be the case that we cease all private arrangements, because I think it is likely to be the case that they will continue. But one way to provide at least some form of regulation of the private sector would be to introduce legislation requiring the recording of donor information on a registry—just as it is within clinics—such that people are made aware that it is illegal to not provide that information and to not make that information available to donor conceived children.

At the moment, as we know, donor sperm in clinics is highly screened and very carefully regulated. Obviously that is not the case in the private sector. It would be good to provide some means through which donor sperm that is going to be donated in the private context can be screened. Certainly we have sexual health clinics across the country that allow for free screening for people who fear they may be at risk of sexually transmitted diseases. Access to that sort of screening certainly could be encouraged or promoted or made widely available to people who are going to donate sperm.

Finally, men who are going to donate sperm through clinics have to go through counselling, as do the recipients. In private arrangements that is not the case. Legislation could allow for that to be mandated so that all parties receive counselling. The men really had not given enough thought to it in many instances and did not have anyone to talk to other than the recipients—that was certainly what came out of my interview research—and obviously we can safely assume that at times the recipients' and donor's interests or desires are going to be in conflict. So having some form of counselling available—which is already available in clinics—would be desirable, so that all parties at least can have these conversations with some sort of mediator to ensure they are aware of what they are committing to. Funding for that counselling to be accessed by parties who do not go through clinics would also be desirable.

CHAIR—I want to come back to counselling in a minute. Can you outline some of the key challenges or risks or features of these private arrangements, because we have not had much evidence about that. We have had the clinics give evidence and others talk about the guidelines which apply—obviously to the clinics—but we really have not had much evidence about these private arrangements. What are some of the key features, what are some of the challenges and risks involved? You talked about the need for counselling. Can you just outline that for us?

Dr Riggs—To start off, we do have some legal precedent in Australia, where recipients—particularly lesbian recipients—who negotiated with men to donate sperm to them had a contract, which was obviously not legally enforceable. After the birth of the child, the donor has said, 'Actually, we agreed that I would have access.' The lesbian recipients have disputed this and it has gone to court. And in some instances this has had very negative outcomes for the children and the families.

CHAIR—Can you identify that particular litigation?

Dr Riggs—The particular case I am quoting here is the Re Patrick case. We have an outcome from that. Justice Guest's adjudication on that was very fair. He was very supportive of the lesbian mothers. He certainly recognised them as a two-parent family and he recognised that under the law donors are not automatically parents. Nonetheless, academic analyses have suggested that he was quite interested in asserting that the child should have some sort of father figure. I think that certainly affected the outcome of the case. The mothers disputed to the very end that they had not ever agreed that the donor would have access or custody, whereas the donor said that he would and it would be increasing as the child got older.

In effect what was ordered by the court was that the donor would have increasing access as the child got older. The only model that was adopted is from heterosexual parenting post divorce—that a father will have access on weekends and in school holidays. That was the model that was, I guess, adopted by Justice Guest. He certainly affirmed the lesbian mothers, but he nonetheless also affirmed the donor’s role, which does not really fit neatly with the law that says donors are not parents.

We have that case as an example, and there are certainly comparable US cases. There are significant legal consequences for that particular family. I would see all of those things—the very negative outcomes, the cost of litigation—as obviously significant consequences. Also, there is the fact that donor sperm is not screened in private arrangements. For example, recipients have to trust that the donor is telling the truth about the fact that he has had tests, that he is free of HIV or any STDs. If that is not the case, or if he is unaware of his status or he lies about his status or he checks his status and it is clear but actually it has not been detected yet, as can be the case with HIV, the mother and also the child could be vulnerable to STD and HIV transmission. Those are quite significant consequences of working in the public sector.

Also, obviously there is a reason why clinics give counselling. As my research found, there are aspects that men are not prepared for before they donate sperm. We have a popular conception of what sperm donation might be, but the reality for men is quite different, I think. When it comes to sperm meaning babies and children and offspring, the meanings that men attribute to that are quite complex; certainly they were in my sample. Counselling helps men to consider those things, to consider whether they are bringing their own needs and desires to their donating. I certainly think it is vital for ensuring the wellbeing of all parties.

CHAIR—Who pays for the counselling? Do you have a view on that?

Dr Riggs—I think it is difficult. The clinics obviously cover that at the moment. Obviously they are making money in some respects, whether it be through Medicare or from recipients who actually pay to use services. At the end of the day my bottom line from this research has always been that children’s best interests must come first, much like the other federal and state services that are provided free of charge to families to ensure the best outcomes for children. I think that perhaps the state or the country has to engage with the fact that, if we do not do this, there are instances where children will be likely to be significantly disadvantaged. That can include not being able to have access to information about their donor, if it is not recorded and the donor does not have counselling and then down the track he says, ‘No, I don’t want my information given out. No, I will not meet the child.’ Nothing can be done about that, whereas some counselling in place upfront may prevent some of those outcomes.

CHAIR—Finally, in terms of litigation, you mentioned the Patrick case. What year was that?

Dr Riggs—I will have to look that up and give that back to you on notice.

CHAIR—No problem. Can you identify other litigation in Australia involving these issues? Have you got any other cases you can point to? I am happy for you to take that on notice.

Dr Riggs—Yes, I am happy to provide a paper by Dr Margie Ripper from the University of Adelaide, in which she looked also at media reporting of a number of cases—not just ones that went to litigation around custody but also ones that went to litigation around donors having to pay maintenance. It is not just the fact of donors potentially asking for custody; it is also the fact that some recipients may then turn around and say to donors who are not fathers, not parents:

'You have to pay maintenance.' Some of those cases have gone to trial as well. I can certainly provide that information on notice.

CHAIR—You mentioned the US. We had evidence just before you regarding the US, and it seems that there is no adequate legislation or regulations and no national register and so on in the US.

Dr Riggs—Yes.

CHAIR—You mentioned US litigation. Was that for a reason? What were you referring to?

