NSW Law Reform Commission

REPORT 49 (1986) - ARTIFICIAL CONCEPTION: HUMAN ARTIFICIAL INSEMINATION

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Terms of Reference and Participants

New South Wales Law Reform Commission
To the Honourable T W Sheahan BA, LLB, MP, Attorney General for New South Wales

ARTIFICIAL CONCEPTION: REPORT 1 - HUMAN ARTIFICIAL INSEMINATION

Dear Attorney General

We make this Report pursuant to the reference from the late Honourable D P Landa, LLB, MP, Attorney General for New South Wales, to this Commission dated 5 October 1983.

Keith Mason QC

(Chairman)

Russell Scott

(Deputy Chairman)

Susan Fleming

(Part-time Commissioner)

Eva Learner

(Part-time Commissioner)

Peter Nygh

(Part-time Commissioner)

June 1986

Terms of Reference

1. To inquire into and report on the need to make laws on:

    (i) Human artificial insemination (AI).

    (ii) In vitro fertilization of human ova with human sperm (IVF) and transfer of the resulting embryo to the human uterus (ET).

    (iii) Any other procedure whereby human ova may be fertilized otherwise than by sexual intercourse.

    (iv) Any other procedure whereby the process of human reproduction may be commenced, continued or completed otherwise than in the body of a human female.

    (v) The preservation of human ova, human sperm and human embryo outside the human body.

(vi) "Surrogate mothering" arrangements (arrangements under which a woman agrees to bear a child for another person or persons).

(vii) Any other related matter.

2. To include in its report recommendations on the extent and nature of any recommended laws.

3. In making its inquiry and report the Commission may take into account to the extent that it decides is necessary or desirable:

(i) Social, ethical and legal issues related to the subjects described above.

(ii) Any form of artificial conception of a human child that it considers relevant.

(iii) The public interest and the interests of children, parents, infertile couples, and any other relevant person.

(iv) The nature of and issues raised by arrangements and agreements relating to any of the subjects described above, and to any child that may be born as a result.

(v) The legal rights and liabilities of medical and other personnel involved in such practices and other related practices.

(vi) Present laws including laws concerning children, including custody, adoption, inheritance and anti-discrimination, ownership of and dominion over human tissues, and the treatment of human infertility.

(vii) Proposals and activities in relation to the subjects described above under consideration by the Standing Committee of Attorneys General, and by any Committee or other Organisation established in Australia by a State or Territory or by the Commonwealth.

D P Landa

Attorney General and

Minister of Justice

5 October 1983

Membership of the Commission

The Law Reform Commission is constituted by the Law Reform Commission Act 1967. The members of the Commission are:

Full-time Commissioners

Mr Keith Mason QC (Chairman)

Mr Russell Scott (Deputy Chairman)

Mr Paul Byrne

Ms Helen Gamble

Part-time Commissioners

Dr Susan Fleming

Greg James QC

Eva Learner

Her Honour Judge Jane Mathews

The Honourable Justice Peter Nygh

Professor Colin Phegan

The Honourable Mr Justice Adrian Roden

The Honourable Mr Justice Andrew Rogers

Mr Ronald Sackville

Mr H D Sperling QC

The Honourable Mr Justice J R T Wood

Participants in Artificial Insemination Project

Commissioner-in-charge of Reference

Mr Russell Scott

Members of Artificial Conception Division

Associate Professor Bettina Cass (to 8 August 1984)

Dr Susan Fleming

Eva Learner

Mr Keith Mason QC

The Honourable Justice Peter Nygh

Mr Ronald Sackville (to 31 December 1984)

Mr Russell Scott

Honorary Consultants to the Commission

Mr Brian Bromberger

Dr D A Cooper

Dr G Driscoll

Dr R Jansen

Mr I Johnston

Professor John Leeton

Dr D C R Macourt

Mrs Lindsay Napier

Dr Graeme K Rawson

Dr Struan Robertson

Professor D M Saunders

Dr S Steigrad

Dr J Tyler

Professor Carl Wood

Research Director

Mark Richardson (to 21 June 1985)

Ms Fiona Tito (Acting to 19 September 1985)

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Research

Mrs Annabelle Bennett (Principal Consultant to 31 July 1984)

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Georgina Hone

Ms Anna Nemanic

Ms Brigitte Pers

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Mr Gary Gibson (Acting to October 1984)

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Artificial Conception Reference Publications

The following have been published in the course of the Artificial Conception Reference.
Discussion Paper

New South Wales Law Reform Commission, Human Artificial Insemination (DP 11, 1984).

Booklet

New South Wales Law Reform Commission, Human Artificial Insemination *Public Hearings* (Sydney, 16 April 1985).

Table of Abbreviations

AI	Human artificial insemination
AID	Human artificial insemination using donor semen
AIDS	Acquired Immune Deficiency Syndrome
AIH	Human artificial insemination using a husband's or a partner's semen
GIFT	Gamete intrafallopian transfer
Husband or Wife	References to a wife or a husband in this Report include couples living in stable "de facto marriage" relationships, unless the context plainly refers only to legally married persons. The words "marriage" and "married" have corresponding meanings.
IVF	Human in vitro fertilization
Advisory Committee	New South Wales Advisory Committee on Human Artificial Insemination, chaired by Russell Scott, Deputy Chairman New South Wales Law Reform Commission
Advisory Committee Report	Graeme Rawson for the New South Wales Advisory Committee on Human Artificial Insemination, *Australian Attitudes to* Human Artificial Insemination (1984)
Discussion Paper	New South Wales Law Reform Commission, Human Artificial Insemination (DP 11, 1984)

Family Law Council	A sub-committee of the Family Law Council was established in 1984 to prepare a report relating to AID, IVF, Embryo Transfer, surrogate arrange-ments and related matters, chaired by the Honourable Mr Justice Asche. The Family Law Council is chaired by the Honourable Mr Justice Fogarty
Family Law Council Report	Family Law Council, *Creating Children: A uniform approach to the law and practice of reproductive technology in Australia* (July 1985)
Marshall Review Report	*Review of Adoption Policy and Practice in New South Wales* (December 1984)
Ontario Report	Ontario Law Reform Commission, *Report on Human Artificial Reproduction and Related Matters* Volumes I and II (1985)
New Zealand Report	Law Reform Division Department of Justice, *New Birth Technologies: An Issues* Paper on *AID, IVF* and *Surrogate Motherhood* (New Zealand, March 1985)
Queensland Committee	Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters, chaired by the Honourable Mr Justice Demack
Queensland Report	*Report of the Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters* Volumes I and II (March 1984)
Swedish Report	Insemination Committee, *Children Conceived by Artificial Insemination* (Sweden, 1983)
Tasmanian Committee	Committee to Investigate Artificial Conception and Related Matters, chaired by Professor Don Chalmers

Tasmanian Report	Committee to Investigate Artificial Conception and Related Matters, Final Report (Hobart, June 1985)
United Kingdom Committee	Committee of Inquiry into Human Fertilization and Embryology, chaired by Dame Mary Warnock DBE
United Kingdom Report	*Report of the Committee of Inquiry into Human Fertilization and Embryology* (July 1984)
Victorian Committee	Committee to Consider the Social, Ethical and Legal Issues Arising From In Vitro Fertilization, chaired by Professor Louis Waller
Victorian Report (1983)	The Committee to Consider the Social, Ethical and Legal Issues Arising From In Vitro Fertilization, *Report On Donor Gametes in IVF* (August 1983)
Victorian Report (1984)	The Committee to Consider the Social, Ethical and Legal Issued Arising from In Vitro Fertilization, *Report On the Disposition of Embryos Produced by In Vitro Fertilization* (August 1984)

Glossary

AI
The placement of sperm or semen within the vagina or cervix of a woman by artificial means (see Sperm and Semen).

AID

Human artificial insemination using donor semen.

AIH

Human artificial insemination using a husband's or a partner's semen.

Azoospermia

Absence of living sperm in the semen.

Chemotherapy

Treatment of disease by chemicals or drugs.

Conception

Fertilization of an egg by a sperm.

Epidemiology

Study of the prevalence and spread of disease in a community.

Fallopian Tube

Uterine tube through which an egg (ovum) released from the ovary is conveyed to the uterus, and where conception takes place (see Ovum).

Gamete

An egg or a sperm.

Gynaecology

A branch of medicine dealing with the female reproductive tract.

In Vitro Fertilization

Human fertilization outside the body.

Insemination

The placement of semen or sperm within the vagina or cervix.

Obstetrics

A branch of medicine dealing with the care of women during and immediately after pregnancy.

Oligospermia

A low concentration of sperm in the semen.

Ovum

The female gamete produced in the ovary (plural ova. see Gamete).

Recessive Gene

An unexpressed gene carried by a person that can be passed on to that person's offspring.

Semen

Fluid secretion containing sperm that is emitted during ejaculation.

Sperm

The male gamete produced in the testicle (see Gamete).

Therapeutic

Relating to the treatment, and tending to the cure of disease.

Summary of Recommendations

CHAPTER 4: REGULATION OF AI

Recommendation 1: Legal regulation of AI should be imposed on persons (including institutions) who practise AI publicly or for reward or who hold themselves out as prepared to perform AI. (Para 4.6)

Recommendation 2: The law should restrict the practice of AI to registered medical practitioners and institutions where AI will be under the responsible supervision of the medical profession. (Para 4.7)

CHAPTER 5: THE SEMEN DONOR

Recruitment

Recommendation 3: New approaches to donor recruitment and semen collection which highlight the significant social value of semen donation should be developed and should receive official encouragement. (Para 5.9)

Screening

Recommendation 4: In the interests of public health and good medical practice the medical profession in New South Wales should prescribe standard guidelines or rules for the selection and screening of semen donors for AI programs. Uniformity of such guidelines and rules throughout Australia should be sought. Legislation and legal regulation are not justified to prescribe qualifications for semen donors or procedures or criteria for recruitment of donors or for screening and testing donors. (Para 5.12)

Recommendation 5: The supply by a semen donor of false or misleading personal information when providing medical or other personal particulars should be a specific statutory offence. A section creating the offence should be included in legislation regulating AID pursuant to this Report. (Para 5.18)

Recommendation 6: A statement or warning should be placed at the head of the prescribed form of certificate under section 21C of the Human Tissue Act 1983 to the effect that statutory penalties are provided for the supply of any false or misleading personal information when giving medical or other personal particulars in relation to semen donation. (Para 5.18)

CHAPTER 6: ELIGIBILITY TO RECEIVE AID

Recommendation 7: Legislation should be enacted to provide that a person who performs AI as part of medical practice shall not administer AID to a woman until the person has given due consideration to the following matters:

whether the woman is a member of a couple who are infertile or who have (one or both) a genetic or other abnormality that is likely to affect their children;

the welfare and interests of a child that might result;

the home environment and stability of the household in which the child would live;

whether or not counselling is desirable;

the physical and mental health, and age, of the prospective parent or parents and their emotional reaction to artificial conception. (Para 6.14)

Recommendation 8: Breach of the duty imposed by legislation in accordance with Recommendation 7 should be capable of being found to be "misconduct in a professional respect" either within section 27(2) of the Medical Practitioners Act 1938, or by a comparable provision. (Para 6.14)

CHAPTER 7: CONSENTS AND COUNSELLING

Consents

Recommendation 9: As a matter of good medical practice, consents should be obtained from each of the parties to AI or AID. The development of standard forms of consent is desirable. (Para 7.1)

Recommendation 10: There is no present need in New South Wales for legislation to impose compulsory requirements for consent to be given:

by a woman to receive AID (Para 7.2);

by the husband (or partner) of a woman before she may receive AID (Para 7.5);

by a semen donor before donation; or

by the wife of semen donor to his donation (Para 7.9).

Recommendation 11: There is no present need for further lawmaking or law reform in relation to a husband's consent insofar as paternity and the status of the AID child are concerned. (Para 7.8)

Counselling

Recommendation 12: No action should be taken to enact legislation with a view to making counselling compulsory for any party to AID or in relation to any part of the procedure of AID, or for the training or availability of counsellors. (Para 7.1 1)

Recommendation 13: Good professional practice should encourage and, if possible, ensure the availability of skilled, fully-trained counsellors to all parties to AI and AID if needed at any stage of the procedures involved. (Para 7.1 1)

CHAPTER 8: ANONYMITY, SECRECY AND CONFIDENTIALITY OF INFORMATION

Anonymity

Recommendation 14: Legislation should be enacted whereby certain persons are forbidden to disclose or give, or otherwise placed under a duty or obligation to refrain from disclosing or giving, to any other person any information or document whereby the identity of a person who is a party to AI or AID (including a recipient woman, her husband or male partner, the semen donor and each AI or AID child) may become publicly known. The persons to be forbidden or placed under the duty or obligation are AI and AID practitioners, clinics, hospitals in which AI and AID are practised, staff and keepers of relevant records. (Para 8.2)

Recommendation 15: The legislation proposed in Recommendation 14 should be framed so as to provide for the following exceptions:

where the person to whom the information relates gives consent;

where a judge or a magistrate makes an order, but subject to the conditions, if any, in the order;

where the disclosure of information is necessary for the administration or execution of the legislation outlined in Recommendation 14:

when the information is to be used for hospital or clinic administration or medical research. (Para 8.2)

Confidentiality

Recommendation 16: Legislation should be enacted so as to impose upon AI and AID practitioners, clinics, hospitals in which AI and AID are practised, staff and keepers of the relevant records, the same duty and obligation to maintain confidentiality in relation to information obtained by them or any of them about any person who is a party to AI or AID (including a recipient woman, her husband or male partner, a semen donor and each AI or AID child) as medical practitioners have in relation to information obtained by them about their patients. (Para 8.13)

CHAPTER 9: SEMEN - TESTING, STORING, LIMITS ON USE

Testing and Storing Semen

Recommendation 17: Legislative regulation is not called for in relation to testing and storing semen for use in AI. (Para 9.11)

Recommendation 18: The medical profession should prepare guidelines for testing and storing semen for use in AI. Bodies such as the Royal Australian Colleges of Medicine and the Australian Fertility Society have the capacity for this. (Para 9.11)

Limits to Quantity of Semen from One Donor

Recommendation 19: Legislative regulation is not called for in relation to limiting the quantity of semen from one donor to be used in AI. (Para 9.15)

Recommendation 20: The medical profession should prepare guidelines for limiting the quantity of semen from one donor to be used in AI. (Para 9.15)

Recommendation 21: AID practitioners should have regard to the risk of innocent consanguineous mating between half siblings born as a result of AID and should accordingly limit the usage of the semen of a semen donor. (Para 9.15)

The Use of Mixed Semen in AID

Recommendation 22: Legislative regulation is not called for in relation to the use of mixed semen from two or more semen donors or the use during one menstrual cycle of a woman of multiple or successive single donations of semen produced by one man. (Para 9.24)

Recommendation 23: The use of mixed semen, and any action in AID by a medical practitioner or by medical personnel aimed to cause confusion about a child's parentage, should be regarded as falling outside the bounds of good medical practice. (Para 9.24)

CHAPTER 10: SEMEN - COMMERCE AND OWNERSHIP

Commerce

Recommendation 24: The reimbursement of any expenses necessarily or reasonably incurred by a semen donor in relation to the lawful donation of his semen for AID should be allowed and legislation enacted to ensure that such reimbursement is lawful. (Para 10.9)

Recommendation 25: The Minister should give consideration to setting from time to time a standard fee under section 32 (4) of the Human Tissue Act 1983 for payment to semen donors as well as permitting further reimbursement of expenses to the extent that they exceed the standard fee in a particular case. (Para 10.9)

Recommendation 26: Legislation should make provision to the following effect:

(a) As a general rule the AI clinic should have the power to determine whether, and in what manner, semen donated to it for AID will be used, stored and disposed of. (Para 10.13)

(b) The power in (a) should be subject to any agreement made by the donor and the clinic setting out the terms applicable to his semen donation for AID. (Para 10.18)

(c) If a man and a clinic make an agreement for the storage of his semen for his or his wife's or partner's subsequent use, the clinic should, subject to the terms of the agreement, have power to discontinue storage and to dispose of the semen only after first giving the depositor a reasonable opportunity to make alternative arrangements. The clinic's power of disposal will also be exercisable if the donor or depositor dies, cannot be traced by the clinic or fails to respond. (Para 10.18)

