CHAPTER 4

Payments for donors and provision of counselling services

4.1 This chapter examines the conduct of clinics and medical services, specifically in relation to payments for donors and provision of appropriate counselling and support services.

Payments for donors

4.2 While there is a prohibition on commercial trading in human gametes and embryos, 'reasonable expenses' are able to be paid to donors for costs incurred in making a donation. However, the term 'reasonable expenses' is not defined, and this appears to have created confusion in practical terms.

Prohibition on commercial trading in human oocytes, sperm or embryos

4.3 As discussed earlier in the report, the *Prohibition of Human Cloning for Reproduction Act 2002* (Cth) prohibits the payment of 'valuable consideration' for a donated oocyte, sperm or embryo.[1] However, it permits the payment of 'reasonable expenses' incurred by the donor in connection with supplying the oocyte, sperm or embryo.[2] 'Reasonable expenses' are defined as including, but not limited to, expenses relating to the collection, storage or transportation of the oocyte, sperm or embryo.[3] All states and the ACT have enacted complementary provisions.[4]

4.4 However, Commonwealth and state and territory legislation does not specifically provide any guidance in relation to monetary amounts for 'reasonable expenses'. This has given clinics significant scope to themselves determine what payments will be made.

Variation in payments for 'reasonable expenses'

4.5 Evidence to the committee suggested that there is a difference between reasonable expenses paid to men for sperm donations and to women for oocyte

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1 Section 21 of the *Prohibition of Human Cloning for Reproduction Act 2002*.

2 Section 21 of the *Prohibition of Human Cloning for Reproduction Act 2002*.

3 Section 21 of the *Prohibition of Human Cloning for Reproduction Act 2002*.

4 *Prohibition of Human Cloning for Reproduction Act 2008* (Vic), *Human Cloning for Reproduction and Other Prohibited Practices Act 2003* (NSW), *Prohibition of Human Cloning for Reproduction Act 2003* (SA), *Human Reproductive Technology Act 1991* (WA), *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003* (Qld), *Human Cloning for Reproduction and Other Prohibited Practices Act 2003* (Tas), and *Human Cloning and Embryo Research Act 2004* (ACT).

donations.[5] Nevertheless, some submissions argued that these amounts do not take into account the inherent difficulties in harvesting oocytes from women.[6] One of the risks faced by oocyte donors is Ovarian Hyper-Stimulation Syndrome.[7] This syndrome results in the ovaries becoming enlarged and, in some cases, ovaries can become enlarged to the point where hospitalisation is required.[8] If that happens, Ovarian Hyper-Stimulation Syndrome can become a life-threatening condition due to an 'extensive accumulation of abdominal fluid, changes in blood clotting, and dehydration' which can ultimately result in 'blood clots, heart failure and kidney failure'.[9]

4.6 At the public hearings, both Mr Richard Egan from FamilyVoice Australia[10] and Ms Elizabeth Marquardt of the Centre for Marriage and Families, Institute for American Values,[11] commented on the differing requirements that procedures have for male and female donors. In particular, Ms Marquardt noted:

> [s]perm 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.[12]

4.7 In many clinics, there appear to be discrepancies between amounts paid to male and female donors. For example, according to its website, Monash IVF in Melbourne does not provide out-of-pocket expenses for a clinic recruited oocyte donor.[13] However, the donor will be reimbursed $25 for each visit to the clinic to

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5 See, for example, *Submission 39 (name withheld)*, p. [1]; Ms Sharon Somerville, *Submission 50*, p. 1.

6 See, for example, Canberra Fertility Centre, *Submission 48*, pp [2]-[3]; Ms Sharon Somerville, *Submission 50*, p. 1; Ms Elizabeth Marquardt, *Committee Hansard*, 2 November 2010, p. 27.

7 See, for example, Wesley Monash IVF, 'Ovarian Hyperstimulation Syndrome', http://wesley.monashivf.edu.au/infertility-female.htm, accessed 29 November 2010.

8 See, for example, Wesley Monash IVF, 'Ovarian Hyperstimulation Syndrome', http://wesley.monashivf.edu.au/infertility-female.htm, accessed 29 November 2010.