Dr Riggs—The litigation was very similar to the Re Patrick case. It was a similar example of a lesbian couple who had a child through donor sperm. Their allegation was that there was no agreement that the donor would have any contact. He said that there would be contact. They took it to trial. I think the outcome was different to the Australian one. The donor won, but then it was overturned on appeal. That obviously required it to go to the Supreme Court. For the mothers the outcome was positive, but certainly financially it would not have been. There are comparable examples in the US as well, but none that I am aware of from the UK.

CHAIR—Are you familiar with the UK's regulatory regime for donor conception?

Dr Riggs—Very basically. My awareness of the UK regime is that the changes it has made—and they are similar in Sweden—are very positive models that Australia could follow in regard to mandating for identity relief and allowing for payment to donors. I think payment is a very vexed question and it is probably beyond my research to answer the question about payment, but it is certainly one that the UK has had to tackle to ensure there are enough men willing to donate to clinics. I think that is part of the larger picture that the UK and also Sweden give to us in Australia: we cannot just keep assuming that men will donate sperm to clinics for free out of the goodness of their hearts. I think, if that were the case, there would be enough sperm in clinics across Australia, which is not the case. What we see then is that people are resorting to these private arrangements for one reason or another, and those men who are donating in private arrangements may well be willing to donate to clinics as well if there were some clearer legislation around that and perhaps some sort of financial support for doing so.

CHAIR—Do you support the principle that whatever legislation or regime we come up with, if we do, should be based on the best interests of the child?

Dr Riggs—As long as the best interests of the child are to be supported in the family that intended to have them, and that that included supporting children that lesbian women intended and planned to have. If that were the case, then yes. I think that any donor legislation should be centrally about children's rights to access information about their donor and include ways in which that is assured, because the research suggests that at the moment there are still considerable numbers of heterosexual recipients of donor sperm who do not plan to tell their children that they were donor conceived. So I think any ways that can make it more viable for children to know this would be ideal.

CHAIR—Thank you.

Senator TROOD—Thank you for joining us, Dr Riggs. How big was your sample for this survey?

Dr Riggs—There were two surveys. The first one was a qualitative interview research project with 30 Australian men. The other research that I mentioned earlier was an examination of 1,500 profiles on an international sperm donor registry website, including Australian sperm donors.

Senator TROOD—In the second there were 1,500; how many were in the first?

Dr Riggs—Thirty.

Senator TROOD—Are the 30 all Australians?

Dr Riggs—Yes, from across four Australian states.

Senator TROOD—How did you identify the 30?

Dr Riggs—That number?

Senator TROOD—How did you identify those individuals whom you surveyed?

Dr Riggs—I put advertisements in local newspapers in a number of states, I posted to a number of sperm donor registry type email groups on the internet and some people referred other people on to doing the interview. There were a number of different ways that people came into the research.

Senator TROOD—So they were all locals, but the 1,500 were not.

Dr Riggs—The 1,500 were profiles that are freely listed. There are many websites across the world that list profiles. Some are run by clinics and some are not. This one is not; it is an independent, not-for-profit website that I have no involvement with that lists thousands of profiles of men willing to donate sperm freely, without payment. Potential recipients pay a small fee to access these profiles to go through them, and they independently have to contact the men and negotiate sperm donation. A colleague and I looked at a sample of them from across the four countries that had the largest number of people in each of them, which were Canada, Australia, the US and the UK. We examined some of their characteristics—their demographic characteristics and how they potentially related to their willingness to be identified to children, their willingness to meet children and their motivations to act as donors.

Senator TROOD—Are you familiar with the NHMRC guidelines in relation to donations?

Dr Riggs—Yes.

Senator TROOD—Do you think they are adequate to regulate or cover this area of behaviour in relation to private practice or do you think they need attention in that respect?

Dr Riggs—The ethical stance that the NHMRC guidelines take is appropriate certainly, but I think by default it can really only apply as it stands, in my understanding, to the clinical sector. I certainly would acknowledge that my sample was perhaps skewed towards men who were donating in the private sector because perhaps they were people who had not had access to things like counselling and who wanted to talk about their experiences, but I do not think it is unrealistic to suppose that there are nonetheless a large number of people who have made use of private arrangements. As we know, it is only in the last decade that legislation has changed across Australia, other than in South Australia, allowing lesbian and single women to access donor sperm in clinics. Before that, all of those women were most likely accessing sperm in private arrangements. So I do not think the numbers are small or inconsequential.

Senator TROOD—You are not advocating that this be outlawed, are you?

Dr Riggs—No, because I think the reality is that accessing clinics costs money, requires a medical diagnosis of infertility and is not available to lesbian or single women in South Australia unless they are medically infertile. So I think there are likely to be instances, such as those and other instances where people just do not want to go through clinics, where private arrangements will continue. I do not think making them illegal is at all useful. It was the case in Victoria until recently that they were illegal. That places people who cannot make use of clinics or do not want to make use of clinics in a very invidious position, so I certainly would not advocate for making it illegal to have private arrangements.

Senator TROOD—On page 2 of your submission, under subheading (iii) ‘provision of appropriate counselling and support services’, you mention:

> … men who donated sperm in private arrangements did not appear to have given adequate consideration to the emotional consequences of sperm donation …

Do you mean for themselves or for the implications it might have?

Dr Riggs—Yes, for themselves. Perhaps because of a popular misconception, they may have thought that sperm donation would be a very simple, non-threatening process. But the men who donated to clinics and also those who donated privately found that it was very emotionally taxing. It was demanding. It required them to be on a particular time regime to match up with women’s cycles in private arrangements. For those in clinics, a clinic is not a particularly pleasant situation for anyone and certainly not one that the men I spoke to reported as being a pleasant situation to donate sperm in. So neither the men in clinics nor the men in private arrangements were prepared for the emotional consequences of what it would mean to be a sperm donor. I think these are things that need attention both in the clinical sector and in the private sector.

Senator TROOD—This is just in relation to the aspect of donation.

Dr Riggs—Yes.

Senator TROOD—None of these people were confronted by the reality of a child having been born of their sperm and then meeting them later—is that right?