CHAPTER 12: AIH AND POSTHUMOUS USE OF SEMEN IN AI

Recommendation 27: Direct legislative regulation of the practice of AIH is not necessary. (Para 12.1)

Recommendation 28: The law should recognise the deceased husband as the father of a child born as a result of AIH, provided that the woman is his widow and unmarried at the time of insemination and birth. (Para 12.4)

Recommendation 29: The law should allow the register of births to record the deceased husband's paternity in the case of AIH using the deceased husband's sperm, provided that the woman is his widow and unmarried at the time of insemination and birth. (Para 12.4)

Recommendation 30: No action should be taken to enact legislation to regulate directly or prohibit directly AIH where a widow wishes to use that procedure to become pregnant by her late husband's stored sperm. (Para 12.5)

Recommendation 31: Legislation should provide that, for the purposes of inheritance or succession to property whether on the testacy or intestacy of the father, the child is not to be regarded as the child of the father, except to the extent that the father has made specific provision for the child in his will. Otherwise, that child should have the right or power to make a claim under the Family Provision Act 1982. (Para 12.11)

CHAPTER 13: RECORD KEEPING

Access to AI Records

Recommendation 32: No person should have a legal right of access to information that may identify a party to AID and no record keeper should divulge such information, unless the person who is the subject of the information formally consents. (Para 13.23)

Recommendation 33: Information about any party to AI or AID that does not identify a person may be made available "for good cause" by a record keeper. In the event that agreement cannot be reached on "good cause" the matter should be determined by a person or body nominated by the Minister for

Health. "Good cause" should be defined or indicated by legislation and should be based, in principle, on the health and welfare of a party to AI or AID. (Para 13.23)

Recommendation 34: The supply of information should not necessarily confer a right of access to or inspection of the records themselves. (Para 13.23)

Creating and Keeping Records

Recommendation 35: All clinical records relating to AI and AID and to the parties to AI and AID shall be retained. (Para 13.28)

Recommendation 36: The extent of the records, and their contents and the methods to be used to assist in preserving confidentiality and anonymity, are matters for good medical practice and should not be prescribed in a statute. (Para 13.28)

Who Should Keep Records

Recommendation 37: Records should be created and kept by AI clinics and practitioners. There should be no establishment of an official or other central register. (Para 13.30)

Duration of Record Retention

Recommendation 38: There should be no fixed time limit for retention of records, but a procedure should be provided whereby a record keeper may apply for permission or authority to dispose of records or transfer them to an acceptable custodian.

Record Keeper's Duty to Inform a Person at Risk

Recommendation 39: No action should be taken to create or impose by legislation an obligation or duty on the part of the record keeper to seek out and advise parties to AI whose health is found to be at risk. (Para 13.33)

Retrospectivity of Legislation

Recommendation 40: Legislation pursuant to Recommendations 32 and 33 above, conferring rights of access to recorded information, should apply to existing records.(Para 13.35)

CHAPTER 14: LEGAL LIABILITY OF MEDICAL PERSONNEL, DONORS AND RECIPIENTS

Recommendation 41: No action should be taken to enact legislation to impose specific legal liability upon medical personnel, semen donors or parents to pay compensation for damages or injury resulting from AI or AID. (Para 14.9)

Recommendation 42: No action should be taken to enact legislation to confer exemption from liability upon medical personnel who act in good faith and without negligence when performing an act or duty imposed by legislation in relation to AI or AID. (Para 14.11)

Forward

The Commission's Inquiry into human artificial insemination (AI) was the first of its kind in Australia. This Report and its recommendations for reform and lawmaking are deliberately confined to AI. As mentioned in Chapter 1, the Commission has divided its Reference *Artificial Conception* into three parts and will produce three separate reports. The Inquiries will cover respectively human artificial insemination, in vitro fertilization (IVF) and surrogate motherhood.
The Commission believes that this procedure is desirable because each of the three subjects raises important discrete issues as well as issues that are common to all. We believe that the community will be better served by separate Inquiries.

A reading of Chapter 4, for example, will indicate the value of this approach because it presents, for the first time, aspects of AI that ought to be considered without reference to other means of artificial conception. The Commission's recommendations in Chapter 4 differ markedly from the recommendations made on AI by other Inquiries (for example the Queensland Inquiry), organizations (for example the Council of Europe) and jurisdictions (for example Victoria), which have not drawn the distinction between AI as an act performed by private persons and AI carried out as a continuing practice. Our conclusion is that attempts by the law to regulate and control every act of AI are unlikely to be effective. Legal regulation of the act of AI could not be policed or monitored and would be likely to be ignored, creating a risk of bringing the law into contempt.

Separate presentation of this Report will enable the Parliament to focus attention directly on AI without the risk of being diverted to controversial issues and questions intimately bound up with related but different procedures such as IVF. For example, the moral status of the fertilized human ovum or pre-embryo has attracted a great deal of public attention, but that question arises in the context of IVF not AI. It seems to us that discussion of such questions could diminish or divert discussion and consideration of important issues raised by AI (and surrogate motherhood) if all three subjects were presented to the Parliament in one legislative measure, as has already happened in another Australian jurisdiction.

In making its recommendations, the Commission has borne in mind practical aspects of government administration in New South Wales. We have endeavoured to present the recommendations in such a way that those matters which fall within the jurisdiction of separate departments, such as Health, Attorney General and Youth and Community Services, may be readily identified.

The Commission has been assisted by many persons in its work on AI. The Division which has produced this Report comprises the following Commissioners:

Mr Keith Mison QC (Chairman)

Mr Russell Scott (Deputy Chairman and Commissioner-in-charge of Reference)

Dr Susan Fleming

Eva Learner

The Honourable Justice Peter Nygh

The Commission is also indebted, for their advice and comments, to its Honorary Consultants, appointed for the purposes of the Reference. They are named in the terms of reference and participants page.

The Commission wishes particularly to acknowledge the outstanding contribution by way of research and written material made by its Legal Research Consultant, Ms Fiona Curtis. It also wishes to make specific reference to the assistance it has received from Legal Research Consultants, Miss Yvonne Williams and Mr Ian Collie.

Submitted with this Report, is draft legislation which reflects the Commission's recommendations. The recommendations themselves appear in bold type in the respective Chapters in which they are made, namely Chapters 4-15 inclusive. We wish to record our thanks to Parliamentary Counsel, Mr D R Murphy and in particular to Assistant Parliamentary Counsel, Mr D Colagiuri for their assistance and advice on the form and content of the draft legislation.

Keith Mason QC

Chairman

Russell Scott

Commissioner-in-charge

Date: June 1986

1. Background to Report

I. INTRODUCTION

A. The Reference

1.1 On 5 October 1983 the Attorney General referred to this Commission a number of matters that the Commission has collectively entitled *Artificial Conception.* The terms of reference are set out in the preliminary pages to this Report. The reference was related to previous work done by the New South Wales Advisory Committee on Human Artificial Insemination, and the Commission decided to divide the subject matter into three parts:

human artificial insemination;

in vitro fertilization; and

surrogate motherhood.

As a consequence, it is envisaged that the Commission will produce three reports. These reports and the aspects of reproductive technology which they cover will be, to some extent, interconnected. Basic principles and values applied by the Commission to each report will be the same. For example, it can be expected that the same importance will be attributed in each to issues involving the welfare of the child and to procedures concerning donated gametes.

1.2 In December 1984 the Commission published a substantial Discussion Paper entitled *Human Artificial Insemination*. The paper provided background information relating to the history and practice of AI in New South Wales and elsewhere, reviewed recent legislative policy and official initiatives and presented in detail issues for law reform. The paper sought submissions from the public.

B. Membership of the Commission

1.3 Between mid 1984 and early 1985, the membership of the Commission changed. Following the resignation of Associate Professor Cass, the expiry of the term of office of Mr Sackville and the appointment of Mr Keith Mason QC to the office of Chairman of the Commission, the Artificial Conception Division was reconstituted on 12 April 1985. Mr Russell Scott and the Honourable Justice Peter Nygh, the remaining members of the former Division, were joined by the new Chairman and by Eva Learner and Dr Susan Fleming.

1.4 The Commission's policy in the Inquiry on human artificial insemination has been to integrate three major events, namely publication of the Discussion Paper, the consultation period which was formally concluded by a public hearing, and this Report. Accordingly there is extensive reference in this Report to the Discussion Paper and a deliberate attempt to keep repetition of material to a minimum.

II. PUBLIC CONSULTATION

1.5 Copies of the Discussion Paper were widely distributed. A public hearing was conducted by the Commission at the Maitland Lecture Theatre, Sydney Hospital on 16 April 1985. The hearing was well publicised and attended. Over 100 members of the public, including representatives of a variety of organisations, were present for much of the day and 21 made oral submissions.[1] A full transcript of the proceedings was made. The public hearing provided a forum in which members of the public could express views and make a direct contribution to the process of law reform. The Commission has carefully considered the views expressed both at the meeting and in written submissions and is grateful for the efforts of those interested groups and individuals. At the end of 1985, 48 written submissions were held.[2]

III. THE RESEARCH PROGRAM

1.6 In addition to public consultation, the Commission has informed itself of the range of issues and possible solutions from a number of sources. This has included the following:

> Literature Search: We have collected and examined a large amount of written material from Australian and overseas sources, ranging from scholarly and scientific publications to press reports which have been systematically accumulated and recorded. Appendix E describes part of this material.
>
> Research Papers: The Commission's research staff has prepared a series of original papers for the internal use of the Commission on subjects that have special significance for law reform on AI. The subjects covered by the papers are listed in Appendix B.
>
> Observation Visits: Apart from the direct acquisition of information by letter, telephone and questionnaire, we have visited all known AI clinics operating in New South Wales and have interviewed principals and staff "on site".
>
> Examination of Existing Laws: We have collected information about legislation on AI enacted in Australia and overseas and have made comparative studies. This comparative work has also involved examination of the reports of a number of official and government Inquiries into AI conducted in Australia, North America and the United Kingdom.

1.7 The Commission has also had regard to the report of the Advisory Committee on Human Artificial Insemination dealing with Australian attitudes to AI.[3] This report was prepared for the committee by Dr Graeme Rawson and was based on two community surveys. The first was a general population survey and the second a survev of members of 40 community groups. The surveys were both designed to gauge public opinion on the issues raised by AID, and were the first of their kind undertaken in Australia. The report has been printed and widely distributed under the title *Australian Attitudes to Human Artificial Insemination*.[4]

IV. THE AI PROCEDURE

1.8 AI has been described as:

> .....a simple procedure from the medical point of view. Semen is obtained by masturbation and is deposited by means of a syringe in or near the cervix of the woman's uterus.[5]

The act of insemination is typically performed by a qualified nurse under the supervision of a doctor. The nurse will first use a "speculum", an instrument of metal or plastic designed and shaped for insertion into the vagina, to enable the cervix to be seen. Next, a straw of semen will be placed in a syringe or "gun" which will be used to expel the semen so that it is lodged at the entrance of the cervix, as happens when sperm is ejaculated during sexual intercourse. The insemination is timed to coincide with ovulation which is the time of the woman's maximum fertility in her monthly cycle. Normally inseminations will be performed on two or three successive days as this has been found to increase the likelihood of pregnancy. The semen used may be from the woman's husband or partner or from a "donor". It may be fresh semen or, as is more likely, it may have been frozen. The successive inseminations during any particular cycle may be from one semen donor, if frozen semen is used, or several donors when the procedure involves fresh semen. Although AID is most commonly performed under the supervision of a doctor, the techniques involved are simple and could be performed by persons without medical training.

FOOTNOTES

1. Appendix F.

2. *Ibid.*

3. Advisory Committee Report.

4. See also Discussion Paper, ch 4.

5. Ciba Foundation Symposium 17, *Law and Ethics of AID and Embryo Transfer* (1973) at 3.

2. The Present Law

I. THE AUSTRALIAN POSITION

A. Introduction

2.1 Laws in existence at the time modern AI procedures became effective were plainly not designed to regulate those procedures. Neither statute law nor common law was developed with AI in mind. It followed that the application of existing legal principles to the practice of AI was likely to produce results that were unexpected, and often unwanted. In the case of AIH, that is, a married couple using the husband's sperm, there appeared to be few legal problems (see paragraph 12.1 below). However, with donated sperm undesirable legal consequences were likely to be caused by traditional legal principles. Confirmation is given by the United Kingdom Report in the following words:

> Under existing law neither AIH nor AID is unlawful. A child born to a married couple as a result of AIH is the legitimate child of that couple . . . In theory the husband of the woman who bears an AID child has no parental rights and duties in law with regard to that child: these in principle lie with the donor, who could be made liable to pay maintenance, and who could apply to a court for access or custody.[1]

2.2 The Commission therefore sees limited utility in analysis of the "existing" law. The need for reform is obvious. We will, however, refer by way of example to two discussions of "existing" Australian law by Mr Justice Asche of the Family Court of Australia in 1980 and 1983.[2] Mr Justice Asche expressed the opinion that no legal complications arise out of AIH because the resulting child is in all respects the child of the parties to a marriage.[3] It is the use of donated semen that leads to complexity under the common law, for example in relation to the legal obligation to maintain a child, the rights of the child to be maintained, the inheritance of property by the child and from the child, the inclusion or exclusion of the child from the gifts in a will in favour of a testator's "children", and the stigma of illegitimacy in those jurisdictions that have retained the notion of illegitimacy. In his May 1983 paper delivered at a conference at Monash University, Mr Justice Asche suggested that the "existing" law had no ready answer to the following questions:

> When donated sperm is used who is the resulting child's father?
>
> When a man who has stored his sperm leaves a gift by will to his "children", what is the entitlement of a child born some years after his death?
>
> How should the rights and obligations of parenthood be applied in such cases?
>
> How can paternity be proved?
>
> If a medical practitioner is involved, what is the extent of his duty of confidentiality and to whom is it owed?
>
> What are the respective rights and liabilities of donor, recipient and medical practitioner in a case where there is a defect in the reproductive tissue that leads to the appearance of disease or defect in a resulting child?

> What information should be placed on the birth register and what consequences flow from a registration containing false information?

Mr Justice Asche opened his 1980 analysis with the following words:

> The legal problems arising from AID are so far-reaching and presently so complicated that only clear and precise legislation can clarify the situation.[4]

B. Government and Official Interest in AI

2.3 Since late 1983 most Australian legislatures have enacted uniform legislation clarifying the legal status of AID children. The Victorian parliament enacted unique additional legislation in November 1984 imposing statutory control upon AI and IVF. The commencement of government and official interest in AI in Australia may be reasonably dated at 1977 when the Australian Law Reform Commission completed its report Human Tissue Transplants. In its Working Paper No 5 dated 18 January 1977 and in its subsequent report, Report No 7 dated 30 June 1977, that Commission devoted specific attention to medical and scientific advances with human reproductive tissues. In chapter 4 of the report it made the following recommendation:

> Legislation, following separate inquiry, should be considered in relation to the artificial insemination of human beings, and the consequences which may ensue from the acts of donating semen for reproductive purposes and the artificial implanting of semen in a woman. Related matters such as the legitimacy of children, the inheritance of property, and matrimonial or family law rights and liabilities, should also be carefully considered.[5]

2.4 Except as described in the succeeding paragraphs the call of the Australian Law Reform Commission went unheeded until 1982, although AI was an agenda item on the successive meetings of the Standing Committee of Attorneys-General from July 1980.[6]

2.5 In 1982 the Australian States began independent action, and since that time official Inquiries and (committees concerned with reproductive technology have been set up in every State. Details of state and federal Inquiries together with Australian legislative measures on AI are described in chapters I and 3 of the Discussion Paper and are referred to in the following paragraphs of this Report.