9 See, for example, Wesley Monash IVF, 'Ovarian Hyperstimulation Syndrome', http://wesley.monashivf.edu.au/infertility-female.htm, accessed November 2010.

10 *Committee Hansard*, 29 October 2010, p. 18.

11 *Committee Hansard*, 2 November 2010, p. 27.

12 *Committee Hansard*, 2 November 2010, p. 27.

13 Monash IVF Fact Sheet, *Donor Egg (Oocyte) Program*, November 2006, http://www.monashivf.com/site/DefaultSite/filesystem/documents/donor_egg_program.pdf, accessed 29 November 2010, p. 2.

cover travelling expenses.[14] Sperm donors, on the other hand, receive an 'allowance' of $90 each donation to cover 'reasonable travelling expenses, car parking, [and] time off work'.[15] A sum of $400 is paid after five donations to cover time spent in counselling, medical consultations and for the five donations.[16] A further $200 is paid after the tenth donation and a final $300 is available when the sperm is no longer quarantined.[17]

4.8 According to its website, Fertility First, a clinic in Sydney, pays 'travelling expenses' of $100 for each sperm donation, of which $50 is paid at the time of collection, and the remaining $50 is paid after the sperm is released from quarantine.[18] Fertility East, another clinic in Sydney, advises on its website that it will cover expenses 'within reason (travel, time etc)' for sperm donation.[19]

4.9 However, it appears that in some clinics, an oocyte donation is paid more than a sperm donation. For example, the Concept Fertility Centre in Perth 'reimburses' $75 each sperm donation[20] and $200 for each donation of oocytes.[21]

4.10 IVF Australia's policy in relation to both oocyte and sperm donation is that the recipient (in the case of oocyte donation) or the clinic (in the case of sperm donation)

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14 Monash IVF Fact Sheet, *Donor Egg (Oocyte) Program*, November 2006, http://www.monashivf.com/site/DefaultSite/filesystem/documents/donor_egg_program.pdf, accessed 29 November 2010, p. 2.

15 Monash IVF, *Donor Sperm Program*, 'Compensation for Reasonable Medical and Travel Expenses', http://www.monashivf.com/Services/Donor_Programs1/Donor_Sperm_Program.aspx, accessed 29 November 2010, p. 4.

16 Monash IVF, *Donor Sperm Program*, 'Compensation for Reasonable Medical and Travel Expenses', http://www.monashivf.com/Services/Donor_Programs1/Donor_Sperm_Program.aspx, accessed 29 November 2010, p. 4.

17 Monash IVF, *Donor Sperm Program*, 'Compensation for Reasonable Medical and Travel Expenses', http://www.monashivf.com/Services/Donor_Programs1/Donor_Sperm_Program.aspx, accessed 29 November 2010, p. 4. Gametes are quarantined because, like most human tissues, they may carry diseases. Sperm and fertilised eggs are held in cryo-storage for six months to be tested before being implanted or otherwise used.

18 Fertility First, *Submission 104*, pp 1-2, and *How to Be a Good Sperm Donor*, 'How much money is reimbursed?', http://donatedontwaste.com.au/about-fertility-first/, accessed 29 November 2010.

19 Fertility East, 'Become a sperm donor', http://www.fertilityeast.com.au/pdf/become-sperm-donor.pdf, accessed 29 November 2010.

20 Concept Fertility Centre, http://www.conceptfert.com.au/spermdonors.html, accessed 29 November 2010.

21 Concept Fertility Centre, http://www.conceptfert.com.au/eggdonors.html, accessed 29 November 2010.

should meet all expenses 'directly incurred in making the donation ([for example] travel [and] parking [fees]) but cannot compensate donors for lost time at work'.[22]

4.11 In a case that was cited by a number of submitters,[23] Reproductive Medicine Albury sought to offer a package to a number of Canadians in 2003 that included return airfares, accommodation for two weeks and an allowance of $150 each day in exchange for sperm donations.[24] It was estimated that the total package was valued at about $7,000 at that time.[25] While it appears that the NHMRC was involved in overseeing the ethics of this offer,[26] it is unclear whether the clinic ultimately proceeded with the offer.