Dr Riggs—None had had that happen yet. I am sorry, there was actually one man who had donated through a clinic and had been quite keen to be made aware if a child was born. He was made aware of that and did end up being in contact with that child. But that was only one person out of the entire sample. The rest had no knowledge of whether children had been born or that the recipients were still pregnant. So I certainly could not comment very clearly on the emotional consequences of actual children being met.

Senator TROOD—Thank you very much.

Senator CROSSIN—Dr Riggs, thanks for your evidence. All those references that you have cited in your submission: if we google them will we be able to find some of them?

Dr Riggs—If you have access to the journals through a university library catalogue, you could. I am more than happy to provide copies of all of them to the committee.

Senator CROSSIN—I was mainly interested in your narrative about the best interests of donor conceived children—the last one that you did with, I am assuming, a Mr Schultz.

Dr Riggs—The research that that comes from were interviews with 30 men. The research was focused primarily on the motivations men had to donate, how they understood their role as donors and any emotional consequences that they experienced. Those were the things we expected to find from the research because we were asking about them. There were two other topics that came out of the research that we had not asked about where, in most instances, the men raised them as topics of their own accord, which we thought was of note. One was what they thought the best interests of children were and the other was the other paper listed which is the understanding of the meaning of genetic material.

We thought those two topics were quite salient across 30 interviews and required closer attention. That particular paper was on best interest. The main group of men who spoke about this were gay men, who did not have children of their own, so it is a very particular subsample. I think we need to think carefully about what the reasons might be for that particular group of men. They perceived they could not have children and perceived they had no way of being parents so for them sperm donation was a way of engaging in, and I will use their words, ‘leaving a mark on the world’ and passing on their genetic legacy.

There is another paper that is in that list as well that also focuses on this. In some respects they had not given enough thought to the difference between having donated sperm to someone and that person having conceived a child and saying, ‘I am a parent’. There was a big gap between those two things that had not been considered. Many of the men defaulted to talking about themselves in terms of fathers, or their parents or having some sort of ongoing relationship to recipients and children. When questioned many of them said they had not actually spoken about that to the recipients. This was just an assumption they were operating on.

Again I would really encourage careful consideration of the fact that many of these men were gay men who really felt they had no other options to having children. So I certainly do not think they were being sneaky or underhanded, nor do I think they were being duplicitous. I think they just felt they live in a context where the only option available to them was to be a sperm donor to have some sort of relationship to children. I think that needs to be given consideration. Seventeen out of the 30 men spoke about best interest largely as being determined by adults and certainly by themselves as having a large role in determining that.

Senator CROSSIN—My other question goes to a comment that you make in your submission under payment for donors. The two sentences encapsulated some of the main ideas here. You said:

> Any factor that reduces the capacity of children to … make contact with their donor, should be avoided.

In other words you are advocating that there should be comprehensive records. I am assuming they should be nationally consistent and available for children of a donor conceived outcome. Then of course you balance that with:

> … any factor that is likely to reduce the willingness of men to act as sperm donors …

Dr Riggs—That is why we looked at the 1,500 profiles to try and map out what it looked like. What does an ideal donor look like? Perhaps someone who really meets those characteristics and is willing to be identified with children—which is what we want—but is not going to want to assert themselves within the donor conceived family, who is going to do the best by the child, but is not going to be put off from donating.

Earlier this morning I mentioned to you that payment is a possible consideration and that it does occur in the UK and the US, but we need to take my point and any point in that regard with caution because I think the research does suggest that in the UK, in particular, where men are paid to donate sperm, they tend to treat it as a one-off thing. They walk away and expect that they will never have to think about it again. Now, if they are not conducive to children being able to meet them, then payment is not a good idea.

Senator CROSSIN—Where then, in your findings, do you slot the person who might have donated 50 times? If you look at the two sentences I just read out, where you are trying to balance access, transparency and honesty with the right sort of donor, who is willing to be revealed, then surely your research must come to some conclusion about the number of times you should donate as an ideal outcome.

Dr Riggs—My research does not comment on that and cannot really comment on that, but I do not think it needs to because we have Australian guidelines that say for clinics that 10 is the maximum, and that is obviously based on factoring the likelihood of consanguinity. I think that increasing that number would be unwise, even if we have a small donor pool. If we want to make the most of that donor pool, we could potentially say, ‘Fine, we will let those groups of men donate to more families.’ I do not necessarily think that is a wise move.

Senator CROSSIN—Dr Riggs, we are hearing that people are not convinced that the guidelines are being followed, and they certainly cannot be enforced. You might donate 10 times at a clinic in the ACT but then you can go to Perth and donate 10 times there because there is no national register. Ten is a rather arbitrary number; that is what most of the submissions are saying to us.

Dr Riggs—My research could not comment on what would be the appropriate number—and the number of times is not the point; it is the number of families that make use of the sperm.

Another point I would make that is that, as far as I know, in clinics across Australia at the moment, if a lesbian couple accesses some donor sperm in a clinic, they count as one of the donor’s 10 families, where one woman carries the child. However, if the other woman wants to then carry a child, she is classed as a separate family and must use a separate lot of sperm. I think that is probably a nonsense in the sense that both women are the parents of the children, so the children are not likely to have any relationship as adults that is inappropriate because they know they are brother and sister or brother and brother et cetera. That is something that I certainly think could be looked at in regard to this legislation. We are in a sense wasting some of our available donor resources because we are mandating that if both women in a lesbian couple decide to get pregnant they must use different donor sperm, which to me does not make any sense. So that is certainly something that could be taken into consideration.

But I think your point is very well taken: there does need to be a national register. A man should not be able to donate sperm in one state that can be used for 10 families and then go to another state and do that. There could be a huge number of children born from that, because his sperm can be used for 10 families but, obviously, those families could have three children each. So there are a very large number of potential children from one man’s donated sperm.

Senator CROSSIN—Thanks.

Senator PRATT—Dr Riggs, your research does begin to point to some of the things that determine when donor arrangements work best. Could you perhaps give us a run-down of what you think those are.