C. Commonwealth Legislation

2.6 In late 1983 and 1984 the first Australian legislative steps were taken to deal with the legal status and paternity of AID children. The Family Law Amendment Act 1983 (Cth), which commenced on 25 November 1983, inserted a new provision in the Family Law Act 1975 (section 5A) under which an AID child, born to a married woman who has been inseminated with donor sperm with her husband's consent, is "deemed to be a child of" the husband. Legislation which allows recognition by the Marriage Act 1961 (Cth) of the above-mentioned presumption if created by a state law was enacted by the Marriage Amendment Act 1985 in March 1985.[7] There are limitations on the scope of these provisions. The limitations arise from the Australian Constitution, which gives power to the Commonwealth to make laws relating to "marriage" and to "divorce and matrimonial causes: and in relation thereto,

parental rights and the custody and guardianship of infants".[8] Thus, the presumption of paternity created by section 5A is only for the purposes of the Family Law Act 1975 and will have no wider application than that Act. The effect of the section is to broaden the meaning of "child of the marriage" for the purpose of the application of the Family Law Act. The amendments to the Marriage Act 1961 will prevent the concept of illegitimacy from applying to AID children under federal marriage law if the law of a State shows an intention that the child is to be treated as the child of the recipient and her husband.

D. New South Wales Legislation

2.7 In February 1984 the New South Wales parliament passed Australia's first self-contained statute dealing with artificial conception. That Act, the Artificial Conception Act 1984, deals with the legal status and paternity of AID children and IVF children using, in principle, the same approach as the Commonwealth legislation amending the Family Law Act 1975. It came into effect on I August 1984. The Act contains only six sections and rejects biological paternity in favour of social paternity when a husband consents to the use of donor sperm to achieve his wife's pregnancy by artificial means, whether AID or IVF. It is retrospective, so that the paternity presumption applies in relation to children whenever born and the presumption itself is irrebuttable. De facto marriages or relationships are included in the reference to marriage. The sperm donor has neither the rights nor the obligations of paternity. He is presumed not to be the father of the child whether the recipient woman is married or not, and that presumption is also irrebuttable. Therefore in the case of an AID child born to a woman who is not married, there will in law be no father.

2.8 A cognate Act, the Children (Equality of Status) Amendment Act 1984, was passed at the same time for the purpose of preserving the presumptions of paternity that could arise in cases where a husband has not consented to his wife's AID.

E. Victorian Legislation

1. Status of Children (Amendment) Act 1984

2.9 The Victorian Status of Children (Amendment) Act 1984 was enacted in May 1984 and by arrangement with New South Wales also commenced on 1 August 1984. The Act reflects the draft legislation that had for some time been under consideration by the Standing Committees of Attorneys-General and uses in principle the same approach as the Commonwealth legislation amending the Family Law Act 1985. It clarifies the legal status of children born following AID and children born following IVF when donated gametes (sperm or ova or both) have been used. The Act contains five sections and its approach to AID is similar to the New South Wales Artificial Conception Act 1984. However it does not use identical phrasing, and different judicial interpretations may therefore ensue. It attributes paternity of an AID (and an IVF) child in the same fashion as the New South Wales Act.[9]

2. Infertility (Medical Procedures) Act 1984

2.10 The Infertility (Medical Procedures) Act 1984 was passed in November 1984 and received Royal Assent on 20 November 1984. At the time of writing, only three sections were operative; sections 1 and 2 (formal preliminary provisions) and section 29 which provides for the establishment of a Standing Review and Advisory Committee. These sections were proclaimed to commence on 14 May 1985. The Act contains an extensive regulatory system for human artificial insemination, in vitro fertilization and surrogate motherhood.

2.11 Significant provisions of the Infertility (Medical Procedures) Act 1984 relating to AI are the following:

Only medical practitioners may “carry out a procedure of artificial insemination”. An exception is made for persons who carry out artificial insemination “in an approved hospital”. The Act provides a procedure whereby a hospital may make application to the Minister for approval of the hospital as a place at which AI may be carried out.[10]

AI shall not be carried out unless the recipient woman and her husband have received “counselling, including counselling in relation to prescribed matters, from an approved counsellor”.[11]

Hospitals and medical practitioners who carry out AI must create and keep detailed records as prescribed. Information must be transmitted to the Health Commission and kept there in a government register.[12]

Particulars of a donor must be provided in writing to the recipient woman.[13]

It is an offence to carry out “a procedure of artificial insemination . . . where the semen used for the artificial insemination or relevant procedure was produced by more than one man”.[14]

It is an offence for a donor to “make a statement that is false or misleading by reason of the inclusion in the statement of false or misleading matter or of the omission from the statement of any material matter” unless the person “believed on reasonable grounds that the false matter was true, the misleading matter was not misleading or, in the case of an omission, that no material matter had been omitted.”[15]

F. South Australian Legislation

2.12 The Family Relationships Act Amendment Act 1984 was passed by the South Australian parliament in December 1984. Royal Assent to the legislation was given on 20 December 1984 and the Act was proclaimed to commence on 14 February 1985. It follows the scheme of the Victorian Status of Children (Amendment) Act 1984 described in paragraph 2.9 above. The Act also contains a “sunset” clause which provides that it will not apply to children conceived after 31 December 1986.[16]

G. Tasmania, Western Australia, the Australian Capital Territory and the Northern Territory

2.13 Recent legislation on the status of AI children enacted by these States and Territories implements a similar policy to the statutes described in paragraphs 2.6,2.7,2.9 and 2.12. Particulars are as follows:

Status of Children Amendment Act 1985 (Tas) - proclaimed to commence on 28 November 1985;

Artificial Conception Act 1985 (WA) - operative as from 1 July 1985;

Artificial Conception Ordinance 1985 (ACT) - gazetted on 7 November 1985; and

Status of Children Amendment Act 1985 (NT) - passed on 22 August 1985.

H. Queensland

2.14 We were advised orally by the Department of Health in Queensland in April 1986 that Queensland is in the process of preparing legislation on AID.

II. THE INTERNATIONAL POSITION

A. Introduction

2.15 The following paragraphs are not intended to be a comprehensive statement of the legal position relating to AI at an international level. The assembly of up-to-date information from each individual jurisdiction in the United States is not feasible, nor has it been possible to obtain detailed particulars of the regulatory approach of each European nation. However, the information provided below is, we believe, a useful summary of the legal position in a number of leading Western societies.

B. Europe

2.16 The Discussion Paper provided a description of a draft model code of laws prepared by the Council of Europe in 1979 for its member nations, entitled Draft Recommendation on Artificial Insemination of Human Beings.[17] The recommendation was never adopted by the Council of Europe's Committee of Ministers and lience the model code never became law. However, in November 1985 the Council of Europe's Committee of Experts on Medical Research on Human Beings (CAHBI) met in Strasbourg to give further consideration to a draft code of principles for the regulation of human artificial procreation.[18] The draft principles will be submitted to interested organisations at a hearing at Trieste, Italy in June 1986. In the light of that hearing and further consideration, CAHBI will finalise its recommendations at meetings later in 1986. The completed text will be presented as a model for legislation to the 21 member countries, after approval by the Committee of Ministers of the Council of Europe.[19]

2.17 Apart from the Council of Europe initiatives, direct statutory control of the performance of AI has been achieved in Sweden with the enactment in December 1984 of the Insemination Act. The Swedish Insemination Act contains seven sections and provides that AID may be carried out only in a hospital under the supervision of a specialist physician. The policy of the Act is to restrict the performance of AI so that it is made available only to women who are married or in de facto relationships. Cognate legislation (an amendment to the Parenthood and Guardianship Code) enacted in December 1984 deals with the status of the AID child and follows the same approach as the Australian legislation of 1983 and 1984 described earlier in this Chapter, providing that the consenting husband of a married woman will be presumed to be the father of the child.

C. United Kingdom

2.18 As far as the United Kingdom is concerned, we understand that at the end of 1985, legislation pursuant to the recommendations of the United Kingdom Committee was being prepared for submission to the English parliament. Our Discussion Paper set out the course of United Kingdom Inquiries on artificial conception from 1982.[20] The major recommendations of the United Kingdom Committee which relate to AI are as follows:

> AID should be available on an organised basis under the control of a statutory licensing authority. Persons providing AID services should be licensed by the authority, and the services should be available only to infertile couples.

Good practice requires that written consent of both partners should be given before AID treatment begins.

The law should presume that the husband has consented to AID unless the contrary is proved.

There should be a limit of 10 children who can be fathered by one donor.

Semen donors should be given only their expenses.

The AID child should be treated by law as the legitimate child of its mother and her consenting husband.

Semen donors should by law have no parental rights or duties to the child.

A central government register comprising the National Health Service numbers of semen donors should be established and clinics should check the National Health Service numbers of all donors against that register.[21]

D. United States

2.19 The United States has a longer legislative history of action on AI than other Western nations. This was described briefly in the Discussion Paper.[22] Our most recent information is that 25 States have adopted laws which provide that the artificial insemination offspring is the legal child of the sperm recipient and her consenting husband.[23] Further, 11 States require that the husband's consent to artificial insemination of his wife be filed with the State.[24]

E. Canada

2.20 According to the Ontario Law Reform Commission, in its 1985 report on Human Artificial Reproduction,[25] two Canadian jurisdictions, Quebec and Yukon Territory, have responded to the growth in the practice of artificial conception by enacting artificial insemination laws. The Ontario Report itself contains recommendations regarding the practice of artificial insemination, which are expected to be enacted into laws. Some of the most significant of the Committee's recommendations relating to AI are as follows:

Legislation should expressly require a donor's free and adequately informed consent as a precondition to the donation or use of his gametes.

At the time of donation, a donor should be entitled to restrict the use of the donated gametes to a specified purpose.

After donation, but prior to the use of their gametes in a fertilization procedure, donors should be entitled either to require their donation to be wasted or returned to them, so that the gametes may not be used for artificial conception, research or any other purpose.

A donor's consent to the donation of his gametes, given at the time of donation, should remain of legal effect until withdrawn or otherwise altered.

Sperm banks should be permitted to operate on a commercial basis. However, they should be allowed to operate only under licence and under stringent regulations setting standards of operation.

An AID child should be presumed to be the legal offspring of its birth mother, and that woman's consenting male partner.

A donor of sperm should be presumed to have no legal relationship to the child arising from the fact of donation.

With respect to registration of the birth of an artificially conceived child, the gamete donor should not be named in the register of births, nor should the fact of artificial conception appear in such register.

Where a woman gives birth to a child conceived posthumously by means of her deceased husband's or partner's preserved sperm, the woman should be entitled to register the birth showing the deceased as the father of the child.

Anonymity concerning the identity of all parties involved in artificial conception-the donor, the recipient, her spouse or partner (if any) and the child-should be preserved in the medical records.[26]

FOOTNOTES

1. United Kingdom Report, para 4.9.

2. A Asche, "AID and the Law" in C Wood et at (eds), Artificial Insemination By Donor (1980) at 109; A Asche, "Ethical Implications in the Use of Donor Sperm, Eggs and Embryos in the Treatment of Human Infertility", paper delivered at Monash University, 4 May 1983.

3. A Asche (1983), *id* at 1.

4. A Asche in C Wood et at (eds), note 2 at 109.

5. Australian Law Reform Commission, Human Tissue Transplants (ALRC 7, 1977) para 42.

6. Discussion Paper, para 1.17.

7. s26.

8. Commonwealth of Australia Constitution Act 1901 (Cth), s5l (xxi), (xxii).

9. Discussion Paper, para 3.10.

10. ss17,7.

11. s18.

12. ss 19,21 and 22.

13. s20.

14. s26.

15. s27.

16. s6.

17. Discussion Paper, para 3.19.

18. Australia was present as an observer, represented by Mr Russell Scott and Dr W A Langsford, on the initiative of the National Health and Medical Research Council.

19. Council of Europe, *CAHBI Meeting Report,* CAHBI (85) 3 (Strasbourg, 19-22 November 1985).

20. Discussion Paper, para 3.22.

21. United Kingdom Report, paras 4.16, 4.17, 4.22-4.24, 4.26 and 4.27.

22. Discussion Paper, paras 3.20,3.21.

23. Hearings before the Subcommittee on Investigations and Oversight of the Committee on Science and Technology, House of Representatives, Human Embryo Transfer (Ninety-eighth Congress, Second Session, August 1984) at 176.

24. *Id* at 181.

25. Ontario Report.

26. *Id* at 275-280.

3. Our Principles

I. INTRODUCTION

3.1 In Chapter 2 we noted the inability of the common law to deal adequately with the consequences of the development of new reproductive technology. The number of public Inquiries is evidence of the concern felt within our own and other communities about AI. Because AI is a means of human reproduction, attitudes to it are influenced by the moral, ethical and religious views of members of the community to sexual behaviour, family formation and the bearing and raising of children. Hence, the Commission believes that acceptance of its recommendations for law reform in this area will be governed to a significant extent by the acceptance and credibility of the principles underlying them. In this Chapter, we attempt to outline our main principles and indicate our answers to some frequent objections to AI.

3.2 An important factor to which the Commission has paid regard is public opinion. Because of the nature of AI and the depth of feeling it arouses in some sections of the community, the Commission felt that it had a duty to ascertain public opinion. In Chapter I we outlined measures we took to do this, including our program of public consultation and studying closely the Advisory Committee Report on attitudes to AID. However, the Commission's recommendations are not intended to be an unqualified reflection of majority "public opinion". Considerable differences of opinion exist within the community, and such differences were apparent in submissions made to us. The Commission has made recommendations that provide a balance between the often strongly-held views of individuals and groups within the community, within the framework of its own underlying principles.

3.3 The members of the Division bring with them a diversity of professional expertise and personal views, and like the members of the community from which they are drawn, have different views on some questions. As has been stated by the National Health and Medical Research Council:

> Ethics as a subject is not an exact science; there are many issues to which the question "right or wrong?" cannot be given a simple answer; and there are some matters that cannot be settled by consensus. When a judgment is made that a procedure is ethically acceptable, that will often mean not that the procedure is clearly right, rather that it is ethically defensible but may still legitimately be controverted. Judgements in these matters must always permit dissent (and the exercise of conscientious objection); they are always subject to revision in the light of new evidence, further thought, or both.[1]

II. DISCUSSION

A. Underlying Principles

3.4 In the course of making its recommendations, the Commission formulated some basic principles. These were as follows:

> It is desirable, where possible, to alleviate the consequences of infertility through practices such as AI.
>
> The paramount consideration in the practice of AI shall be the welfare of the AI child.
>
> The formation of stable families is socially desirable and necessary.
>
> Personal freedom and individual autonomy should, so far as possible, be respected.

B. Acceptability of AI

3.5 While accepting that some individuals and families will choose to live a life without children, the majority of women have children at some stage in their reproductive lives. In the 1981 Census, at least 64 per cent of women 15 years or over in New South Wales had children.[2] To be thwarted in this choice by involuntary infertility is a cause of great distress to many people. Further it is generally considered in our community that people should be able to control their own fertility. We do not address the vexed question of the manner or extent of exercising this control. However, the ability where possible, to alleviate infertility or its consequences would seem to be a necessary corollary to this premise. The social desirability of the alleviation and the prevention of involuntary infertility also relates to the special value attributed to children. Community opinions, as ascertained in the Advisory Committee Report, indicate a wide acceptance of the availability of AI, at least to certain groups. For example, the approval rate of AID for helping married couples who cannot have children because of the husband's infertility was 70 per cent while disapproval was 17 per cent.[3] There was no significant variation in male and female responses. In the survey of Opinion Leaders the overall approval rate was 60 per cent and disapproval 29 per cent.[4]

C. Some Objections to AI

3.6 As we have already indicated, there is widespread community approval of AI as a means of alleviating the consequences of involuntary infertility. Nevertheless, a number of objections or concerns about the practice of AI have been raised in submissions to us and elsewhere. We address some of these briefly here.

3.7 AI *improperly separates human* procreation from bodily *sexual love.*[5] In the typical case, the couple seeking to have a child cannot achieve pregnancy through normal sexual intercourse. AI is not performed to replace the sexual act but to give couples, whose normal sexual activity does not result in conception, another means whereby the woman may achieve pregnancy and bear a child.