Altruistic donation without payment

4.12 Most submissions and witnesses supported the maintenance of altruistic donation without payment in Australia. Reasons provided in support of such altruistic donation include:

- a potential negative impact on a donor conceived child or person to know that their donor was paid for a donation;[27]
- payment for a donation creates a commercial contract between the donor and recipients, and could give rise to the donor feeling that they have particular rights or privileges in relation to the donor conceived child;[28] and

22 IVF Australia, *Egg Donation*, http://www.ivf.com.au/ivf/upload/file/CLN-009_eggdonation_16DEC09.pdf, accessed 29 November 2010, p. 4.

23 See, for example, *Submission 1 (name withheld)*, p. [3]; FamilyVoice Australia, *Submission 17*, p. 5; DCSG, *Submission 122*, pp 94-95.

24 See, for example, Foschia L, 'Proposal to fly men in from overseas to donate sperm', *PM*, ABC Radio, 9 July 2004, transcript, http://www.abc.net.au/pm/content/2004/s1150717.htm, accessed 29 November 2010, Hiscock, G, 'Sperm donors rush holiday offer', *CNN International.Com*, 19 December 2003, http://edition.cnn.com/2003/WORLD/asiapcf/auspac/12/18/australia.sperm, accessed 29 November 2010, and Murphy, C, 'Sperm and the quest for identity', *BBC News*, http://news.bbc.co.uk/2/hi/health/3410351.stm, accessed 29 November 2010.

25 Hiscock, G, 'Sperm donors rush holiday offer', *CNN International.Com*, 19 December 2003, http://edition.cnn.com/2003/WORLD/asiapcf/auspac/12/18/australia.sperm, accessed 29 November 2010.

26 Foschia L, 'Proposal to fly men in from overseas to donate sperm', *PM*, ABC Radio, 9 July 2004, transcript, http://www.abc.net.au/pm/content/2004/s1150717.htm, accessed 29 November 2010.

27 See, for example, Mr Damian Adams, *Submission 38*, p. [3].

28 Rainbow Families Council, *Submission 73*, p. 2.

- payment for donations may attract people to donate out of financial need and possibly without due consideration of the long-term implications for their emotional wellbeing, or that of a donor conceived child.[29]

4.13 Dr Damien Riggs, a researcher in the field of sperm donation, noted that his research found that almost all of those sperm donors he surveyed acted out of genuine altruism or the desire to support a known recipient.[30] He indicated that international research suggests that payment can negatively affect such motivations, and that payment can result in donors 'treating sperm donation as a one-off service, following which they have little willingness to be contacted by children conceived of their donations'.[31]

4.14 However, some submissions and witnesses considered there should be no reimbursement for any costs at all, because payment negates the donation being a truly altruistic donation, and because there are no payments for expenses incurred for people giving blood or organ donations.[32] One submission noted that some clinics provide up to $100 per donation in travel assistance and that some donors have mentioned that this is enough to entice them to donate.[33]

4.15 Some witnesses at the public hearings, such as Mr Lyle Shelton from the Australian Christian Lobby, opposed any type of payment at all, including for 'reasonable expenses'.[34] Mr Richard Egan of FamilyVoice Australia agreed:

> [t]here should be a complete ban on any payment at all. I cannot see how a bloke has any expenses for turning up at a clinic and making a semen donation. Maybe he caught a taxi there, but if you are going to be altruistic you can spare 30 bucks for the taxi fare.[35]

4.16 This was also the view of Mr Warren Hewitt from the DCSG:

> 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.[36]

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29 Ms Kylie Dempsey, *Submission 114*, p. [2].

30 *Submission 19*, p. 2.

31 *Submission 19*, p. 2.

32 See, for example, Mr Damian Adams, *Submission 38*, p. [4]; Mr Lyle Shelton, Australian Christian Lobby, *Committee Hansard*, 29 October 2010, p. 44; Mr Richard Egan, FamilyVoice Australia, *Committee Hansard*, 29 October 2010, p. 20.

33 *Submission 64 (name withheld)*, p. [1].