Dr Riggs—Certainly. The study of the 1,500 profiles suggested that men under the age of 26 and over the age of 46 are the most willing to be identified to children and to meet children, and they were the ones most likely to report an altruistic motivation. Of men between the ages of 26 and 46, a significant motivation was to procreate, and I think we need to take with considerable precaution any man who has that as his primary motivation.

We also found that single gay men across all age ranges—in this sample it was gay men in same-sex relationships; that is how it is coded—were the most likely ones to be willing to meet children and to have contact with children. Men of any age who were in a heterosexual relationship, married, were much less likely to report a willingness to meet a child or children or even be identified with them. That piece of research would suggest that men in a particular set of age ranges are the most amenable to donating sperm in the context of identity release legislation and that there is a particular group of men for whom this is most likely to be the case. It is important to note that we have these two age ranges—18 to 26 and 26 and over. We have to be very cautious about the 46-and-over age range in the sense that the quality and motility of sperm decrease as they age. So targeting men over the age of 46 is perhaps not one of the wisest things to be doing. We need to treat with a bit of caution the fact that that age group was identified as a positive one to target.

Senator PRATT—Have you any research that indicates why single men and gay men are more likely to have that positive attribute of being more open to having contact?

Dr Riggs—My research does not. The research that we read which informed that particular paper suggests that there are a number of reasons. One might be that in a country like the US, where payment is available, younger men might be more likely to be open to it simply because part of the agreement is that they will get paid if they are willing to donate their sperm. In relation to the part about the identity release program, a young man—a uni student is a typical example—may be willing to go along with that simply to get access to the money. So. again, we have to be cautious about that particular motivation because, as I suggested before, it may preclude them from actually having any interest when it comes to the point of contact—and that is the big difference between someone saying they will meet a child and actually doing that when the child turns 18. I guess that indicates why that may be the case with the younger men. With the older men, it is the complete opposite. The Swedish research in particular suggests that, once identity release legislation was introduced, it was the older heterosexual men who were more willing to donate. That was because they had children of their own and were very comfortable with that. I guess they had thought about their identity as parents and that they could not be deemed parents as donors. So in Sweden there was a big drop in the number of men willing to donate and then it sort of recovered, but the demographic changed from younger men to older heterosexual married men.

When it comes to single men being willing to donate, there are probably a whole range of possible reasons for that—some of which I have already talked about this morning. Interestingly, there was certainly no significant association in that research, in the 1,500 profile research, that said that gay men were more likely to be motivated by a desire to procreate. That is an interesting contrast.

Senator PRATT—Have you considered the changing the perception of secrecy—for example, with adoption and the way it used to be conducted and that it is more open now because there are more families with lesbian or gay parents? Some of the concepts behind secrecy and families and the detriment caused by secrecy have changed.

Dr Riggs—Most definitely. I think that is the point. We have to be very cautious when we apply the previous research to donors and donor recipients in the current situation when it comes to lesbian recipients because the previous research was almost exclusively on heterosexual recipients. Heterosexual recipients, if they wish, potentially can hide the fact that there was donor sperm involved. They do not have to tell their child. At the moment, there is no legislation that says they must tell their child. No-one can walk into someone’s house and force them to tell a child, whereas as soon as a child learns about the birds and the bees they are going to know that sperm was coming from somewhere: they have two mothers and there must have been donor sperm. Certainly this context is very, very different. I think we do need to be very mindful that those contexts are different and that that is the challenge for the legislation that you are developing. It has to take into account the fact that there is a growing number of lesbian mothers who are having children through donor sperm. Their needs and their children’s needs are possibly going to be somewhat different from heterosexual recipients.

Senator PRATT—Thank you.

CHAIR—Thank you, Dr Riggs. We appreciate your time and your submission.

[11.50 am]

BAILEY, Ms Robyn, Founder, Solo Mums by Choice Australia

FLETCHER, Ms Cheryl, Member, Solo Mums by Choice Australia

HEARNE, Ms Fiona, Director, Solo Mums by Choice Australia

CHAIR—I welcome representatives of Solo Mums by Choice Australia. Do you have comments to make about the capacity in which you appear today?

Ms Fletcher—I am also a social worker in child and family mental health and a parent, and I have done research on single mothers in Australia using donor conception.

CHAIR—Thank you very much. SMC Australia has lodged with the committee what we have referred to as submission No. 99. Do you wish to make any amendments or alterations to it?

Ms Bailey—No.

CHAIR—We invite you to make a short opening statement, after which we will have some questions.

Ms Bailey—Thank you. As the founder of the only national support group for solo mums by choice in Australia, I have seen many stories over the years and would like to bring just a small sample of these to the committee. Firstly, our advocacy and support group was founded in 2005 and now consists of around 400 active members. However, over the years I think we have seen up to about a thousand women, maybe more, contact us for support. These women have been thinking about or trying to have a baby or may already be a mum to a donor conceived child or children. We are fully self-funded. We are a support and advocacy group. Members often report that support provided by the group far exceeds any other clinic or counsellor based support received.

I myself have three donor conceived children aged nine, six and two years old. Fiona has a seven-year-old and Cheryl has a 16-year-old. We represent our members who are living the experience of donor conception. We are not spectators or academics; we are mums.

Today we would like to tell you the real truth about donor conception. Take Tyson, Connor and Ella. They are three young children conceived in Queensland. Tyson is a chess champion, Connor loves his footy and Ella just loves mum. Tyson was conceived in 2000, when donors were truly anonymous, before the RTAC code of practice guidelines recommended that only ID release donors were used. Tyson and his brother and sister lead a happy, fulfilling life full of love, but they will probably never have the information that you and I have today: where 50 per cent of their make-up comes from.

Then there are Rory and Vince, two happy, funny brothers. Rory was conceived in Sydney and Vince in Queensland, by separate donors. Vince is Rory's younger brother. He is just one year old. Less than two years ago, the Queensland clinic advised the boys' mum that Vince's donor was ID release when she went to conceive him. The clinic have recently discovered that they made a mistake. In fact, Vince's donor has asked to remain anonymous. This mammoth error happened as recently as 2008. Rory and Vince's mum has very recently received word that Rory may in fact have an anonymous donor too, despite her being told the contrary about seven years ago.