3.8 *The intrusion of technology into the creation of a human life is unnatural and therefore wrong*.[6] Every medical intervention could be described as unnatural because it interferes with the natural course of disease or disability. Few people would limit or even question the obligation of medical practitioners to treat properly any disease or health abnormality by such means as are available and approved by the patient, including technological treatments. On the basis that infertility is a defect in the reproductive process, the use of technology to treat the defect is acceptable. It is also necessary to note that the labelling of actions as "natural" or "unnatural" frequently proceeds from some fundamental moral or religious belief held by the person making the description and, as such, may not be acceptable to others. AI is arguably a more "natural" form of reproduction than some other means of artificial conception. The physical procedure of AI, unlike IVF, bears comparison with reproduction by sexual intercourse. Indeed, in the past, some United States courts held AID to be adultery.[7] The semen is placed in a similar location to that occurring in normal sexual intercourse, and if conception results, it does so as it would have done with such intercourse.

3.9 AI *involves a waste of public funds.* Proponents of this view often say that funds should be diverted to ascertaining the causes of infertility and treating them, rather than in practising AI. While the investigation of the causes of infertility is an important matter, it will not alleviate the involuntary infertility of couples in the interim, nor will it assist those whose infertility could have been prevented but was not. The allocation of resources between one area of health research and practice and another is a matter of balancing many factors and, in the end, applying value judgments. We have received no indication that public moneys directed to AI are excessive or misdirected or that the money involved would produce better results for those currently suffering from involuntary infertility if it were spent elsewhere.[8]

D. The Paramount Welfare of the Child and Family Formation

3.10 The laws of New South Wales and Australia have long reflected a commitment to the principle that the welfare of children should be the first and paramount consideration in relation to legal questions concerning their upbringing, custody and property. Statutory expressions of this principle, which comes from Australia's British legal heritage, may be found in family law and adoption

legislation.[9] The interpretation of the principle has changed as notions of parenthood have changed. In the past, family law courts tended to accept the proposition that, up to a certain age, children automatically needed their mother's care rather than that of their father. The custody of children of tender years was therefore normally given to the mother. As the rigid roles previously assigned by society to mothers and fathers have become more flexible, and it has been acknowledged in principle that each parent, and indeed others, could reasonably be entrusted with a child's upbringing, this practice is no longer so strictly followed.

3.11 Interpretation of the principle will undoubtedly continue to reflect social changes. However, this does not detract from the principle itself. Whatever may be the best understanding of the welfare of the child at a particular time and in a particular case, may be given effect by appropriate laws relating to children, including those born as a result of AI.[10]

3.12 Traditionally, a precursor to the birth of children has been the formation of a new family unit, either within an extended family group or as a separate "nuclear family". In Western society (and others) this new family formation is symbolise(i by the marriage of a man and a woman. The act of marriage itself has been considered by the community as an indicator of an intention to form a permanent, stable relationship, within which children can be cared for and grow. However, there have always been other types of households and families. It may be said that the birth of a child is itself the creation of a family, even if there is no other person than the mother concerned in its upbringing.

3.13 Stable family formation whether in marriage, a de facto relationship, an extended family or some other household has generally been considered by the community as necessary to provide a child with the best conditions in which to grow up. Even with divorce and family breakdown the law attempts to foster continuity and security in the child's life through stable custody arrangements. It is therefore appropriate that the Commission pay due regard to the desirable goal of stable family formation and encourage this so far as possible. It is, however, equally important that the Commission's recommendation acknowledge the reality of modern family life in Australia. There are diverse kinds of households bringing up children currently in Australia. This is partly a result of family change and reformation, partly from the growing diversity of the Australian population because of cultural, racial and religious differences, and partly because of increased tolerance within the Community.

3.14 For example, single parent families and de facto relationships are not only established features of the Australian community today but have achieved recognition and acceptance by the community and by legislatures. Social welfare support is available to single parents with children, and the New South Wales parliament has recently enacted extensive legislation regulating de facto relationships[11] pursuant to this Commission's Report *on De Facto Relationships* of 1983.[12] It is also significant that current birth statistics show that 27.5 per cent of children born in Australia to women under 25 are ex-nuptial.[13] The Commission's recommendations which are designed to reflect the importance of stable family formation also attempt to accommodate this diversity.

E. Personal Freedom and Individual Autonomy

3.15 There are and should be limits to the law's intervention in human affairs. This is a simple recognition of the extent of the cultural, social and religious differences of individuals, the need to respect personal liberty and the impossibility of the State completely controlling private human conduct. Whilst people may debate the extent to which the law should enforce morality, it is we believe generally accepted that some areas must be left to private conscience not only as a matter of principle but in order to prevent the law falling into disrepute because of the impossibility of its enforcement.

FOOTNOTES

1. R P S Jansen and J D McCaughey, "A Background Paper on In Vitro Fertilization and Embryo Transfer" in National Health and Medical Research Council, *Ethics In Medical Research* (October 1982) at 31.

2. A significant proportion (11 per cent) of women 15 years or over did not reply to this question. The figure of 64 per cent may therefore be an under-estimate: Australian Bureau of Statistics, *Cross-Classified Characteristics of Persons and Dwellings 1981* (ABS Cat No 2444.0) at 104-106 (table 63). At least 79 per cent of women aged 45 or more had children at the date of the Census.

3. Advisory Committee Report at 9 (table 2. 1).

4. *Id* at 13 (table 2.1 1).

5. Note 1 at 32.

6. *Ibid.*

7. See eg *Doornbos v Doornbos* 23 USLW 2303 (Super Ct I1 1 1954). An appeal was taken but dismissed in an appellate court (1956) 12 III App 2d 473; 139 NE 2d 844. See also the Canadian case of *Orford v Orford* (1921) 58 DLR 251; Lord Dunedin's comments that "fecundation ab extra..... is adultery" in *Russell v Russell* [1924] AC 687 at 721.

8. For a general discussion on allocation of medical resources see W Walters and P Singer (eds), *Test Tube Babies* (1982) at 134-137.

9. See eg Family Law Act 1975 (Cth) s64 and Adoption of Children Act 1965 s 1 7. For references to judicial expressions of the principle see sources cited in *Halsbury's Laws of England* (4th ed) Vol 24, paras 511, 520 and 534.

10. CommissionerEvaLearnerhaspreparedthefollowingobservationsonthissubject:

(i) Currently, the principle that the child's interests are to be protected and promoted is widely accepted. That principle is of comparatively recent origin, having been introduced in the late 19th and early 20th Centuries, displacing an earlier proposition that legitimate children were the sole responsibility of their fathers and illegitimate children the responsibility of their mothers.

(ii) Certain abuses of children were proscribed and became the subject of statutory prohibition in England under the Offences Against The Person Act 1861.

(iii) As late as the middle of the 20th Century the prevailing view was that men were incapable of rearing young children. However, experience has shown that there are circumstances in which men can satisfactorily rear young children with assistance from family, friends and the welfare system.

(iv) The interests of the child cannot be disassociated entirely from the interests of those who beget and nurture the child. In a situation where these interests conflict, protection of the child's interests must be given priority.

11. De Facto Relationships Act 1984, proclaimed 1 July 1985.

12. LRC 36, 1983.

13. Australian Bureau of Statistics, Australia's Youth Population 1984 (ABS Cat No 4111.0) at 15 (table 1.13).

4. Regulation of AI

I. PERCEPTIONS OF AI

4.1 The question whether insemination of women by artificial means is acceptable to the New South Wales community is no longer in issue. The enactment in recent years of state and Commonwealth statutes clarifying the status of AI children carries an implicit acceptance of the practice of human artificial insemination.[1] In addition, the results of public surveys conducted by the New South Wales Advisory Committee on Human Artificial Insemination provide explicit support for the same conclusion.

4.2 The first question to be answered in this Report is whether the law should regulate AI at all. If AI is seen only as a treatment for the infertility of a couple there may be little justification for specific legal regulation. Seen in this way it could be classified as a proper subject of medical practice and hence would not require specific legal regulation any more than treatments for other conditions or diseases that are proper subjects of medical practice. However, in the Commission's view AI should be seen primarily as a technological procedure for enabling a woman to become pregnant and providing her with a child.[2] Classification of AI as procedure for enabling a woman to have a child, raises the question of the welfare of the resulting child, which in turn justifies consideration of legal regulation of AI. Of course, AI may also be seen as a treatment for the infertility of a couple and a proper subject of medical practice. This was discussed in more detail in the Discussion Paper.[3]

4.3 Another more practical reason for our view that legal regulation of AI is justified, is that neither common law nor the existing statute law provides satisfactory answers to the questions raised by AI technology. As has already been discussed in Chapter 2 (paragraphs 2.1 and 2.2), unexpected and often unwanted results are likely to be caused by the application of traditional legal principles to the practice of AI. Direct legislative clarification is necessary, and has begun in Australia with the legislation referred to in paragraphs 2.6 to 2.14.

4.4 Neither AI itself nor its classification as a proper subject of medical practice calls, in the Commission's view, for legislative restrictions on eligibility of women for treatment for infertility. On the other hand, it does not follow that a woman will have an entitlement or right to receive AI as part of the treatment. The normal right of a medical practitioner and a clinic to accept or refuse a patient should apply. We deal with the eligibility of patients in Chapter 6.

II. AI AS A PRACTICE AND AI AS AN ACT

4.5 In Australia, AI as a *systematic procedure* has been developed by the medical profession.[4] AI as an act is easy to perform without medical management. However, the treatment of infertility in marriage usually requires medical knowledge and AI is now regarded as one aspect of such treatment, to be used in appropriate cases. We have reached the conclusion that AI may be accepted as a proper part of medical practice without the necessary consequence that it must always be seen as the practice of medicine.[5]

4.6 Our last-mentioned conclusion led us to distinguish AI carried out as a continuing practice from AI carried out as an act by private persons.[6] We believe that in the former case the public interest calls for legal regulation. In the latter there is, in our opinion, insufficient reason in favour of regulation and good practical reasons against it. The lack of supporting reason may be illustrated by a number of propositions that are widely advocated, namely that neither the law nor the parliament should presume to regulate the private sexual behaviour of mature, competent persons, that the principles of personal freedom and autonomy should apply so far as possible, and that if a woman chooses or a man and a woman choose, to achieve pregnancy by AI that is no concern of the State. Any woman may achieve pregnancy by heterosexual intercourse in such manner as she decides, without legal restriction, and AI is not so different as to warrant legislative interference. The practical reasons against legal control of AI

as an act are based on our view that it is unlikely to be effective. Regulation could not be policed or monitored and would be likely to be ignored, creating the risk of bringing the law into contempt. As mentioned earlier there should be limits to legal intervention in private human affairs.[7] We therefore recommend that legal regulation of AI should apply when it is practised publicly or for reward or by a person who holds himself or herself out as prepared to perform it.

4.7 We further recommend that the practice of AI be restricted to registered medical practitioners. Such a restriction would not prevent the administration of AI by recognised institutions such as family planning centres and skilled persons such as qualified nurses, provided that professional medical control or supervision is present. This recommendation has two bases, both essentially practical. The first is that the public practice of AI in New South Wales has been carried on by the medical profession, and in the last decade has developed rapidly, in the main in specialised clinics in public hospitals.[8] Our direct visits and inquiries have satisfied us that high professional standards are maintained by the clinics, that satisfactory success rates are achieved and that abnormality rates in resulting children are not higher (and may even be lower) than in children born as a result of normal sexual intercourse. Further, the surveys conducted for the Advisory Committee showed a high degree of public confidence in the public hospital system for the practice of AI.[9] We believe that there is not another group in the community with the aggregation of skills and training that presently justify permission to practise AI.

4.8 The second liasis is that a regulatory system for AI, which envisages the practice outside the medical profession, would involve considerable expenditure of public money. It would be necessary to make provision for a separate scheme of licensing, and for inspection and supervision whereas the professionals who have developed AI to date are already controlled by legislation and by professional and ethical standards of behaviour.

III. SUMMARY OF RECOMMENDATIONS

(1) Legal regulation of AI should be imposed on persons (including institutions) who practise AI publicly or for reward or who hold themselves out as prepared to perform AI.

(2) The law should restrict the practice of AI to registered medical practitioners and institutions where AI will be under the responsible supervision of the medical profession.

FOOTNOTES

1. See Artificial Conception Act 1984, Infertility (Medical Procedures) Act 1984 (Vic) and other legislation described in paras 2.6-2.13 above.

2. This opinion and statement is intended to be descriptive of the procedure and is not to be interpreted as a comment on the eligibility of a woman for treatment Eligibility is referred to in para 4.4 and dealt with in Ch 6 below.

3. Discussion Paper, paras 5.3,5.4.

4. *Id*, para 5.2.

5. *Id*, paras 5.3,5.4.

6. *Id*, paras 5.5-5.7.

7. Para 3.15 above.

8. Discussion Paper, paras 1.14, 2.4 and 2.5.

9. Advisory Committee Report at 42 (table 5.2).

5. The Semen Donor

I. RECRUITMENT

A. Semen Shortage

5.1 In the Discussion Paper we drew attention to the fact that shortage of semen is a feature of AID practice in New South Wales.[1] This traditional problem became much more serious during 1985 following official action taken to deal with the epidemic disease known as “acquired immune deficiency syndrome” or “AIDS”.

5.2 Details of the official action taken will be discussed later in this Chapter (paragraphs 5.16-5.18). In summary, new legislation in New South Wales, the Human Tissue (Amendment) Act 1985, forbids a person to donate semen for an AID program unless he has first made a prescribed declaration in writing. The declaration provides the AID program with a quantity of personal information concerning the donor. AI clinics will carry out screening and testing procedures at the time of semen donation and if the semen appears not to be “healthy” will reject it. However, even if the semen appears to be “healthy” it will be frozen and stored and will not be used immediately in a program. This is because the blood of a person exposed to the AIDS virus will not show a positive antibody response using current scientific tests until enough time has passed from exposure to the virus for antibody development. The antibody test of a recently-infected person whose semen was collected shortly after exposure to the virus could be negative.[2] Generally after the expiry of not less than three months from the time of semen donation a donor will return to a clinic for further blood testing. If this proves to be “AIDS negative”, the semen taken at least three months earlier may safely be used. These requirements and procedures are likely to reduce the quantity of semen that is available and suitable for use for AID. We understand that this has in fact happened, and that at present the shortage in New South Wales is acute.

B. Methods of Recruitment

5.3 The existence of acute shortage following years of chronic shortage of semen makes this a suitable time to review the methods of recruitment of semen donors in New South Wales. If semen donation is to be encouraged, changes in the methods of recruitment may be needed.

5.4 Our investigations in New South Wales have shown that semen donors are actively sought by AI clinics, and are usually carefully and thoroughly interviewed before acceptance. With some clinics, notably those in public hospitals, donors are normally medical students working in the Obstetrics and Gynaecology department of the hospital for one year of their studies. The main categories of semen donors according to our information are:

> medical students and hospital workers;
>
> husbands of gynaccology or obstetrics patients who have been successfully treated for other problems; and
>
> persons responding to advertisements or appeals in the press, the clinic or institution itself or to word-of-mouth request.[3]

No reliable records are available, but our information suggests that the first category provides the majority of donors. Donations by persons in those categories tend to follow direct, informal oral requests by clinic personnel. This method of recruitment appears to us to be ill-suited to cope with the more formal, lengthy arid complex procedures required directly and indirectly by the new legislation.

However, not all clinics experience acute shortage. Some appear to have been able to devise systems and procedures that continue to satisfy their demand for suitable semen.[4]

C. A New Approach to Recruitment

5.5 Speaking generally, what should be done in order to obtain suitable semen in greater quantities? One answer is that the net should be more broadly and more systematically cast and that a much wider public or segment of the public be approached. We have been advised by Dr Bridgett Mason of London, a recognised expert in AI, that in France approximately one-third of' all donors are actively recruited by the couples receiving AID treatment and their friends and relatives, that one-third are pre-vasectomy patients who are approached before sterilization, and that donors are, as a general rule, married men of proven fertility.[5] Regulation of AID through an organization known as the *Centre d'etude et de conservation du sperrrie* hurriaine (CECOS), requires that clinics use as donors only married men having at least one healthy child.[6]

5.6 It has been suggested to us that a substantial supply of' suitable semen donors is to be found among the husbands and partners of female patients under treatment for infertility. Such patients may be more likely to sympathise with the plight of women Suitable for AID and may be prepared to encourage their husbands to become donors. We are aware that one clinic has obtained many donors in this fashion over a long time. On the other hand, another clinic expressed strong reservations, stating that undesirable pressure could be placed on patients arid the impression given that treatment for infertility is conditional upon semen donation by husband or partner. It is apparent that much would depend on the timing and method of making a request. It should not be difficult to make the request in such a way as to preclude any suggestion of pressure. for example, in a pamphlet handed to the patient. Alternatively, the request could be made long after treatment began or even at or near its termination.