34 *Committee Hansard*, 29 October 2010, p. 44.

35 *Committee Hansard*, 29 October 2010, p. 20.

36 *Committee Hansard*, 2 November 2010, p. 14.

Donation with payment

4.17 A few submissions argued that, as there is a genuine shortage of sperm in Australia, generous payments should be made for donations in order to satisfy demand.[37] The Canberra Fertility Centre suggested the possibility of a payment of $200 for sperm and embryo donations, and $1000 for oocyte donations.[38] One submission considered that the prohibition on payment for oocyte donors forces this practice into 'almost a black market'.[39]

4.18 Some submissions noted that overseas donors may receive payment in their country of origin.[40] One clinic advised that it provides overseas donors with a sum for 'out-of-pocket' expenses.[41]

4.19 Ms Marquardt argued that women should be compensated more for their donations:

> 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.[42]

4.20 Dr Damien Riggs noted the inherent difficulties involved in the issue of payments for donors, and drew analogies with the United Kingdom and the United States of America:

> 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...[W]e 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.

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37 See, for example, *Submission 1 (name withheld)*, p. [4]; Canberra Fertility Centre, *Submission 48*, p. [3].

38 *Submission 48*, p. [3].

39 *Submission 39 (name withheld)*, p. [1].

40 See, for example, FamilyVoice Australia, *Submission 17*, p. 4; Ms Elizabeth Hurrell, *Submission 101*, p. [3].

41 Fertility First, *Submission 104*, p. 4.

42 *Committee Hansard*, 2 November 2010, p. 27.

...

> ... payment is a possible consideration and...it does occur in the UK and the US, but we need to...regard [that] 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.[43]

What sort of expenses should be compensable?

4.21 Many submissions supported the reimbursement of out-of-pocket expenses incurred as a result of donation, such as travel expenses.[44]

4.22 Several submissions noted that there is currently considerable uncertainty about what constitutes reasonable reimbursement of expenses, particularly in relation to imported donations, and there needs to be more detailed guidance and national consistency.[45] SMC Australia suggested that there should be a comprehensive list of travel and medical expenses which may be reimbursed so that there is no misunderstanding as to what is covered.[46]

4.23 There was some variation in the type of expenses that contributors to the inquiry considered should be reimbursed. Some were of the view that only travel expenses should be reimbursed,[47] while one submitter considered that both travel and medical expenses should be reimbursed.[48] Monash IVF suggested that the level of reimbursement needs to be more generous to recognise the time commitment given by donors in attending appointments and to acknowledge the disruption to their lives.[49]

Provision of appropriate counselling and support services

4.24 Evidence presented to the committee suggested that more could be done to provide specialised counselling to support donor conceived people and their families.

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43 *Committee Hansard*, 2 November 2010, pp 32 and 36.

44 See, for example, Victorian Infertility Counsellors Group, *Submission 68*, p. 2; Fertility First, *Submission 104*, p. 4.

45 See, for example, SMC Australia, *Submission 99*, p. 4; Fertility Society, *Submission 106*, p. [11]; DCSG, *Submission 122*, p. 139.

46 *Submission 99*, p. 4.

47 See, for example, DES Action Australia – NSW, *Submission 18*, p. [3]; Ms Lynette Mason, *Submission 24*, p. [2]; *Submission 123 (name withheld)*, p. [1].

48 Ms Elizabeth Hurrell, *Submission 101*, p. [3].

49 *Submission 120*, p. 3.

What counselling currently exists and is it effective?

4.25 Under donor conception legislation in Victoria and Western Australia, it is mandatory that participants receive counselling prior to undergoing a donor conception procedure.[50] In the remaining states and territories, clinics must at least make counselling available for participants.[51] There are different requirements across the jurisdictions in relation to the qualifications and experience that counsellors must possess.

4.26 The RTAC Code of Practice, and the NHMRC Guidelines, stipulate that individuals considering donor procedures must receive counselling before they commence any such procedure.[52]

4.27 The Fertility Society advised the committee that the following matters should be covered in counselling provided to donors:

- the circumstances that led to considering being a donor;

...