Maggie and Sarah, beautiful blonde haired sisters who both love dancing, were conceived in Queensland back in 2003, also at a time when truly anonymous donors were accepted. Maggie, being the inquisitive girl that she is at seven years old, recently asked her mum if she could get more information on her donor. Maggie's mum contacted the clinic and was told that the donor still wishes to remain anonymous and the person could give out no further information. Maggie's mum questioned the clinic further. Only after this further prompting did the clinic contact the donor and ask him if he was willing for the girls to contact him when they turned 18. He said he was. Luckily for Maggie and Sarah, they have a proactive mum.

Laura was conceived in Western Australia just a few years ago, when only donors who were willing to have their identity released to the child at 16 were accepted. Laura's mum thought that was great until she contacted the clinic recently to see if they could contact the donor to ask if he was willing to be contacted earlier. The clinic advised that they had lost his contact details and could not think of a way to contact him. It remains to be seen what method of contact they will use in 12 years time if Laura decides she wants to know who her donor is.

Our members have reported several, almost identical, cases where clinics fail in their duty to do all they can for the children in not only Western Australia but also other states. But it can be done well. Elisa and her mum live a busy and happy life in Sydney where Elisa excels in year 2 at school and has a wide circle of friends that she often talks to about her donor dad. Elisa's donor and mother established email contact via a clinic. The clinic were open-minded enough to see that passing on a thank-you letter was a good idea, even though he was an anonymous donor. The donor was open to contact prior to the child turning 18. After years of email contact they now meet for lunch once a year. The writing and subsequent passing on of that first letter has given both Elisa and her donor a lot of joy.

Paul and Lisa, from Holland, are children of an ID release donor. Under Dutch law, when they turn 16 they have the legal right to receive the full name, address and date of birth of their donor. The Dutch ministry of health organises and strictly maintains a registry of all donors and donor conceived children, so there is no risk of losing contact details of their natural father. When Paul and Lisa want to meet their donor a counsellor, who represents the government, will guide them through the process, will establish the contact and will be present at the first meeting. Paul and Lisa are very lucky to have been born under these legal conditions. All children should have these rights.

You can see from these stories that, at best, clinic governance is ad hoc and, at worst, non-existent around Australia. Obviously, it varies between the states. SMC Australia members call on you to help deliver a national donor conception framework that upholds the rights of all humans. This must include a national register that is complete, accurate, current and retrospective and which provides a sound basis to ensure that all children are treated the same, regardless of birthplace or date.

Finally, I draw the committee’s attention to the recently documented research by Elizabeth Marquardt. The committee should be aware that, as such, the research has not undergone ethical or peer review, has used a substandard and biased method of participation and has been refuted by many subject matter experts. We would like to table a report from Wendy Kramer, of the US. Wendy is a world-renowned donor conception expert. She actually set up a donor sibling registry, which has around 29,000 members worldwide. It is probably the biggest international registry of donors and donor conceived people.

CHAIR—Can I just clarify: you are asking to table that document?

Ms Bailey—Yes.

CHAIR—Thank you, Ms Bailey. Is it the wish of the committee that the document be accepted as evidence? There being no objection, it is so ordered.

Ms Bailey—We have also tabled some research by Wendy Kramer. I would now like to introduce Cheryl Fletcher. As she mentioned, she is a social worker and is about to complete her thesis on donor conception for her PhD. Cheryl realises the value of peer and ethical review and, as such, has not yet released her full research but would like to provide you with some information.

Ms Fletcher—Thank you very much for allowing us to speak today. As stated, I am currently doing research. Because it has not as yet been examined and peer reviewed I have not been able to present it in written form. But I am happy to give a bit of an idea of the emerging themes. I am also the mother of a 16-year-old. She has put in a submission to the committee, as No. 81, stating that she would like access to her donor and his information. In speaking about my research, I interviewed 24 single women throughout Australia, in approximately 2005, 2006 and 2007. The majority of the women had conceived at a time when anonymous donors were being used. In fact, only one or two of them had identifiable donors. The women had uniformly spent a long time thinking about the ethical issues related to having a child, particularly through donor conception, and they knew from doing their own research and looking up articles and experiences from around the world that children do want to know about their fathers. So when they were looking through donor profiles at clinics they often sought out donors who were agreeable to being identified at a later stage, even though there was not legislation to support that.

However, some found that—even though the donors had said that they were willing to be identified—the clinic was not willing to do that, and we often hear from clinics that donors do not want to be identified, though that is in fact not the truth. One clinic—I think it was in Sydney—insisted that the woman sign a legal document saying that she would never pursue information on the donor, despite the fact that he had agreed that he would be willing to be contacted. She sought legal advice but feels there is nothing she can do about that. So there are instances of that.

On the other hand, at the opposite extreme, there was a woman in Melbourne—and Victoria does have good legislation around donor conceived people’s rights—who was able to get in touch with the donor. She said: ‘The first email that he sent was just unbelievable—gorgeous! Incredible!’ She was teary with emotion. ‘It was fantastic just to see that. And you know, he has been great. And his attitudes—he is really supportive of the whole process.’ So that really just helped such a lot for her to have had this contact and to know so much about him. So that is one really good example of where the person was able to have contact with the donor. But there are frequent examples of where they are not.

I think, Senator Barnett, you asked a question about the challenges of raising children conceived using donors. One of the challenges women in this research expressed was to do with how to talk about the fact that you are donor conceived and the lack of advice that some of them had. I think Melbourne IVF provides very good counselling and advice, and they have groups where women can meet and talk about these issues. Other clinics have pretty well nothing. At some clinics, if you want anything other than the original counselling you have to pay quite a large fee to get counselling. They would like more help on how to discuss that.

The other major challenge they had was of their children asking questions from a very early age: ‘Why can’t you tell me about my donor dad? Why can’t you give me the information? Why won’t the clinic—why won’t the government tell us?’ The children do not like this. They would like the information. So that is a big challenge for the mothers. They feel, sometimes, guilty that they have brought this about. And that was not their choice—they really did try to find donors who were willing to be identifiable.