5.7 Another proposal that uses a wider community approach has been suggested by the Director of the AID clinic of the Royal Newcastle Hospital, Dr Max Brinsmead. This involves placing a large advertisement in a number of popular publications such as *New Parent and Parent and Children Magazine*. The advertisement could highlight the need for semen donors[7] and draw attention to the protective provisions of the new "status" legislation.[8]

5.8 We approve of any procedure that places the question squarely before the community. In our opinion such an approach carries the possibility of reflecting in due course the community's willingness or unwillingness to participate in AID both in numbers of donors and in the quantity of semen to be made available. If potential donors could be reached and could make donations with proper knowledge of the consequences (legal and otherwise) the acquisition of semen for AID could become an acceptable and recognised step in public health procedures, comparable in some respects with blood donation and the donation of other tissues, including organs.

D. The Value of Semen Donation

5.9 In view of the widespread community acceptance of AID, the Commission believes that semen donation for AID should be regarded by the law in New South Wales as acceptable and as offering real benefits to infertile couples. We believe that the donation of semen for the purpose of assisting infertile couples to have children may be considered an act of significant social value.[9] It follows that we approve of procedures designed to obtain an adequate supply of semen, which are well organised, frank and directed to potential donors who are likely to understand not only the benefit that their donation can confer, but the reasons for caution that may be exhibited on the part of the clinic and the inconvenience they may experience under current legal regulations. Unless some recognition of the social value of semen donation is extended to a semen donor we can see little tinder present conditions that will balance the inconvenience and sanctions that he must accept. We recommend that procedures and approaches to semen collection and donation referred to above should be developed and should receive official encouragement.

II. SCREENING

A. The Purpose of Screening Donors

5.10 Why should the law impose regulation on semen donors and their semen? Before answering this question it is relevant to consider the following:

> Any disease or defect that can be transmitted by artificially placed semen can be transmitted by sexual intercourse.
>
> The law does not presume to regulate sexual intercourse between mentally competent and consenting men and women.

Despite these considerations we believe that the recipient of AID and the resulting child should be protected from avoidable disease and harm that could be caused by diseased or defective semen. This justifies regulation.

5.11 Assuming the AID recipient to be entitled to protection from the possibility of receiving diseased semen or chromosomally defective sperm that might transmit a hereditary disease,[10] how much protection should be given, and to what extent should the law be involved? We believe that the AID patient who deals with a medical practitioner has a measure of "built in" protection arising from the duty of' care that the common law imposes upon the practitioner[11] as well as the statutory controls and professional standards that apply to the practice of medicine in New South Wales.[12] In addition, we believe that an AID patient and her husband should take some initiative to acquire enough information about the normal possibilities and risks of the treatment to enable them to make a careful and responsible decision. However, there still remain the procedures of screening including taking a medical history of the donor, interviews, physical examination and other steps that should be taken under the heading of "good practice".

5.12 The Commission recommends that the medical profession in New South Wales should prescribe standard guidelines or rules for the selection and screening of semen donors for AI programs. Uniformity of such guidelines and rules throughout Australia is desirable. In our view, legislation and legal regulation are not justified to prescribe those guidelines for the following reasons:

> Medical judgment would be replaced by legal rigidity. Thus, if medical practice changed or technical advances were introduced, existing criteria could become outmoded with the result that the law should be changed. However, there can be no guarantee that statutes or regulations will be amended as needed, or at all. The result could be that obsolete procedures would remain compulsory.
>
> New South Wales clinics do not all follow identical procedures or use identical criteria for donor selection. Some are more concerned than others to "match" physical and other characteristics of donor and recipient couple. Some are little concerned about a donor's social or emotional background. Others collect detailed particulars such as schooling, artistic interests, sporting activities and intelligence. A;; seem agreed on the need to record basic physical detail such as height, weight, complexion, hair and eye colour, and racial origin. Again, some recipients have strong requirements related to religion, nationality and other matters which a clinic will wish to satisfy, if possible. There appears to be general agreement that some basic matching is necessary, but opinions on the extent of matching vary widely.[13] In our view, there is no useful role for the law to play on this subject.
>
> Without exception, the AID practitioners and clinics in New South Wales with whom we have communicated follow the practice of taking a thorough personal and family medical history of donors by direct interview. The experienced practitioner is able, from the above, to acquire much of the information needed to decide on a donor's suitability. If the medical history indicates a risk of inherited defects by reason of personal or family illness or disease, the donor may be rejected at that stage. Sometimes further testing is carried out, and the decision whether to use the donor's semen postponed.

5.13 At this point we should refer to the fact that semen is capable of transmitting many diseases and defects. These include venereal or sexually transmitted diseases (STD), hepatitis, allergies, inherited disorders such as cystic fibrosis, haemophilia and Huntington's disease, and those diseases that afflict particular social groups such as thalassaemia, sickle cell anaemia and Tay-Sachs disease. It has been written that every human being carries "single..... genes for 5 or 10 different serious recessively inherited conditions".[14] That fact alone suggests that it would not be surprising if substantial numbers of defective children were born as a result of normal sexual intercourse, but this does not happen.[15] The incidence of abnormality and disease in children at birth is low[16] and our community has never regarded it as necessary for citizens to undergo health testing as a condition of marriage or procreation. In view of these matters and in the light of the practices described in paragraph 5.12, we have concluded that, subject to the discussion in the succeeding paragraphs, established medical procedures now used in New South Wales to recruit and screen semen donors offer enough protection to outweigh the benefits and detriments that could flow from statutory prescription of procedures.

B. Transmission of Disease or Defect by Semen

5.14 There are two circumstances in which established medical procedures are not, in our opinion, able to give protection to the AID recipient and her child from avoidable disease. The first is the case of the semen donor who deliberately or negligently provides false or misleading information about his health. The second is the case where a semen donor is unaware that he carries a particular disease or defect that can be transmitted through his semen, where there exists no established procedure that will disclose its existence and where there is no reason to cause an experienced medical interviewer to have reservations. In each case the question arises whether the law should provide specific regulation. In the Discussion Paper we expressed the opinion that the likelihood of a donor deliberately or negligently providing false information should not be overstated.[17] Other reason was (and is) that under New South Wales procedures, donors have no real financial incentive to give semen, no other material advantage accrues to them, and the interviewing doctor usually has a strong chance of discovering unsuitability during the personal history interview. Even so, we came to the conclusion that a basis existed for the creation of a specific statutory criminal offence for the supply of false or misleading information.[18] The reason for our conclusion was our belief that, the recipient and any resulting child should have legal protection. Since that time legislation creating such an offence and offering other protection has been enacted in New South Wales following widespread public concern about the disease called AIDS.[19]

5.15 In the second case a donor may be unaware that he carries a disease or defect capable of transmission by his semen, no test will disclose its presence, and the "interviewer's is not likely to be alerted when taking the medical history. It may be thought that such cases would be rare, and we agree that they would be. By way of example, it is possible that a person who has been orphaned or adopted could be ignorant of a personal family history that will result in Huntington's disease. There is also the possibility that the sperm of a donor with a recessive gene could unwittingly be used to inseminate a woman with a similar recessive gene, resulting in a child with a condition such as phenylketonuria or cystic fibrosis. However, the same possibility attends reproduction by sexual intercourse and we have already alluded to the favourable comparison between abnormality rates in children born following that normal activity and those born following AID. It is for this reason, in our opinion, that legal regulation has not been considered to be required to deal with such rare cases. However, the appearance of the AIDS epidemic in Australia has given this kind of case a different dimension in the public mind. Despite the low per capita incidence of AIDS, public and official concern forced the urgent enactment in 1984 and 1985 of legislation directed specifically to the reduction of public health risks from the donation of semen and blood.[20] The legislation compels every donor of semen, under pain of criminal penalties, to give careful thought to his personal behaviour and health, and that of his spouse and all sexual partners, over the preceding five years. The donor must provide a written certificate on the subject, and faces a heavy fine, or gaol or both if he knowingly signs a certificate that contains a false or misleading statement of a material kind.

C. Acquired Immune Deficiency Syndrome (AIDS)

5.16 Our understanding of AIDS disease is that the first case in Australia was positively identified in 1983.[21] Since then it has increased rapidly in incidence and at the time of writing the number of persons diagnosed as having the syndrome is over 100. The number of persons estimated to carry AIDS antibodies is substantial, and at least one study has suggested that in Sydney there could be up to 50,000 homosexual male carriers of the AIDS virus.[22] It is believed that the principal means of spreading the AIDS virus in Western countries to date has been, and remains, male homosexual "high risk" practices.[23] Transmission through sexual contact is predominantly genital.[24] Other substantial means of transmission have been blood transfusion with infected blood and blood products, and the sharing of contaminated needles by intravenous drug users.[25]

5.17 In our Discussion Paper we suggested the creation of a statutory offence for semen donors deliberately giving false information or concealing information about their health and possibly causing a diseased or defective child to be born.[26] At the same time a great deal of attention was given nationally in Australia to the spread of AIDS. Federal and State parliaments acted rapidly in response to public concern, setting up official committees, creating guidelines and enacting legislation.[27] The New South Wales parliament enacted the Human Tissue (Amendment) Act 1985 in May 1985, specifically to deal with AIDS. The Act was proclaimed to commence on 19 July 1985 and regulations for its practical application were gazetted to commence on the same day. The penalties for the knowing supply of false or misleading information are substantial.

5.18 The question arises whether there should be wider application of this new offence, so that criminal sanctions would apply to the provision of false or misleading information by a donor in relation to his health or personal particulars generally and not just to those relevant to AIDS. We believe that there should be a wider application so as to afford the kind of protection to the AID recipient and child mentioned earlier. We are of the view that a provision of the kind appearing in the Victorian legislation[28] would be desirable and would achieve our objective. We do not, however, wish to pre-empt the draftsman's discretion. Our reference to the Victorian legislation is made because it addresses the subject of semen donation for AI. We have also studied the Human Tissue Act 1983 and find the scheme of sections 21C and 21D to be both relevant and clear. **We recommend the creation of a specific statutory offence for the supply by a semen donor of false or misleading personal information when providing medical or other personal particulars.** Such a step would create uniformity of law between New South Wales and Victoria both on the general subject of the transmission of disease and defect through donated semen and on the specific subject of AIDS. Our principal concern on this subject is to ensure, if possible, that the truth about a semen donor's health is obtained at. donation rather than to place emphasis on punishment after the damage has been done. We therefore recommend that a warning which directs the donor's attention to the fact that statutory penalties are provided for the supply of false information when giving personal particulars, be placed at the head of the certificate to be signed by semen donors under section 21C of the Human Tissue Act 1983.

III. SOME RELATED QUESTIONS

5.19 There are a number of questions that have been asked in relation to semen donation to which our answer is that legislative intervention is not justifiable. We believe that the answers should be given by the particular clinic as cases arise. The questions are:

(1) Should the law require that donors of semen be proven fathers of healthy children? While this qualification for donors would be both welcome and comforting to clinics and recipients, it is an ideal that is not attainable in New South Wales under present conditions. If it was practicable, we believe that the clinics themselves would pursue it. We can see no justification for legislative intrusion.

(2) Should the law require that semen donors be married? Some clinics prefer married men as donors, just as some prefer donors to be proven fathers. However, this is not a universal requirement and is not demonstrably the only way to obtain healthy, effective semen. We can see no justification for legislative intrusion.

(3) If a donor is married, should the law require his wife to consent to his giving semen? The reasons for our negative answer to this question are given in Chapter 7 which deals with consent as a discrete matter.

IV. SUMMARY OF RECOMMENDATIONS

(1) Procedures and approaches to semen collection and donor recruitment, discussed in paragraphs 5.5 to 5.8, should be developed and should receive official encouragement.

(2) In the interests of public health and good medical practice the medical profession in New South Wales should prescribe standard guidelines or rules for the selection and screening of semen donors for AI programs. Uniformity of such guidelines and rules throughout Australia should be sought. Legislation and legal regulation are not justified to prescribe qualifications for semen donors or procedures or criteria for recruitment of donors or for screening and testing donors.

(3) A specific statutory offence for the supply by a semen donor of false or misleading personal information when providing medical or other personal particulars should be created. The section creating the offence should be included in legislation regulating AID pursuant to this Report.

(4) A statement or warning should be placed at the head of the prescribed form of' certificate under section 21C of the Human Tissue Act 1983 to the effect that statutory penalties are provided for the supply of any false or misleading personal information when giving medical or other personal particulars in relation to semen donation.

FOOTNOTES

1. Discussion Paper, para 7.1.

2. G J Stewart et at, "'Transmission of Human T-Cell Lymphotropic Virus Type III (HTLV-III) By Artificial Insemination by Donor" (1985) 2 *The Lancet* 581 at 583.

3. Discussion Paper, para 10.7.

4. Communication with Dr R Jansen in July 1985 indicated that King George V Hospital had no shortage of semen at that time.

5. B Mason, submission to Advisory Committee, February 1983.

6. Family Law Council Report, para 4.13.2.

7. Letter from Dr M Brinsmead, 18 July 1985:

Message to Fathers-We Need your Help

Not everyone can father a child. About 10% of couples have difficulty. In a substantial number this is due to sperm problems. Mostly such sperm problems are untreatable. For genetic reasons some other men should not conceive.

This means that without a sperm bank a lot of parents can't be!

At present we have several hundred couples on waiting lists for donor sperm at artificial insemination clinics.

Sperm Donors are Urgently Required

Legislation in NSW declares that the child conceived by artificial insemination is the legal child of the couple who accept this treatment. Semen banking, like blood banking, is performed anonymously. If you would like further information please contact: Sister Sue Porter, Royal Newcastle Hospital, phone 26-6403.

8. Artificial Conception Act 1984, ss5, 6.

9. Comment on this subject was made in a number of written submissions to the Commission.

10. See generally L A Alexander, "Liability in Tort for the Sexual Transmission of Disease: Genital Herpes and the Law" (1984) 70 *Cornell Law Review* 101.

11. See *Furniss v Fitchett* [1958] NZLR 396; Botam *v Friern* Hospital Management Committee [1957] 2 All ER I 1 8: *Sidaway u Bethlem Royal Hospital Governors and others* [1985] 1 All ER 643.

12. See generally Medical Practitioners Act 1938; Public Hospitals Act 1929: *Australian Medical Association, Code of Ethics* (1984 ed).

13. See eg S L Corson et at, "Donor Insemination" (1983) 12 *Obstetrics and Gynaecology Annual* 283 at 289: Ciba Foundation Symposium 17, *Law and Ethics of AID and Embryo Transfer* (1973) at 30; Victorian Report (1983), paras 3.8,3.9.

14. C Wood et al (eds), *Artificial Insemination By Donor* (1980) at 97, 98.

15. Discussion Paper, para 7.8.

16. Note 14 at 101.

17. Discussion Paper, para 7.11.

18. Discussion Paper. para 7.16.

19. The Human Tissue (Amendment) Act 1985 and Regulations came into force on 19 July 1985.

20. *Ibid*: see also Transplantation and Anatomy Amendment Act 1984 (Qld), Infectious Diseases (Donors) Regulations 1985 made pursuant to Health Act 1958 (Vic), Blood and Tissue (Transmissible Diseases) Regulations 1985 made pursuant to Health Act 1911 (WA) and Blood Donations (Acquired Immune Deficiency Syndrome) Ordinance 1985 (ACT).

21. A B Hill et at, "AIDS and Related Conditions" (1984) 141 *Medical Journal of Australia* 573.

22. Sydney AIDS Study Group, "The Sydney AIDS Project" (1984) 141 *Medical Journal of Australia* 569: "Where AIDS goes from here" *Sydney Morning Herald*, 2 August 1985 at 9.