- the psychological and social aspects of being a donor;
- the legal aspects of being a donor including the possibility that a child who is born as a result of the donation may contact the donor...;
- the possible impact of the donation on the donor's relationship with his or her intimate partner;
- the possible impact of the donation on the donor's own children; and
- the possible impact of the donation on the donor's relationship with the recipient if they are known to each other.[53]

4.28 The Fertility Society advised that the following matters should be covered in counselling provided to donor recipients:

- how a donor was found;
- the lack of a genetic tie to one or both parents of a child born after a donor procedure;

...

- psychological and social aspects of using a donor to conceive;

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50 Sections 13 and 18 of the *Assisted Reproductive Treatment Act 2008* (Vic) and subparagraph 22(7)(a) of the *Human Reproductive Technology Act 1991* (WA), respectively.

51 Subparagraph 12(2)(b) of the *Assisted Reproductive Technology Act 2007* (NSW); Regulation 8(2) of the *Assisted Reproductive Treatment Regulations 2010* (SA); paragraph 9.3.1 of the NHMRC's *Ethical Guidelines on the Use of Reproductive Technology in Clinical Practice and Research* (2007).

52 *Submission 106*, p. [11].

53 *Submission 106*, p. [12].

- legal aspects of using a donor to conceive;
- possible impact of using a donor to conceive on the intimate partner relationship;
- possible impact of the donation on the recipient's relationship with the donor if they are known to each other;
- the importance of disclosing the use of a donor to a child born as a result of gamete or embryo donation;
- when, how and to whom to disclose the use of donor gametes or embryos; and
- possible future interaction between the child and the donor.[54]

4.29 The DCSG recognised that most (but not necessarily all) doctors encourage counselling and that most people who are now referred to fertility clinics engage in at least one counselling session as part of their acceptance into a donor conception program. However, in the past, counselling was very limited or, in fact, non-existent when donor conception practices began.[55]

4.30 Despite a number of people commenting positively on the usefulness of counselling they had received (when more recently seeking to undertake donor conception),[56] some considered that the current level of counselling is generally inadequate.[57] Some submissions also noted that, while counselling is, for the most part, readily available prior to a donor conception procedure, follow up counselling for donors, recipient parents or donor conceived offspring is rarely provided.[58]

4.31 SMC Australia advised that most of its members feel that counselling is a 'tick in the box' exercise; many also feel that their counselling sessions did not add any value to the process and did not provide them with any tools for talking with their child about their conception or origins.[59]

4.32 SMC Australia also asserted that there does not appear to be a consistent approach or consistent costing across fertility clinics or even across clinics within the

54 *Submission 106*, p. [12].

55 DCSG, *Submission 122*, p. 77.

56 For example, *Submission 89 (name withheld)*, p. 3; *Submission 98 (name withheld)*, p. [2]; SMC Australia, *Submission 99*, p. 8.

57 See, for example, Rainbow Families, *Submission 73*, p. 3; Fertility Society, *Submission 106*, p. [11]; DCSG, *Submission 122*, p. 73.

58 See, for example, Ms Kate Bourne, *Submission 31*, p. 4; SMC Australia, *Submission 99*, p. 8; Ms Antonia Clissa, *Submission 105*, pp 2-3.

59 *Submission 99*, p. 8.

same group, with some members not paying, others paying $200 per session for three compulsory sessions, and one member paying $1500 for one session.[60]

Counselling by appropriately trained counsellors

4.33 A key criticism of current counselling services is that they are provided in the clinical context and by infertility counsellors who are experienced in dealing with grief issues, and not with the issues involved in donor conception. As Ms Romana Rossi, the mother of a donor conceived person, noted:

> [t]heir strengths lie in dealing with the grief of infertility prior to giving birth. The clinics are focused only on treatment and success is measured in terms of having a baby not dealing with what happens afterwards. The counselling is parent oriented, not child centric.[61]

4.34 Ms Marianne Tome of the Victorian Infertility Counsellors Group drew the committee's attention to the fact that Victoria no longer has a body to 'provide this comprehensive counselling and support service and as such it is currently being performed in a haphazard way dependent on the goodwill of private clinics'.[62] She went on to state that it is 'essential that such a service be provided through a central body with suitably qualified and experienced counsellors in the donor conception field'.[63]