We have already talked about the submission of this paper, which is refuting some of the comments made by Elizabeth Marquardt. Through the literature reviews for my thesis I found much research that showed that children from donor conceived families were in fact doing quite well. A lot of this research was peer reviewed and appeared in articles in reputable journals such as *Human Reproduction* and *Fertility and Sterility*.

They have ongoing research. For instance, Golombok’s group has a lot of research that shows that the children are doing well, especially if they are told from an early age. Jadva has done quite a bit of research on how donor conceived people feel about being donor conceived. Mostly they are quite happy about it when they have been told from the beginning. Those who are angry are angry because they were not told until later in their lives and felt that it disrupted the trust between them and their parents. Research found they would like to know more about the donor—not always to have contact, but that possibility may come up later in life. I think a key point is when donor conceived people are going to have their own children; at that point they may want to know a bit more about the donor. Those who have had access to photos of the donor and his family feel quite relieved, happy and content with that.

So I think there is a lot of research showing that families are doing very well. But the main issue for them is knowing how to talk about donor conception, and wanting information to provide to their children, because their children are actually asking.

CHAIR—We do need to leave some time for questions. Are you done, Ms Fletcher?

Ms Fletcher—I am done.

CHAIR—Ms Hearne, do you need to make an opening statement?

Ms Hearne—No.

CHAIR—Then we can move to questions. Perhaps I can just kick it off. Do you have a relationship with or do you interact with the Donor Conception Support Group at all?

Ms Bailey—Yes.

CHAIR—Could you tell us about that relationship?

Ms Bailey—There is no formal relationship. A few of our members initially started off as members of the Donor Conception Support Group. Some still are. Caroline and I keep in contact probably once every month or two to talk about common issues and that sort of thing.

CHAIR—Going back to your group, I think you, Ms Bailey, started as a foundation member. Can you tell me the reasons why you established the group and the main objectives of the group.

Ms Bailey—Yes. I started it when my oldest child was about one or two, I think. I have always said that it is about the children. We are a national group. We hold regular get-togethers in every capital city and beyond in Australia, and it is mainly for the children to get to know other children in their situation. For myself and my children, I can see that that has proved absolutely invaluable—knowing that they are not the only ones who do not have their identity or do not have a dad in the house and that sort of thing.

CHAIR—I am trying to understand your view on the role of fathers. Can you explain that to me.

Ms Bailey—Fathers or dads?

CHAIR—What is the difference?

Ms Bailey—We all have our own personal views on what we call the donor. Some families may use the terminology ‘donor dad’. I believe that the father is the biological father—that is, the donor—but we do not have a dad. In our family, for instance, we do not have a dad but the children have a father. Everybody has a father; everybody has a mother. I think you are asking about the role of dads. There is definitely a place for boys, especially, to have male role models. My father died when I was quite young, and I had an older brother. I think there is definitely a place for a male role model, but not necessarily a dad that lives in the house.

CHAIR—There is a view that was put to us on Friday—and it is a view that I share—that, all things being equal, outside tragedy and other situations a child is entitled to an expectation to come into the world with both a mother and a father. What do you say to that view?

Ms Bailey—What do I say to that view?

CHAIR—Do you agree with it?

Ms Hearne—Personally, you mean, as opposed to speaking for—

Ms Bailey—Personally I think that in an ideal world we would have lots of things but we are not living in an ideal world. I have always said that ideally I would have met the right man, we would live a very happy life together, we would have the perfect relationship and I would have two children that have a mother and a father—a mum and a dad—that live in the house together. I am not sure how many families today meet that ideal, though. I do not think we are living in an ideal world. You could also look at it from the point of view of quality or quantity of parenting. I believe that I give my children excellent quality of parenting, even though the quantity of parenting is not there.

CHAIR—We do not have adequate time to pursue this in great detail, which I would very much like to. I think I will pass to Senator Crossin and then the other senators.

Senator CROSSIN—Thanks for your submission today. I want to go to the issue of what sort of information you think should be required to be kept by clinics and whether or not that complete suite of information should be available to children or to offspring.

Ms Bailey—Fully identifying information including name, address, contact details, email address and that sort of thing is kept for later use, and the information on health, eye colour, hair colour and all that sort of thing is what we are getting at the moment. There needs to be something put in place so that contact is not lost in 16 or 18 years time or whenever a child goes looking.

Ms Hearne—Or in two years time.

Ms Bailey—Yes, exactly—whenever a child wants to go looking.

Senator CROSSIN—Could I interrupt you there. Is that an issue? You register as a donor and you donate. Five years later you move, you change your telephone number and therefore the clinic loses contact with you, so you think there is a need—

Ms Hearne—Absolutely. Here is an example. We have a member with a child who is not yet one year old. She has asked her clinic to see whether her donor would be open to receiving a letter, which he indicated on his form. The clinic have told her that they have lost contact with him. This is not a donor who would have donated 10 or more years ago; this is a recent donation.

Ms Bailey—It is also about the effort they are willing to put in. A clinic in Western Australia—and the same thing has happened in Tasmania—came back and said, ‘Sorry, the phone number does not work. We can’t find him.’ That is it. Maybe a Google search or—

Ms Hearne—That is not the business they are in. They are in the business of getting people pregnant, and that is it. If you are going to a clinic and expecting a nice warm, fuzzy, long-term relationship, sorry, but that is not going to be it.

Senator CROSSIN—Is that why, in your submission, you call for a national body that might coordinate this sort of information and also look at the regulation of these clinics?

Ms Hearne—That is right. There are guidelines that everyone operates under, supposedly, but the adherence to the guidelines is so different between clinics and between clinics that are in different states, which is where problems arise.

Senator CROSSIN—We heard last Friday that RTAC actually registers clinics, and they do that on the basis of clinics sticking to the guidelines, so it seems to me that the gap is that RTAC has no national consistency. That is, you can be sticking to the guidelines in the ACT, you can also be sticking to the guidelines in New South Wales, but the variation can be quite different.

Ms Hearne—But the clinics see the guidelines in different ways.