23. Communication with Dr D A Cooper, 6 November 1985. Dr Cooper is Staff Specialist in Immunology at the Centre for Immunology, St Vincent's Hospital Sydney and Project Co-ordinator of the Sydney AIDS Study Group. He is an Honorary Consultant to this Commission.

24. *Ibid.*

25. D G Penington, "The AIDS Epidemic and Some Problems it Poses" (1985) 18 *The Australian Journal of Forensic Sciences* 13 at 17-22. The AIDS virus may be transmitted from an infected mother to her infant during pregnancy or parturition, and possibly after birth through her breast milk: J B Ziegler, "Postnatal Transmission of the AIDS-Associated Retrovirus from Mother to Infant" (1985) 1 *The Lancet* 896. In New South Wales, there has been an instance of AIDS virus being transmitted through an artificial insemination procedure. A female patient in an AID program who was inseminated in 1982 with cryopreserved semen from a symptom-free carrier of the AIDS virus subsequently developed generalised, persistent lymphadenopathy. Neither the patient nor her husband (who was

“AIDS antibody negative”) had “known” risk factors for acquisition of the virus. Of the eight women who were inseminated with this semen, four have been found to be “AIDS antibody positive”, and three of these women have remained symptom-free for three years after insemination. This is the first reported evidence of transmission from a symptom-free carrier. A low risk of female-to-mate transmission is suggested by the fact that all four husbands have remained “antibody negative” despite regular sexual intercourse without the use of condoms for Lip to three years. Three of the four women found to be “antibody positive” have subsequently become pregnant by AID and their children (now all over one year of age) do not have AIDS antibodies. These cases appear to confirm the role of semen in heterosexual transmission of the AIDS virus and to indicate that transmission can occur by semen implanted in the vagina without trauma and other bodily contact. Further, in women with the antibodies, pregnancy and subsequent breast feeding does not necessarily lead to infection of an infant. See note 2 at 581-584.

26. Discussion Paper, para 7.16.

27. See eg AIDS Task Force, *Infection Control Guidelines-AIDS and Related Conditions* (March 1985).

28. Infertility (Medical Procedures) Act 1984 (Vic) s27: for details see para 2.1 1 above.

6. Eligibility to Receive AID

I. INTRODUCTION

A. Australian Public Opinion

6.1 In our Discussion Paper we asked whether all women of child-bearing age should be regarded as eligible for, or perhaps entitled to, access to AID technology.[1] As a basis for our question we drew attention to the significant community disapproval of the availability of AID to unmarried women disclosed by the Advisory Committee surveys and the low proportion of people prepared to give positive approval to that availability.[2] The results of those surveys are as follows:

> The practice of AID as a means of conception for a married woman when she and her husband are not fertile or carry a genetic disease is approved by almost three-quarters of the community over 14 years of age.
>
> Approximately 60 per cent of the community expressly disapprove of the availability of AID to unmarried women.
>
> No more than 15 per cent positively approve of AID for unmarried women.[3]

6.2 However, it should be noted that the surveys were designed to ascertain broad attitudes[4] and were not intended to provide answers for all possible circumstances that could apply to all women. The questions and responses and some other matters related to the surveys were examined in the Discussion Paper.

6.3 Apart from public opinion, tenable arguments and propositions may be put for and against a restrictive approach to the provision of AID. Propositions for a restrictive approach include the following:

> statutory acceptance of AID (implicit in the enactment of the Artificial Conception Act 1984) does not imply that it should be available generally;
>
> modern AID in Australia has developed as a means of alleviating infertility or dealing with genetic abnormality in marriage and legislation on AID should have the same objective.

Propositions against a restrictive approach and in favour of more general availability of AID include the following:

> the claim of the individual woman to autonomy, freedom and the achievement of pregnancy by means of AID services should be balanced against such evidence of community opinion as has been produced to date and should be resolved in favour of the individual;
>
> unmarried or single women are not by law forbidden to become pregnant. Accordingly, the law should not exclude them from pregnancy by means of AID;
>
> refusal of AID to particular women or groups of women is inconsistent with the spirit or intention of modern laws that declare human rights, support the principles of equality and prohibit discrimination in the supply of services.

B. Other Official Inquiries

6.4 Treatment of this subject by other Inquiries has been uneven. The United Kingdom Report did not discuss it at all, but concluded that AID should be subject to licensing and available only to "infertile couples".[5] The Victorian Report resulted in legislation that totally excludes from IVF treatment women who are not legally married and exhibits a similar exclusionary attitude to AI, although the relevant provision on AI is ambiguous.[6] On the other hand, the Ontario Report gave detailed consideration to eligibility and acceptance for AID, opening its discussion in the following words:

> One of the most controversial issues respecting the new reproductive technologies concerns eligibility to participate in an artificial insemination or IVF programme, and, more specifically, the question of marital status.[7]

As shown below, the Ontario Report recommended wide eligibility of persons to be considered for artificial conception services, but restrictions on acceptance of applicants according to standards to be prescribed "focusing on the human factors involved, and not on the matter of status."[8]

II. ANTI-DISCRIMINATION AND THE LAW

A. Discrimination and the Duty to Treat

1. The General Question

6.5 The existence of legislation that forbids discrimination in the supply of "services" on the grounds of marital status or sex[9] makes it desirable to consider the general question whether a medical practitioner has an unfettered legal right or power to accept or refuse patients and to refuse to continue treatment once it has begun. Depending on the answer to the general question will be the need to address the specific question whether carrying out AI is a "service" that falls within the statutory prohibitions.

2. New South Wales

6.6 At common law a medical practitioner, like any other person providing a service, is free to accept or refuse any person as a patient. Further, the common law imposes no general duty upon a physician to give treatment to the sick or injured.[10] In New South Wales legislation has varied this last mentioned principle, and the Medical Practitioners Act 1938 requires a doctor to attend and treat a person when requested to do so, if there is "reasonable cause to believe that such person is in need of urgent attention".[11] However, the requirement of urgency makes it unlikely that this legislative provision would apply to patients who are to receive AI.

6.7 The Anti-Discrimination Act 1977 could give rise to arguments that denial of AID amounts to prohibited discrimination. Legislation of this kind is now widespread in Western countries.[12] Typically, it provides that, except when acting in compliance with a conflicting statute, a person behaves unlawfully by withholding "services" from another person for reasons of a discriminatory kind, for example on the ground of marital status, sex, race or handicap. In the case of AI the circumstances may determine what are properly to be described as the "services" provided.[13]

3. South Australian and Ontario Approaches

6.8 This problem has been recognised by other jurisdictions, for example South Australia and Ontario in Canada. The South Australian legislature amended its anti-discrimination legislation in February 1985 by specifically excluding AI from the reach of that legislation.[14] The Ontario Law Reform Commission in its 1985 report Human *Artificial Reproduction and Related Matters*[15] discusses the question of eligibility of women for admission to AI and IVF programs at length, in the light of the Canadian *Charter of Rights* and Freedoms and the Ontario Human *Rights Code, 1981* both of which prohibit discrimination in the supply of services. The Ontario Commission stated its final view in the following words:

> [A] majority of the Commission has come to the conclusion that, while participation in an artificial conception programme should not be a right given to every infertile or genetically diseased person or couple wishing to have a child, eligibility for participation should not be restricted to married couples or, indeed, even to Couples.[16]

The Ontario Commission appears to have been reluctant to recommend an exemption of AI and IVF from anti-discrimination legislation:

> [I]t should be borne in mind that, under section 46(2), the Legislative Assembly may legitimise other Acts or regulations violative of the [Human Rights] Code where "the Act or regulation specifically provides that it is to apply notwithstanding [the Code]. This option, however, may well be unpalatable to the Legislature.[17]

The Ontario Commission's approach stands in contrast with the actions of the South Australian legislature, although both supported the proposition that receipt of AID from an AI clinic should not be seen simply as an enforceable legal right of any person.[18] We also support that proposition.

B. Discontinuance of Treatment

1. The Medical Practitioner

6.9 It will often be the case that despite the regular administration of AI over a period of time, for example over six or 12 menstrual cycles, a female patient fails to become pregnant. In such a case the patient could justifiably be refused further treatment if the medical practitioner forms the genuine opinion, after taking into account all the circumstances, that further treatment is useless or not likely to succeed. This result proceeds from the principle that a doctor may terminate treatment when a patient has no further need of medical treatment or where further treatment is, in the doctor's reasonable opinion, pointless or not justified.[19]

2. The Hospital Clinic

6. 10 Is an institution, for example, a public hospital, under the same duty or a greater or lesser duty to patients than an independent medical practitioner? It appears that a hospital has no special legal duty or obligation to accept patients, except for the obligation imposed upon public hospitals under section 30(6) of the Public Hospitals Act 1929 which provides:

> No destitute person shall be refused relief at any hospital by reason only of his inability to pay therefor.

A further question arises about the allocation of treatment and resources by a hospital when demand exceeds supply, for example an insufficient number of kidney dialysis machines to treat patients suffering from kidney failure. Opinions have been expressed that a public hospital cannot be under a legal duty to apply treatment beyond that which is ordinarily available according to its resources, and that there is no absolute duty upon such a hospital to provide medical treatment.[20]

6.11 Scarcity of hospital resources is relevant to AI and IVF programs conducted by public hospitals which are usually confined to a limited number of patients at any given time.[21] Other limitations that are necessary are related to the age of patients, the number of "treatment cycles" per patient, and the time of a patient's ovulation.[22] Our conclusion is that a patient refused treatment or continued treatment because of insufficient resources in a hospital will in principle, have no legal claim or action on the basis of the refusal.

C. Contrary Agreements

6.12 Our comments in relation to the decision to treat or to discontinue treatment all relate to cases where there is no contrary agreement between the parties. If the agreement or contract made with the patient contains terms or conditions applicable to treatment and discontinuance of treatment, those

terms or conditions can be expected to apply. A prudent practitioner or hospital should therefore cover these matters by making a clear arrangement at the outset.

III. ACHIEVING REFORM

6.13 We have expressed the belief that the availability of AI services is not a matter for legislation alone.[23] In the preceding Chapter we referred to the continuing shortage of donated semen in New South Wales, and discussed ways to overcome it. In relation to claims upon scarce AID services a balance must be achieved between the historic fact that the practice is normally a means of treating infertility in marriage, the need to have regard to the welfare of the resulting child and the community attitudes disclosed by the Advisory Committee Report referred to in paragraphs 6.1 and 6.2. We note that the Queensland Committee recommended that AID should "normally" be given only to married women (including women in "de facto marriages") and that the subject should be dealt with by ethical guidelines rather than legislation.[24] We interpret this as indicating that in the Queensland Committee's view a restriction against unmarried women should be capable of relaxation in some cases. Much more unyielding are the United Kingdom Report and the Victorian legislation, already described in paragraph 6.4. On the other hand the approach taken in the Ontario Report commends itself to this Commission. In that report, the Ontario Commission recommended that while all people should be *prima facie* eligible for artificial conception services, actual acceptance into an artificial conception program should depend upon satisfaction of certain criteria.

6.14 We recommend the enactment of legislation to provide that a person who lawfully performs AI as part of medical practice shall not administer AID to a woman until the person has given due consideration to the following:

> whether the woman is a member of a couple who are infertile or who have (one or both) a genetic or other abnormality that is likely to affect their children;
>
> the welfare and interests of a child that might result;
>
> the home environment and stability of the household in which the child would live;
>
> whether or not counselling is desirable;
>
> the physical and mental health, and age, of the prospective parent or parents and their emotional reaction to artificial conception.

Provided that consideration is duly given to the matters listed above, we recommend that there should be no other restriction on the decision-making power. The Commission does not envisage the creation of an offence punishable by fine or imprisonment for breach of the duty imposed by the foregoing recommendation. However, the Commission recommends that the concept of "misconduct in a professional respect" which is applied by section 27(2) of the Medical Practitioners Act 1938 should be applicable to such a breach.

6.15 We have recommended criteria for the administration of AID and not for medical treatment for infertility. Acceptance for treatment for infertility is not the same thing as acceptance for treatment for AID. If the function of a clinic is to treat infertility it should have the powers, rights and duties applicable to decisions to accept patients and begin treatment. It should not be liable or compelled under complaint based on anti-discrimination law or any other law to provide as a separate service a procedure that may or may not have become advisable in the course of infertility treatment. If this were possible, a person could select particular medical skills and compel their exercise.

6.16 Our intention is that eligibility to be considered for treatment for infertility will not be restricted by any recommendation in this Report. It will be no narrower than eligibility for any other medical treatment offered by a clinic or practitioner. If treatment is begun, administration of AID will only lawfully occur if the prescribed criteria for its administration are fulfilled. Anti-discrimination principles will be applicable at that stage, but they will be subject to the criteria themselves.

6.17 It follows that a person not affected by infertility whose wish is to receive AI from a “fertility” or “infertility” clinic will have no legal right to compel the provision of AI by the clinic. On the other hand, a person affected by infertility would be entitled to be considered for treatment and would be able to call anti-discrimination laws in aid if they were applicable, for example if treatment were refused on the ground of marital status, race or handicap. Of course, if a clinic did not restrict its function to the treatment of infertility but held itself out as simply providing the service of AI, the prescribed criteria and anti-discrimination laws would be applicable to the initial decisions to provide AI to a particular person.

6.18 Our recommendations are intended to pay due regard to existing legal principles, including those of anti-discrimination. At the same time we have taken community opinion as expressed in the Advisory Committee Report into account in the form and context of the criteria prescribed in paragraph 6.14. We have also been concerned to leave untouched, as far as possible, the established general right of medical practitioners to accept or refuse any patient for treatment, to decide the nature of the programs they are prepared to offer and the diseases they are prepared to treat, and to conduct their practices as they reasonably see fit, according to their resources and ability.

IV. SUMMARY OF RECOMMENDATIONS

(1) Legislation should be enacted to provide that a person who performs AI as part of medical practice shall not administer AID to a woman until the person has given due consideration to the following matters:

> whether the woman is a member of a couple who are infertile or who have (one or both) a genetic abnormality that is likely to affect their children;
>
> the welfare and interests of a child that might result;
>
> the home environment and stability of the household in which the child would live;
>
> whether or not counselling is desirable;
>
> the physical and mental health, and age, of the prospective parent or parents and their emotional reaction to artificial conception.

(2) Breach of the duty imposed by legislation in accordance with recommendation (1) should be capable of being found to be “misconduct in a professional respect” either within section 27(2) of the Medical Practitioners Act 1938, or by a comparable provision.

FOOTNOTES

1. Discussion Paper, para 6.1.

2. Advisory Committee Report at 21 (table 3.1), 24 (table 3.6).

3. Id at 21 (table 3.1).

4, *Id* at 4.

5. United Kingdom Report, para 4.16.

6. Infertility (Medical Procedures) Act 1984 (Vic) ssl7, 18. Although the Act does not specifically require a woman to be married to receive AI, s18 does provide that AI can only be administered when both a woman and her husband have received counselling.

7. Ontario Report at 153.

8. Id at 1 58.

9. See Anti-Discrimination Act 1977 s47.

10. See G Sharpe and G Sawyer, *Doctors and the Law* (I 978) at 55.

11. s27(2)(c).

12. Canadian Charter of Rights and Freedoms, being Part I of the Constitution Act 1982 (Can); Human Rights Code. 1981 (Ont). Australian legislation includes Anti-Discrimination Act 1977, Racial Discrimination Act 1975 (Cth), Sex Discrimination Act 1984 (Cth), Sex Discrimination Act 1975 (SA), Equal Opportunity Act 1977 (Vic), Equal Opportunity (Discrimination Against Disabled Persons) Act 1982 (Vic).

13. For a definition of' "services" under the Act, see *L v Registrar of Births, Deaths and Marriages* (1985) EOC, para 92.142.

14. Sex Discrimination Act 1975 s37a (inserted by the Family Relationships Act Amendment Act 1984 s8(4) which came into effect on 14 February 1985).

15. Ontario Report at 46-51, 153-159.

16. *Id* at 157.

17. *Id* at 50.

18. *Id* at 157.