Counselling for donor conceived people, parents and donors

4.35 The committee notes that the Victorian Assisted Reproductive Treatment Authority's (VARTA) *Time To Tell* campaign emphasises the importance of the provision of support, such as counselling, to parents in talking to their children about how they were conceived.[64] The *Time To Tell* campaign also stresses that it is never too late to tell a child that they are donor conceived and that supportive information is available to parents regardless of their child's age.[65]

4.36 Submissions consistently suggested that there is a need for more follow-up counselling for donors, parents and donor offspring, following the birth of a donor

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60 *Submission 99*, p. 8.

61 *Submission 75*, p. 4.

62 *Committee Hansard*, 3 November 2010, pp 72-73.

63 *Committee Hansard*, 3 November 2010, pp 72-73.

64 Victorian Assisted Reproductive Treatment Authority, *Time To Tell*, http://www.varta.org.au/www/257/1003057/displayarticle/1003349.html, accessed 10 December 2010.

65 Victorian Assisted Reproductive Treatment Authority, *Time To Tell*, http://www.varta.org.au/www/257/1003057/displayarticle/1003349.html, accessed 10 December 2010.

conceived person. There is also a need for counselling at the time that a donor conceived person accesses, or attempts to access, information about their donor.[66]

4.37 Many submissions also noted that donor conceived children need counselling at various stages as they mature, to deal with self-identity and other issues arising from their conception.[67] Further, counselling was seen to be vital in sensitively and appropriately facilitating contact between donor conceived people and their donors and genetic half-siblings, as this is still very new and uncharted territory.[68]

4.38 Ms Tome also stressed the importance of counselling and education:

> ...to support parties post donor conception, to support parents in parenting a child that is not genetically theirs, in assisting parents in telling children of their donor conception and to assist children in dealing with learning that they are donor conceived.[69]

4.39 Dr Damien Riggs drew the committee's attention to the importance of male donors attending counselling:

> [a]s 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.[70]

4.40 This view was also supported by the Rainbow Families Council which expressed its concerns about the 'apparent lack of attention paid to the personal impact on a sperm donor himself of having a large number of children born as a result of their donation'.[71]

Counselling for participants in private arrangements

4.41 The committee received evidence from Dr Riggs suggesting that counselling is also very important for men who enter into private arrangements:

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66 See, for example, Victorian Infertility Counsellors Group, *Submission 68*, p. 4; Ms Antonia Clissa, *Submission 105*, p. [2]; Fertility Society, *Submission 106*, p. 12.

67 See, for example, Dr Sonia Allan, *Submission 30*, p. 21; Ms Helen Kane, *Submission 32*, p. 3; Victorian Infertility Counsellors Group, *Submission 68*, pp 5-6.

68 See, for example, Victorian Infertility Counsellors Group, *Submission 68*, pp 5-6; Rainbow Families Council, *Submission 73*, p. 3; Fertility Society, *Submission 106*, p. 12.

69 *Committee Hansard*, 3 November 2010, pp 72-73.

70 *Committee Hansard*, 2 November 2010, p. 31.

71 Rainbow Families Council, *Submission 73*, p. 3.

> ...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...The men [in my research] 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...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.[72]

4.42 While some 'rainbow families', including lesbian, gay, bisexual or transgender families, may be able to access ART procedures through clinics, many participate in private arrangements with known donors.[73] The Rainbow Families Council raised a number of further issues about the counselling and support services that its members access, including a lack of understanding by counsellors about the variety of ways 'rainbow families' create their families, and a lack of understanding of the different legal situations governing the parental recognition accorded to 'rainbow families' under existing legislation.[74]

Other support services

4.43 Several submissions noted that there are other resources and services, besides counselling, which could be used to share information and provide support to donors, donor recipients and donor conceived people. For example, Ms Romana Rossi suggested that potential recipients and donors should attend an extensive and mandatory education program that confronts the issues involved with donor conception.[75] Several other submissions suggested that clinics or counsellors could refer donor recipients to support groups.[76]

4.44 Ms Tome of the Victorian Infertility Counsellors Group advised the committee that:

> [t]he Victorian Assisted Reproductive Treatment Authority's *Time to Tell* program is an important component of this education and support in Victoria. In fact, at their last seminar they had 170 people attend and had to close the books. They have now got a waiting list for the next one.[77]

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72 *Committee Hansard*, 2 November 2010, p. 40.