Senator CROSSIN—That is a good point.

Ms Bailey—I guess you also need to be aware that the RTAC code of practice is written by the FSA. The members of the FSA are the clinics. Who is governing there?

Senator CROSSIN—So it is self-regulation in a way. It does not seem to work in most other places. Have you had a chance to have a look at Friday’s transcript of the Canberra Fertility Centre’s evidence?

Ms Hearne—Yes.

Ms Bailey—Yes.

Senator CROSSIN—What is your analysis?

Ms Fletcher—I do not think he probably hears the requests made, because the requests often get made to the nurses or the counsellors. Often the fertility specialist does not even know about that and is not particularly interested about that.

Ms Bailey—I would probably go so far as to say that it was quite an ignorant point of view.

Senator CROSSIN—Okay. You have got quite a number of recommendations in your submission. They go to a lot of the points we have already read or heard in submissions. Would it be your preference to set up a national consultative committee in the first instance that might guide input into some sort of framework, to actually map out how we might deal with this in a nationally consistent way?

Ms Fletcher—I think that would be a great idea, because we have already got some good examples where our members and members of the Donor Conception Support Group are happy with some of Victoria’s system. They have already done a lot of research and they have got a lot of publications and pages on their website that are very useful. We have got precedents that can work, so if we had some people from their authority who have contributed to that research on that consultative committee, plus consumer representatives—not just fertility specialists; they never meet the kids afterwards and see their point of view. I think that would be an excellent idea, and a register of the donors would stop the importation of donors, where the clinics do not actually know that other clinics have already imported a particular donor. That sort of mistake could not happen if there was a national register of the donors as well.

Senator CROSSIN—Also last Friday you would have heard the Attorney-General say that the Standing Committee of Attorneys-General—each state and territory Attorney-General—is due to get a discussion paper at their December meeting that goes to some of these issues. I think they probably are more likely to go to surrogacy than they are to donor conception, but we will wait and see whether or not they actually accept this discussion paper and then whether or not it has been made public. Have you had any input into that or have you been consulted about that?

Ms Bailey—Not at all. I am from Queensland and I have spoken to our Attorney-General and asked him what the latest on it was—

CHAIR—Who is your Attorney-General?

Ms Bailey—Cameron Dick. I think it was about three months ago that I spoke to him about it and asked him what the status was, and I just got the run around, effectively: 'Yes, we're working on it, yes we're working on it.' I am not very heartened by the fact that they have been working on it for 18 months and nothing has come out of it yet.

Senator CROSSIN—We are waiting to see what happens in December as well.

CHAIR—We are just a bit tight on time.

Senator CROSSIN—I will finish there. I think your recommendations are pretty coherent and I think they are self-evident. They sort of back up what we have read and seen, so thanks for putting those on the last page of your submission. That is helpful.

Senator PRATT—Yes, thank you for those recommendations. I want to ask you about retrospective arrangements and the kinds of things you think could be put in place.

Ms Fletcher—There was mention of a tiered approach. Some of the donor conceived people would be aware that anonymous donors may be reluctant to come and meet initially. It would be good if there was a staggered counselling process where donors could go away and have some counselling, and mull it over for a year or so. I do not think there is a need to rush the retrospective register. I do not agree with anonymous donors being dragged out immediately and forced to meet. That would be against the interests of all parties involved. But there could be national advertising of a register and people could be invited to come forward and the public could be educated like they have done very successfully in Victoria through publications in the *Age* et cetera. We could inform the public about the benefits for donor conceived offspring of knowing their donors and encourage past donors to come forward. We could search electoral rolls. There are many things we could do in a staggered and considered way, not rushing into it. I think that would be of great benefit to the families and the donors.

Senator PRATT—A national register would keep track of how many families someone has donated to, but there could possibly be other benefits to families of being able to access the same donor interstate. There could be protocols so that if a family moved interstate but wanted to create another child they would have some continuity. How much of an issue is that? Does it affect some families?

Ms Fletcher—I think some families have been forced to use different donors. Some of the clinics have offered to keep sperm but then have not, so families have had to use a separate donor. That sort of thing needs to be managed much better than it is currently.

Senator PRATT—Something else that needs to be looked at is regulating clinics to ensure that enough sperm is available to enable siblings to be created.

Ms Fletcher—That is right.

Ms Hearne—If someone requests that and to ensure that that is done.

Senator PRATT—That is not currently guaranteed?

Ms Hearne—Some clinics do, some clinics don’t.

Ms Fletcher—It is very piecemeal. Some clinics are excellent and they provide good counselling and good services, and others don’t. It is quite variable and it is the luck of the game where you live.

Ms Bailey—We have members who have had to use a separate donor for their subsequent children because the clinics run out, and that sort of thing.

Ms Fletcher—The other thing that children benefit from is contact with their siblings. There are quite a few people around the country where the siblings meet at birthdays and at Christmas, and they love that extended family. That is the benefit of a register too.

Senator PRATT—What kinds of arrangements can be put in place for sibling contact as far as registers go?

Ms Hearne—My daughter is in touch with one of her siblings. Our clinic has always given us a list of the sex and the year a child was born. Currently they have just changed and they are slowly catching up. A month or so ago I got a list of all the birth dates and the sex of the children born from our donor. That is really unusual. I am hoping that it becomes a bit more of a standard. We know the number of siblings but, at the moment, if my daughter decides that she wants to be put in touch with siblings the clinic is not interested in helping us until she is at least 18.

Senator PRATT—What would be the ramifications of precluding access by single women to these services? Sometimes single parent head of families are often lumped together in terms of outcomes for children in those families. Would you comment on the fact that you are solo mums by choice as opposed to those who become single parents because of family breakdown.

Ms Hearne—I imagine that the clinics would lose an absolutely huge income stream, quite seriously, in all states.

Senator PRATT—But what would be the ramifications?

Ms Fletcher—The ramifications would be that people would maybe go underground and use unscreened sperm. There would be a lot of grief for people who have perhaps had separations and divorces before they have been able to have children and, through no fault of their own, end up childless. They have not necessarily willingly decided to be single but that is the way life has gone for them. So I think it would cause a lot of grief for a lot of people and they may use other methods that are unsafe.