19. See generally Law Reform Commission of Canada, Euthanasia, Aiding Suicide and *Cessation* of Treatment (WP 28. 1982) at 1-14.

20. D Brahams, "A Doctor's Justification for Withdrawing Treatment" (1985) 135 *New Law* Journal 48: *R v Secretary of State for Social Services, West Midlands Regional Health Authority and Burmingham AHA (Teaching) ex parte Hincks* and *Others* (1984) 2 *The Lancet* 1224.

21. For example, in January 1986 the Royal North Shore Hospital's Department of Obstetrics and Gynaecology had 3,000 female applicants on the waiting list for their IVF program. The waiting period be(,ore the applicant commenced treatment was approximately two years. (Personal communication with Sister Craven, IVF Co-ordinator, 16 January 1985).

22. At Royal North Shore Hospital, a patient is assessed after six treatment cycles of AI. The patient is then permitted another six months of AI treatment, and if no pregnancy has resulted at the end of this time, the patient is referred to an IVF program. (Personal communication with Sister Cover, 10 April 1986).

23. Discussion Paper, para 6.4.

24. Discussion Paper, para 6.3.

7. Consents and Counselling

I. CONSENTS

A. Introduction

7.1 In the practice of AI, various consents may be sought or given-consent by a woman to receive AI or AID, consent by her husband to AID, consent by a man to donate semen and consent by his wife to the donation. The Commission believes as a matter of good professional practice, consents should be obtained from each of these parties to AI and AID. Although our opinion generally is that there is no present need for legislation to impose compulsory consent requirements, we believe that the development of standard forms of consent should be encouraged. If an Advisory Committee is created pursuant to Chapter 15, one of its functions could be the encouragement and development of such uniformity. Failing this, the medical profession should attempt to develop uniformity.

B. Consent to AID by Recipient Woman

7.2 We recommend that no legislation should be enacted to regulate consent procedures by the female recipient of AID. Consent to medical treatment is covered by common law principles[1] and there is no special characteristic of AID that requires a direct statutory statement.

C. Consent to AID by Husband of Recipient

1. Is it Necessary?

7.3 In our Discussion Paper we examined the problems of requiring a spouse's consent as a condition of a person's liberty to pursue a particular course of conduct. Considerations of personal autonomy are relevant to the issue of consent. On the other hand, experienced practitioners may believe that the absence of a husband's consent bodes ill for the AID child and suggests the possibility of an unstable or hostile household.

7.4 There appears to be an overlap or confusion in some reports between the question whether or not a husband should consent to his wife receiving AID and the related question of the effect of the husband's consent upon the status of the AID child and his relationship with the child. The United Kingdom Report and the Victorian Report (1983) dealt directly with the first question. The Victorian Report (1983) took a strict view that consents to IVF must be formally given in writing before treatment can be lawful. The consequent Victorian legislation appears to be ambiguous in relation to AID.[2] The United Kingdom Report, on the other hand, saw no need for the law to require a husband's consent or to specify its form, although it was firmly of the view that good medical practice requires the written consent of both partners before AID is performed.[3] The Queensland Report said nothing on the first question, but spoke clearly on the need for the husband's consent as a prerequisite to his legal paternity. The Ontario Report did the same, discussing the question of paternity but not the question of a husband's consent as such.[4]

7.5 Our conclusion was foreshadowed in our Discussion Paper.[5] We do not believe that the law should prescribe a general requirement for a husband's consent and we so recommend. That decision should be made in a clinical context. Good medical practice requires that both parties should give consent, preferably in writing, to AID. The consents should follow advice and counselling and the written form should be determined after careful consideration by the clinic and its advisers. In the interests of the AID child, insemination should be a joint decision by the couple and they should both appreciate the implication of their actions.

2. The Effect of the Husband's Consent on the Status of the Child

7.6 Under the Artificial Conception Act 1984 the consenting husband is the legal father of the AID child "for all purposes".[6] We drew attention in our Discussion Paper to two unusual consequences of the provisions of this Act, one relating to surrogate motherhood and the other to the artificial insemination of a widow using her deceased husband's stored sperm.[7] The issues raised by the former will be dealt with later in the course of this Reference. The latter is dealt with in Chapter 12 of this Report.

7.7 Because of the important and permanent consequences of the husband's consent, the question of its form and proof is significant. Thorough discussions of the issues raised by this question appear in the Report of the English Law Commission, Family Law-Illegitimacy [8] and the Ontario Report.[9] At the heart of the, matter is the proposition that the husband's consent should always be written, witnessed and in a prescribed form. The United Kingdom Report exposed the weakness of this proposition in the following words:

> The legal status of the AID child should not have to depend on proof of consent to treatment or on the existence of a document evidencing consent. In other words, the burden of proof should rest on the husband to show he has not consented.[10]

Both the Law Commission and the Ontario Report took the same strong view. We agree.[11]

7.8 Discussion of the paternity issue is preempted to some degree by the Artificial Conception Act 1984 which creates a rebuttable presumption that a husband (including a "de facto husband") of a woman who has received AID has consented to the procedure.[12] We do not favour execution of a written consent as a legal condition of paternity in these circumstances. The basis of decision should be an examination of the husband's overall conduct, including taking into account written documents. It would be wrong, in our view, if a person's legal status and paternity depended entirely upon the correct completion of a document. If the written consent did not comply with prescribed requirements such as witnessing, the child's status and paternity might be permanently altered. Neither the New South Wales nor the Victorian status legislation specifies any form for the husband's consent, or the evidence needed to prove it. This suggests that consent is provable according to the normal rules of evidence, from documents or conduct. We agree with this approach. The law could go even further, for example by allowing retrospective consent by a husband by subsequent ratification, or by attributing paternity to him unless he objected at the time of insemination or within a specified period after the child's birth (provided he had been made aware of the facts). However, this would require amendment of the Artificial Conception Act 1984, and we believe that amendment of that recent legislation should only occur for significant reasons, not for marginal "improvement". Accordingly, we recommend that no legislative reform be made in relation to a husband's consent insofar as paternity and the status of the AID child are concerned.

D. Consent to Semen Donation

7.9 We repeat the view expressed in our Discussion Paper[13] that no legislative statement is called for in relation to procedures or documents for consent to semen donation either by the donor or by his wife and we so recommend. However, we believe that clinics normally require donors to sign a written consent evidencing the conditions of their relationship, and some clinics also require the consent of donors' wives.[14] These are matters of medical practice, to be left to the clinic and to agreement between the parties. We note that the relationship of doctor and patient may not normally exist between a clinic and a donor (see Chapter 8 and paragraph 13.28).

II. COUNSELLING

A. The Commission's Conclusions

7.10 TheCommissionbelievesthattheavailabilityofcounsellingisanessential ingredient in the practice of AI, AID and the treatment of infertility generally. In our Discussion Paper we expressed the opinion that every party to AID could benefit from counselling and that counselling is an important prerequisite to the commencement of treatment and to joining a program.[15]

There is no subject or activity in infertility on which there is greater need to have regard to practicality and the reality of available resources than counselling. The amount and quality of counselling available from a clinic will be governed by resources of money and staff. Two initial factors will determine this availability, namely the amount of public money allocated to hospitals and training facilities, and the calibre of the particular clinic. These in turn will be influenced by public demand for the service.

7.11 It is for these reasons, and others mentioned below (paragraphs 7.12-7.14), that the Commission has concluded that counselling is a process that should not be made compulsory by legislation. Infertility is a significant social problem and its alleviation merits the attention and support of the community. This attention and support is not so much a matter for law reform or legislation as one of Organisation, enthusiasm by patients, publicity and the generation of pressure upon governments and parliaments. We recommend that no action be taken to enact legislation with a view to making counselling compulsory for any party to AID or in relation to any part of the procedure of AID, or for the training or availability of counsellors. However, we further recommend that good professional practice should encourage and, if possible, ensure the availability of skilled, fully-trained counsellors to all parties to AI and AID if needed at any stage of the procedures involved.

B. Considerations Governing Our Conclusion

7.12 A number of groups giving evidence in our Public Hearing in April 1985 emphasised the need for counselling opportunities to be available to AID recipients and other persons involved in programmes for technically assisted pregnancy. The importance of distinguishing between counselling for the resolution of infertility as such and counselling before and during participation on an AID program was also mentioned. Other official Inquiries have also strongly supported the need for counselling to be available in the treatment of infertility. The Victorian Committee took the view that counselling is essential for participants in IVF programs.[16] Their recommendations led to the enactment of provisions in the Infertility (Medical Procedures) Act 1984[17] whereby extensive counselling is now compulsory for parties to IVF and also for both spouses in AID. The Queensland Committee took the view that counselling is “a crucial part of any infertility service” and made extensive recommendations about the need to provide trained counsellors for IVF and AID.[18] It is not yet known whether Queensland legislation will make counselling compulsory.

7.13 Turning to Inquiries overseas, we note that the Ontario Report lacks discussion of counselling and contains no recommendations on the subject. On the other hand, the United Kingdom Report expresses strong views in favour of its availability:

> We . . . believe that counselling should be available for infertile couples and for donors The counselling that we envisage is. . . aimed at helping individuals to understand their situation and to make their own decisions about what steps should be taken next . . . it should involve a skilled, fully trained counsellor . . . [and] should be available to all infertile couples and third parties at any stage of the treatment.[19]

The United Kingdom report did not recommend that counselling be compelled by statute, although it did recommend that it should be available “both as an integral part of the National Health Service provision and in the private sector.”[20]

7.14 We have been informed by patient and “consumer” groups involved with the operation of the Victorian legislation, that some patients object to the legal compulsion of the Victorian legislation.[21] They believe it to be unduly paternalistic and a derogation of their autonomy and personal liberty. In addition, we believe that shortages of highly qualified counsellors have led to delays and other objections by patients. The inflexibility of statutory compulsion could, in our view, result in substantial and undesirable difficulties if skilled counsellors were not readily available.

III. SUMMARY OF RECOMMENDATIONS

Consents

(1) As a matter of good professional practice, consents should be obtained from each of the parties to AI or AID. The development of standard forms of consent is desirable.

(2) There is no present need in New South Wales for legislation to impose compulsory requirements for consent to be given:

by a woman to receive AID;

by the husband (or partner) of a woman before she may receive AID;

by a semen donor before donation; or

by the wife of a semen donor to his donation.

(3) There is no present need for further lawmaking or law reform in relation to a husband's consent insofar as his paternity of his wife's AID child is concerned and insofar as the status of that child is concerned. However, in the event that consideration is given in the future to review or amendment of that legislation and the provisions in question, the Commission directs attention to its views expressed in paragraph 7.8.

Counselling

(4) No action should be taken at this stage to enact legislation with a view to making counselling compulsory for any party to AID or in relation to any part of the procedure of AID, or for the training or availability of counsellors.

(5) Good professional practice should encourage and, if possible, ensure the availability of skilled, fully-trained counsellors to all parties to AI and AID if needed at any stage of the procedures involved.

FOOTNOTES

1. For general discussion see P D G Skegg, *Law Ethics and Medicine* (1984), chs 2-4.

2. Infertility (Medical Procedures) Act 1984 sl8. See also Discussion Paper, para 17.5.

3. United Kingdom Report, paras 4.23,4.24.

4. Ontario Report at 1 76-1 78.

5. Discussion Paper, para 17.7.

6. s5(2).

7. Discussion Paper, para 17.9.

8. The Law Commission, Family Law - Illegitimacy (Law Corn No 118. London 1982), paras 12.13-12.1 7.

9. Ontario Report at 176-1 78.

10. United Kingdom Report, para 4.24.

11. Discussion Paper, paras 17.11,17.12.

12. s5(4).

13. Discussion Paper, para 17.14.

14. *Id*, paras 17.14, 17.15.

15. *Id*, para 17.20.

16. *Id*, para 17.18.

17. s18.

18. Discussion Paper, para 17.19.

19. United Kingdom Report, paras 3.3,3.4.

20. *Id*, para 3.4.

21. Confirmed by telephone communication with Dr Barbara Burton, 18 October 1985 and Mr Ken Campbell, 22 October 1985. Dr Burton is Co-ordinator of Combined New South Wales In Vitro Fertilization Support Groups and President of IVF Friends, Sydney. Mr Campbell is President of IVF Friends, Melbourne.

8. Anonymity, Secrecy and Confidentiality of Information

I. ANONYMITY

A. Background

8.1 Our recommendations in this Chapter support the reasonable expectations of parties to AI and AID to anonymity and the maintenance of confidentiality concerning information acquired in confidence. Legislation should, in our view, be enacted for these purposes because existing law appears to be capable of producing different consequences for the respective relationships and parties involved. In Chapter 14 we examine the relationships between doctor and recipient couple, doctor and semen donor, and doctor and AID child.

8.2 The United Kingdom Report and the Ontario Report supported the maintenance of anonymity in the strongest terms. We quote from these reports in paragraphs 13.13 and 13.14 below. Our own opinion is that it is desirable as a general rule to preserve anonymity between donor and recipient. To be more specific, we believe that anonymity between semen donor and recipient as well as between semen donor and AID child should be ensured, except as otherwise provided by Chapter 13. However, it is plain that some exceptions to a rule requiring anonymity are necessary. These exceptions, foreshadowed by the Human Tissue Act 1983, are:

> where the person to whom the information relates gives consent;
>
> where a judge or a magistrate makes an order, but subject to the conditions, if any, in the order;
>
> where the disclosure of information is necessary for the administration or execution of legislation pursuant to this Report;
>
> when the information is to be used for hospital or clinic administration or medical research.[1]

We recommend that legislation be enacted whereby certain persons are forbidden to disclose to any person, information whereby the identity of a party to AID may become publicly known. The persons to be forbidden or placed under the duty or obligation are AI and AID practitioners, clinics, hospitals in which AI and AID are practised, staff and keepers of relevant records. The majority of the Commissioners believe that the legislation should be framed so as to provide for all the exceptions set out above. However, Justice Peter Nygh takes the view that the anonymity of the donor should be more stringently protected. In his view, disclosure of identifying information should only be allowed:

> (a) with the consent of the person to whom the information relates; or
>
> (b) where a judge makes an order, but subject to the conditions, if any, in the order.

B. The “Known Donor”

8.3 In some cases of AID, the semen recipient requests that the insemination be performed with the semen of a particular person. Certain social groups find the use of semen from unknown donors unacceptable, and occasionally donation is privately arranged. Both the Victorian Committee and the United Kingdom Report considered the question,[2] the Victorian Committee’s views resulting in a specific statutory provision enabling the use of “known donors”.[3] While the United Kingdom Report recognised that “known donors” are used, it made no recommendation for legal control, preferring to leave the entire question of anonymity to “good practice”[4] and stating that “such..... arrangements, however, fall outside any general regulation.[5] The Ontario Report contains no discussion of the issues raised by the “known donor”.

8.4 We believe that in some circumstances the semen of a “known donor” may be justifiably used in AID.[6] No specific exception to the legislation requiring anonymity (recommended in paragraph 8.2) would be necessary in such a case, since each party has implicitly consented to his or her identity being disclosed to the other parties. Further, in our opinion, outside the immediate circle of participants in AID with “known donor” sperm, the general legislative prohibition on disclosure of identifying information should be preserved.

II. SECRECY

8.5 The United Kingdom Report strongly supported the maintenance of anonymity in relation to the parties to AID.[7] However, that Report drew a distinction between anonymity and the tendency, which it identified, for AID “to be surrounded with secrecy.”[8] It went on to say:

> This secrecy amounts to more than a desire for confidentiality and privacy, for the couple may deceive their family and friends, and often the child as well.[9]

We find this a useful observation because it shows that entitlement to confidentiality and anonymity may be misused. Our view is that this possibility of misuse or deceit (toes not amount, of itself, to a justification for regulatory legislation. It points more to the need for education and good counselling. In the words of the United Kingdom Report: [W]hile we agree that it is wrong to deceive children about their origins, we regard this as an argument against current attitudes, not against AID in itself.[10] Although anonymity is a form of secrecy, namely the reservation of information about a person’s name, we believe that it is both justifiable and desirable in AID.