73 Rainbow Families Council, *Submission 73*, p. 1.

74 *Submission 73*, p. 3.

75 *Submission 75*, p. 4.

76 See, for example, *Submission 54 (name withheld)*, p. 5; Victorian Infertility Counsellors Group, *Submission 68*, pp 5-6; SMC Australia, *Submission 99*, p.8.

77 *Committee Hansard*, 3 November 2010, pp 72-73.

4.45 Ms Cheryl Fletcher of SMC Australia also spoke of the need for support:

> [o]ne of the challenges women [have is]...how to talk about the fact that you are donor conceived and the lack of advice...I think Melbourne IVF provides very good counselling and advice, and they have groups where women can meet and talk about these issues. Other states have pretty well nothing...They would like more help on how to discuss that.[78]

Potential for conflict of interest for clinics

4.46 A number of submissions and witnesses suggested that it is a conflict of interest for clinics that provide ART services to provide pre-treatment counselling, and recommended that counselling should be made independent from clinics to remove their vested interest.[79] For example, Mr Damian Adams argued:

> [t]he problem that currently occurs is that the counsellors are all provided by the clinics. So they all have a vested interest: if they start turning too many people away, they will be out of a job. So we need to have independent counselling so we can make sure that these people are informed of all the consequences and what may occur to their own family, the offspring and the donors.[80]

4.47 Ms Rita Alesi of the Victorian Infertility Counsellors Group also noted the potential for conflicts of interest:

> [i]t is controversial because the majority of clinics are owned by private equity companies. The focus has very much changed from how it was 10, 15 or even 20 years ago. These clinics are run as businesses. For the services we provide in our clinic certain counselling is funded as part of patients' treatment cycles, up to a certain point. Then anything above and beyond that, even with our current patients, is fee for service.[81]

Should counselling be compulsory or optional?

4.48 The vast majority of evidence to the current inquiry noted that it was critical that donors and recipient parents receive counselling prior to donation, to ensure that they give proper consideration to the full consequences of donor conception.[82] As Mrs Caroline and Mr Patrice Lorbach suggested, families facing infertility may not be in the best position to consider the long-term consequences of the impact of having a

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78 *Committee Hansard*, 2 November 2010, p. 42.

79 See, for example, Mr Damian Adams, *Submission 38*, p. [6]; Ms Romana Rossi, *Submission 75*, p. 5; DCSG, *Submission 122*, p. 77.

80 *Committee Hansard*, 3 November 2010, pp 18-19.

81 *Committee Hansard*, 3 November 2010, pp 76-77.

82 See, for example, Dr Damien Riggs, *Submission 19*, p. 2; Ms Helen Kane, *Submission 32*, p. 2; Victorian Infertility Counsellors Group, *Submission 68*, p. 2; DCSG, *Submission 122*, p. 138.

family through donor conception, and may need someone objective to raise all the issues involved.[83]

4.49 Ms Tome from the Victorian Infertility Counsellors Group advised the committee that her organisation is of the view that 'counselling support is a core component of the establishment of donor registers and donor linking' and that it should 'be mandatory, include facilitation and be available to all parties'.[84] In particular:

> [w]e recommend that it is preferable to establish a system where those seeking information from the registers are supported to think through their motivation for making the application,...what they hope to achieve...and prepar[e] them for possible outcomes. The person whom the request is being made about can then be approached by a donor linkage counsellor who can inform them of their options, including the particular details of the request for information, support them in their decision-making and facilitate any contact or sharing of information between the donor and donor conceived person. A comprehensive counselling service ensures that information is provided in a supportive and comprehensive way that maximises successful outcomes for all parties involved. This counselling support should be provided in an integrated way and tailored to individual needs.[85]