Ms Bailey—I would imagine that the rate of HIV would go up drastically. On that point, Fiona mentioned that the clinics would go out of business. I spoke to a sperm coordinator at one of the Queensland clinics about a year or two ago. I asked her, statistically, roughly how many SMCs—as we call ourselves—they had. In the breakdown of SMCs and lesbians to heterosexual couples, I was told that, if she had 100 women that month, 99 of them would have been SMCs or lesbians.

Senator PRATT—What would be the ramifications of precluding access for these women from those services?

Ms Hearne—People would go underground.

Ms Bailey—People would find a way of creating families anyway. I do not think you can deny a woman's maternal instinct. We are probably leaving it later in life to try to conceive but, if for that to happen we have to go underground, we would probably do it.

Senator TROOD—In one of your recommendations, you have a figure of 16 years of age for information to be given to a child, but others refer to 18 years. Why do you think 16 is a better age for this?

Ms Hearne—Western Australia has the age of 16.

Senator TROOD—I know that.

Ms Bailey—That is right. Personally, I think the earlier the better. It does not mean that they have to go at 16 years of age.

Senator TROOD—Your experience is that 16 is, perhaps, a better time? Some people seem to think that 18 years of age somehow or other indicates a legal age?

Ms Bailey—The age of 18 constituted an adult probably a hundred years ago, but I think we are maturing earlier.

Senator TROOD—We have some differences and I am interested in why you think 16 is the better age.

Ms Fletcher—I think it is variable. I think it is really difficult to say whether it should be 16 or 18. I think my daughter is, at 16, quite mature. She has put in a submission. She wrote it entirely on her own. It is No. 81 and you are welcome to check it. Children think it through. She is a bright kid. Maybe some children are not ready until they are 18. I do not know that we can insist on either 16 or 18 as being the right age, but somewhere around there would be ideal and it would be fantastic if they could get that information.

Ms Hearne—History has shown in the states that, with sperm banks that have used open identity donors—Victoria is a good example—they do not necessarily get a rush from everyone on their 18th birthday, dashing off to get information. It is the fact that they know they can get access to information at that stage if and when they want it. Lots of them do not necessarily want to roll up to the front door and knock on the door; they just want the access to the information.

Senator TROOD—I am sure that is true. Similarly, you say the recommended number of families per sperm donor is limited to 10, and for smaller states and territories it is five. Most of the evidence we have received so far tends to settle on five as the number. Do you have a particular reason for choosing 10?

Ms Hearne—Ten is what they have been using since about 2005, or maybe a little bit longer, in some of the larger states. Some of the smaller states have had five for a very long time. New South Wales has only started that since 1 January. Western Australia and South Australia have had it—

Senator TROOD—Is there anything in your view that attaches to the number? Ms Hearne, I was struck by you saying, when you referred to your daughter, that you have received the sex and the birth dates. How many are there?

Ms Hearne—There are 17. There are 13 families. I was told when I started the treatment that it would be limited to 10. I recently spoke to the clinical director of the clinic I used and he said, ‘I will tell you how that happened,’ and I said, ‘I know how it happened. You guys have stuffed up,’ which was totally true. They were keeping a record but they were not keeping an exact lid on it: ‘This person is using this donor, but we actually have another clinic and this person is also using that donor.’ So my daughter is one of 17. The donor has three children of his own, so she is one of 20.

Senator TROOD—Is there any necessary virtue in a number? Is it important in relation to the behavioural development of a child or is it just the challenge of keeping up with possible half-siblings, if that is what an individual wishes to do? I am interested in why we should choose any number. You have said 10 and others have said five. I am wondering whether you have a particular view about numbers.

Ms Fletcher—I work in the mental health field. I think somewhere between five and 10, because if we have a huge number it is a lot to grapple with—the details of all those people. Some ethnic communities have very large extended families and maybe they would not be so confronted by it, but in our culture we have smaller families, so to know that there is that huge number can be quite confronting for some children. The issue as to why a number of people think it should be limited is because people accidentally marry. If there are identifiable donors and a register, that is less likely to happen, in my view, because it is all there. That would get rid of that issue. But, for the children themselves, having too many to manage is a bit awkward to get their heads around. I do not know that it is necessarily going to cause grievous harm, but I think it is awkward and uncomfortable.

Senator TROOD—You also mentioned a central voluntary Australian register of DNA. That, potentially, seems to take you outside the area of donor conception related issues. I can see how you might make an argument about how they are related, but what is the argument for a register in relation to DNA? It seems to me to be a very broad recommendation.

Ms Fletcher—That was only for people using donor conception.

Ms Hearne—It is actually working in the UK at the moment.

Ms Bailey—And in the US as well. I am sure you are aware that—depending on the state; 10 years or so ago—there is a whole generation of young adults who have no information. The clinics do not hold any information whatsoever. In the US, Ryan Kramer's mother started the DSR—the Donor Sibling Registry. He found his donor and donor siblings through a register of DNA. So it is a way to—

Ms Hearne—For the older—

Ms Bailey—Yes, for the older.

Senator TROOD—So, if everything else fails and the records have not been kept, or they have been lost or destroyed, there is a minor possibility that you can track it down this way.

Ms Fletcher—That would be the only way my daughter would be able to access her anonymous donor. He threatened to destroy the records. In fact, he did destroy most of the records, so we have no hope unless it is through DNA or unless there is wide advertising on a retrospective register and he sees that and comes forward.

CHAIR—Thank you very much. I think there is very legitimate and useful information in the submission. I thank you for that. Do you support the principle that underpins the Family Law Act, which is supported by government, with regard to the best interests of the child and that we should be acting accordingly?

Ms Hearne—Absolutely.

Ms Bailey—Absolutely.

CHAIR—We thank all witnesses at the hearing today. Thank you for your evidence.

Ms Bailey—Thank you very much for everything that you are doing. I am sure our children will thank you in the future.

Committee adjourned at 12.30 pm