4.50 However, there was a suggestion that the requirement for donors to attend multiple sessions of counselling was unnecessary and onerous,[86] and could create a disincentive to donate. One submission also suggested that it is highly unethical to coerce participation in counselling.[87]

4.51 The Victorian Infertility Counsellors Group noted that a recent amendment to the Victorian legislation has removed the requirement that the partner of a donor must undertake counselling; and suggested that this requirement be reintroduced because of the serious implications for a partner and any children or future children born to that relationship if an individual donates without the knowledge of their partner.[88]

4.52 The Rainbow Families Council indicated that it may not be either relevant or necessary for a gay male sperm donor's partner to be required to undergo counselling, as is the case in some jurisdictions:

> [t]he nature of gay male relationships is not the same as heterosexual relationships where a female partner of the sperm donor may have concerns

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83 *Submission 76*, p. 7.

84 *Committee Hansard*, 3 November 2010, pp 72-73.

85 *Committee Hansard*, 3 November 2010, pp 72-73.

86 Tonia, *Submission 7*, pp 2-3.

87 *Submission 93 (name withheld)*, p. 5.

88 *Submission 68*, p. 5.

> about her own fertility or having children in the future or where she may feel compromised by having biological siblings of her and her partner's future children.[89]

4.53 Many submissions suggested that counselling would be beneficial for donors or people conceived by donor conception prior to making contact, although many did not indicate whether they thought that such counselling should be mandatory or optional.[90] However, some submissions, including the submission from the DCSG, suggested that where contact is being made for the first time between a donor and a donor conceived person, counselling should be compulsory.[91]

4.54 Ms Robyn Bailey of SMC Australia supported a 'staggered counselling process' where anonymous donors could have some counselling over a period of time and consider whether to provide information to donor conceived people.[92]

4.55 Mr Gary Coles from the Victorian Adoption Network for Information and Self Help Inc (VANISH) expressed the view that whether or not to undertake counselling 'should be up to the individual, but certainly made available'.[93]

Who should pay for the provision of counselling?

4.56 Some submissions suggested that donor conceived people, donors and parents of donor conceived people should be able to access counselling when it is needed, without cost.[94] However, very few submissions addressed the issue of who should fund counselling if it is to be provided.

4.57 In her submission, Miss Lauren Burns suggested that, if cost was a barrier to the government providing counselling services to those affected by donor conception, infertility treatment clinics could contribute towards the cost of providing those services 'in recognition of their duty of care towards the people they helped create'.[95]

4.58 However, Ms Rita Alesi, of the Victorian Infertility Counsellors Group, stated that she did not think the clinic with which she was employed would be able to undertake an expanded role without additional cost, even for previous patients. She

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89 *Submission 73*, p. 3.

90 See, for example, Ms Helen Kane, *Submission 32*, p. 2; Victorian Infertility Counsellors Group, *Submission 68*, pp 5-6; Rainbow Families Council, *Submission 73*, p. 3.

91 See, for example, Victorian Infertility Counsellors Group, *Submission 68*, pp 5-6; Rainbow Families Council, *Submission 73*, p. 3; DCSG, *Submission 122*, p. 139.

92 *Committee Hansard*, 2 November 2010, p. 46.

93 *Committee Hansard*, 3 November 2010, p. 67.

94 See, for example, *Submission 43 (name withheld)*; p. 2; DCSG, *Submission 122*, p. 139.

95 *Submission 40*, p. 2.

stated that '[t]hey would be looking at that on a fee-for-service basis, if the clinic were to take that on board'.[96]

4.59 One submission suggested that, because the government regulates and allows people to be conceived by donor conception, it has an obligation to fund counselling services required as a result.[97] Another submission suggested that counselling should be funded by Medicare.[98]

4.60 Finally, Dr Damian Riggs observed that counselling may help prevent certain problems occurring in the future:

> [t]he 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...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.[99]

96 *Committee Hansard*, 3 November 2010, pp 76-77.

97 Ms Kate Dobby, *Submission 103*, p. 3.

98 *Submission 72 (name withheld)*, p. 2.

99 Dr Damien Riggs, *Committee Hansard*, 2 November 2010, p. 31.