III. CONFIDENTIALITY

8.6 In our Discussion Paper we discussed the recognition by the common law that certain relationships are seen to impose a duty upon the parties, or one or more of them, to keep confidential, information that is acquired in confidence during those relationships.[11] We expressed the opinion that there is reason to conclude that such a duty is owed by medical practitioners to patients but not necessarily to all semen donors. On the other hand, we can see no reason why such a duty should not relate to semen donors,[12] and to AID children. We take the view that the law should specifically extend support to the maintenance of the confidentiality of personal information that is supplied in the practice of AI and AID by recipient couples and semen donors to the medical profession. Anonymity is a separate but related matter.

8.7 The reposing of confidence in a person, and the corresponding duty of confidentiality, are seen by the Commission as an important social and moral transaction. It is clear that a medical practitioner owes a duty of confidentiality to his or her patients. This is an ethical obligation[13] as well as a legal one. The precise definition of the legal obligation of confidence has been stated as a duty not to disclose voluntarily, without the consent of the patient, information which the doctor has gained in his or her professional capacity.[14] The obligation is enforceable by an injunction and by an action for damages. As is the case with all obligations of confidence, the doctor’s duty is not absolute but subject to the requirement of disclosure under compulsion of law[15] and a limited right to make disclosure in the public interest.[16] The precise circumstances when it will be in the public interest for otherwise confidential information to be divulged cannot be defined in advance. One example relevant to doctors, which is cited in the leading authority on the topic, is where a doctor treats a murderer who is still manic and who would be a menace to society.[17] The obligation of course may be released with the express or implied consent of the patient.

8.8 We do not recommend any statutory underpinning or modification of these well-recognised principles. They are, we believe, clear and flexible enough to accommodate any issues likely to arise concerning the confidentiality of information passing between a medical practitioner and the couple or woman whom he or she is treating for infertility. In particular these principles would operate to secure those parties from having their identity revealed by the medical practitioner to the donor or any other third party.

8.9 However the child born of a successful artificial insemination will, as such, not be a patient of the doctor. Furthermore it is far from clear whether the donor in the normal AID situation is a patient of the doctor or hospital whose clinic makes the arrangement to receive the semen intended for use in an AI program.[18] Is there need to provide for the confidentiality of records containing information about these parties?

8.10 The juristic basis of a doctor's legal obligation of confidence towards his or her patients is an implied condition in the contract of services entered into by the treating doctor. There may or may not be a contractual relationship between the doctor or clinic on the one hand and the donor in AID on the other. The concept of gift implicit in the term "donor" is not itself inconsistent with a contractual relationship existing since the "gift" is directed towards the recipient woman or couple. The common arrangement whereby a donor is paid his expenses in consideration of attending and providing semen suggests that there would be a contract. However this would not invariably be the case with donors, and as we have already noted, it would never be the case with a child whose only relationship with a doctor is that he or she was born to a woman who was the doctor's patient.

8.11 An obligation of confidentiality can however arise between parties who are not in any contractual relationship. Thus, information imparted in confidence by one member of a family to another can give rise to an equitable obligation not to break that confidence. Similarly, where a person imparts secret information about an invention to a would-be investor and negotiations to form a contract do not come to fruition the recipient of the information is not free to disregard the implied obligation of confidence arising out of the circumstances in which the information was provided. These principles which are not dependent on a contractual relationship also operate to place legal obligations of confidence on the staff of the medical practitioner who might have access to confidential records. Like a contractual obligation of confidence, this equitable obligation may be overridden by compulsion of law or in the public interest.

8.12 Thus, whether arising as an implied term of a contract or as an obligation enforceable in equity, an obligation of confidentiality will arise if information which by its nature is confidential is imparted in circumstances where it was clearly understood and intended by the parties that such information would not be divulged to a third party without the consent of the party who first provided it.

8.13 The difference between the position of the patient on the one hand and the donor or child on the other is that in the former case the legal obligation of confidentiality is clearly and automatically recognised, whereas in the latter its basis is dependent upon a close examination of a particular factual context. To the extent that the law confers anonymity and confidentiality upon donors and children who are born by an AI procedure it would, in our view, be desirable that their position should be equated with that of a patient. We recommend that legislation be enacted so as to impose upon AI and AID practitioners, clinics, hospitals in which AI and AID are practised, staff and keepers of the relevant records, the same duty and obligation to maintain confidentiality in relation to information obtained by them or any of them about any person who is a party to AI or AID (including a recipient woman, her husband or male partner, a semen donor and each resulting AID child) as medical practitioners have in relation to information obtained by them about their patients.

IV. SUMMARY OF RECOMMENDATIONS

(1) Legislation should be enacted whereby certain persons are forbidden to disclose or give, or otherwise placed under a duty or obligation to refrain from disclosing or giving, to any other person any information or document whereby the identity of a person who is a party to AI or AID (including a recipient woman, her husband or male partner, the semen donor and each AI or AID child) may become publicly known. The persons to be forbidden or placed under the duty or obligation are AI and AID practitioners, clinics, hospitals in which AI and AID are practised, staff and keepers of relevant records.

(2) The legislation should be framed so as to provide for the exceptions set out in paragraph 8.2 above.

(3) Legislation should be enacted so as to impose upon AI and AID practitioners, clinics, hospitals in which AI and AID are practised, staff and keepers of the relevant records, the same duty and obligation

to maintain confidentiality in relation to information obtained by them or any of them about any person who is a party to AI or AID (including a recipient woman, her husband or male partner, a semen donor and each AI or AID child) as medical practitioners have in relation to information obtained by them about their patients.

FOOTNOTES

1. Human Tissue Act 1983 s37(3). See also Australian Law Reform Commission, Human Tissue Transplants (ALRC 7, 1977), paras 216, 217.

2. Victorian Report (1983), paras 3.19-3.22; United Kingdom Report, para 4.22.

3. Infertility (Medical Procedures) Act 1984 (Vic) s16.

4. United Kingdom Report, para 3.2.

5. *Id*, para 4.22.

6. Discussion Paper, para 21.6.

7. United Kingdom Report, paras 3.2, 4.22.

8. *Id*, para 4.12.

9. *Ibid.*

10. *Ibid.*

11. Discussion Paper, ch 21.

12. See para 14.10 below.

13. Australian Medical Association, Code *of Ethics* (I 984 ed), para 6.11.

14. *Hunter v* Mann [1974] 1 QB 767 at 772.

15. For example, the doctor will be required to produce relevant medical records to the court in answer to a subpoena. Statute may also override the obligation as is the case with legislation requiring the doctor to report a shotgun wound or child abuse.

16. See F Gurry, *Breach of Confidence* (1984) at 148, 149.

17. *Hunter v Mann* [1974] 1 QB 767 at 772.

18. See also Ontario Report at 83, 185.

9. Semen - Testing, Storing, Limits On Use

I. TESTING AND STORING SEMEN

A. Fresh and Frozen Semen

9.1 Semen used for AI may be “fresh” or “frozen”. Our direct inquiries in 1984 indicated that six of the eight substantial clinics and practitioners in New South Wales used frozen semen for their AID programs while two used fresh. Fresh semen refers to semen produced by a donor and used within a few hours. Frozen semen refers to semen that has been frozen after donation and thawed prior to use.[1]

9.2 The respective usage of fresh and frozen semen varies from place to place. In Victoria, all AID clinics use frozen semen.[2] On the other hand a 1978 report of the Royal College of Obstetricians and Gynaecologists, London indicated a substantial usage of fresh semen in the United Kingdom.[3] The report described insemination procedures in 22 AI clinics throughout England, Scotland and Northern Ireland stating that six clinics used fresh semen only, five used frozen only and 11 used both types.

9.3 There are advantages and disadvantages in the use of each type of semen. The principal advantage of fresh semen is that it has a good (perhaps better) fertilization capacity. The use of frozen sperm requires more technology, more technicians and more care with security and records but it also gives more time to match physical characteristics between donor and recipient’s husband and a higher prospect of ensuring the donor’s anonymity. Further, “there is no evidence that freezing introduces a risk of abnormal progeny”.[4]

9.4 Although more AI clinics in Australia prefer to use frozen semen than fresh semen for AID, AI using fresh semen is the original method and it is still used. However, the time needed to complete semen-testing procedures introduced in 1985 in response to the appearance of AIDS in Australia is likely to lead to diminution, if not the elimination of fresh semen in AID programs.

B. Semen Testing

9.5 In semen the primary characteristic sought for the purpose of fertilization is a high sperm count, namely a high number of healthy, active sperm cells. The standard sought by most clinics is described by Mr Ian Johnston, one of Australia’s most prominent medical experts in human fertility,[5] as “at least” 80 million sperm per millilitre of semen.[6]

9.6 In New South Wales all clinics conduct a routine analysis of donated semen in order to ascertain sperm count and “motility”, or the capacity of the sperm to move actively. Semen analysis will also produce information about abnormalities in the sperm cells and the general suitability of the sperm cells to achieve fertilization. Clinics that use frozen sperm normally perform additional tests including semen tests for STD (sexually transmissible disease), AIDS and blood tests to determine blood group, Rh status and the presence of hepatitis B. Tests and semen analyses are also normally carried out at regular intervals on stored semen.[7]

C. Semen Storage

9.7 AID clinics which use frozen semen must have the facilities and equipment for freezing and storing it.[8] The expression “cryopreservation” is often used to describe this activity. The duration of storage will be a policy matter for the particular clinic concerned. Some experts prefer to envisage a time limit.[9] In practice the question of storage duration does not present a problem in New South Wales because of the general shortage of semen for AID and the fact that it tends to be used rapidly.

D. AIH

9.8 In New South Wales, artificial insemination of a woman with her husband's sperm does not normally involve storage. Tests will be conducted in order to acquire as much information as possible about the husband's fertility. Insemination of the wife will normally be performed with the husband's fresh sperm because of its greater fertilizing capacity and his ready availability. To summarise, the purpose of testing in AIH is different from AID because the circumstances are different, and the need for storage will not normally arise.

E. Storage of Sperm under an Agreement or Arrangement

9.9 There could be a number of reasons, both medical and personal, that might impel a man to arrange for his sperm to be stored. For example, he may be about to undergo chemotherapy, radiation or some other medical treatment that could reduce his fertility. We are not aware of any widespread practice in Australia whereby sperm is stored to await the future instructions of a man or a couple, but we believe that it has happened on occasions in New South Wales when a clinic has agreed that good medical reason exists for storage. We do not consider that legislation should be enacted to regulate such storage.

F. Legal Regulation of Testing and Storage of Semen

9.10 The standards of practice observed by the medical profession in New South Wales in AI are of a high order. We believe that these extend to semen analysis and testing, and that public confidence in the medical and scientific standards employed is therefore justiced. Obviously, not every practitioner and clinic will always observe the highest standards and it is clear that mistakes will be made. The question however remains whether direct legal regulation of- standards of practice will give better results and whether the law should involve itself in this part of AI. Our inquiries at the time of our Discussion Paper had produced no complaints on the subject nor any evidence of harm or prejudice to recipients or children arising from the quality of donated sperm. Since that time we have become aware of some cases where disease has been transmitted by AID, but there was no suggestion that carelessness or inadequate standards of practice were the cause.[10] Further, none of the submissions received by the Commission has suggested inadequate standards or the need for legislative control. Of the seven written Submissions to the Commission that dealt with semen testing, only two stated that testing is desirable (one of them suggesting the introduction of guidelines for testing), one advocated that the continuation of storage ot' semen should be reviewed after five years, three took the view that stored semen should be destroyed on the death of the donor and one made general comment without specific recommendations.

G. Conclusions

9.11 In view of the information and reasons set out above and the response of the New South Wales Department of Health and the medical profession to the problems presented by AIDS we have concluded that semen testing and storage is best left to the medical and scientific professions and we recommend that no legislative regulation be introduced. The civil law of negligence and contract is applicable and imposes duties upon practitioners and donors, thus affording protection in appropriate cases. In addition there is the question of professional guidelines. We recommend that the medical profession should prepare guidelines for testing and storing semen for use in AI. Precedents exist in England and the United States for rules of this kind[11] and we are of the opinion that the early promulgation of Australian guidelines would engender public confidence. Bodies such as the Royal Australian Colleges of Medicine and the Australian Fertility Society have this capacity.

II. LIMITS ON USE OF SEMEN FROM ONE DONOR

A. "Accidental Incest"

9.12 We have already described Australian and overseas literature and public discussion on the possibility that two AID children conceived from the sperm of one donor might, without knowledge of

their relationship, marry and have children.[12] They would be hall brother and half sister. Some expressions comniony used to describe the possibility are “consanguineous marriage”, “innocent consanguineous marriage”, “accidental Incest”, “half-sib mating” and “inadvertent inbreeding”.

9.13 Our inquiries into AID practice in New South Wales showed that clinics, almost without exception, controlled very carefully the number of inseminations performed with the semen of one donor. The limits of usage are usually expressed not so much by restricting the absolute number of inseminations as by monitoring the number of pregnancies or live births resulting from one donor. Control is maintained by imposing a temporary limit upon the number of women inseminated with a donor’s sperm, and then suspending usage of his sperm pending results. If pregnancies do not result, further usage may be recommended. if pregnancies do result, usage may remain suspended until the outcome of the pregnancies is known.[13]

B. Conclusions

9.14 The likelihood of innocent consanguineous mating in New South Wales between AID children is mathematically low.[14] As Professor David Danks, a leading Australian geneticist, has noted this likelihood is affected by the size of the “breeding pool” in a particular population. In his words:

> It is clearly important to look at [the] problem realistically when dealing with different ethnic groups and to have a flexible policy rather than just one fixed policy for all groups in the population. It would be undesirable to allow more than one AID offspring per donor in a very small ethnic group: however, considerable numbers might be allowed in the Anglo-Saxon Australian population. The more socially and geographically mobile the donor and recipients the less the risk.[15]

9.15 Our view is that legal intervention is unnecessary and is unlikely to achieve a better result than has already been achieved by the medical profession acting within its own ethical and practical standards. We recommend that no action be taken to enact legislation limiting the quantity of semen from one donor used in AI. No case of consanguineous marriage of the type under discussion has been reported to us, nor have we seen reference to such a case in tile literature on AID. Once more, however, we believe that this is all area where guidelines Would be desirable. We recommend that the medical profession should produce guidelines that provide clear pointers to the considerations that should govern decisions on the recurrent use of a donor’s semen, and provide general directions requiring AID practitioners to have regard to the possibility of innocent consanguineous mating before inseminating a patient.

III. THE USE OF MIXED SEMEN IN AID

A. Semen Mixing

9.16 In the Discussion Paper we described the extensive references by writers, medical experts, scientists and law makers to the possibility that semen from two or more donors will be mixed together and used in one act of insemination.[16] The Victorian Committee was sufficiently concerned about this possibility to make a recommendation which has since been translated into law by the Victorian parliament. Section 26 of the Infertility (Medical Procedures) Act 1984 of Victoria provides:

> A person shall not carry out a procedure of artificial insemination of a woman..... where the semen used..... was produced by more than one man.

Penalty: 50 penalty units or imprisonment for two years.

9.17 The Commission had difficulty in reconciling the extensive discussion and concern about semen mixing with the fact that its own research and inquiries suggested that it was a rare practice. We have been unable to find any evidence that semen mixing is either practised or approved by AI clinics or medical practitioners specialising in AI in New South Wales.

9.18 Semen mixing has taken two forms in the past. In the first instance, the semen of two or more donors is mixed together and then used for insemination. The object of this practice was to contuse paternity and to obviate the possibility of any particular donor being held to be the legal father with the consequent duties and rights of paternity. This no longer has any point in New South Wales since the Artificial Conception Act 1984 has clarified the paternity question in favour of a consenting husband and has relieved the donor of legal paternity.[17] The second circumstance of semen mixing occurred when the donor's semen was mixed with that of the husband prior to insemination. The purpose of this practice was to engender some doubt about paternity and foster a belief by the husband that he may, after all, be the genetic father. Our inquiries indicate that current practice in New South Wales rejects this form of semen mixing on the grounds that it is fosters the husband's self-deceit and that a husband who requests it may not have accepted or come to terms with his own infertility and therefore may not be able to exhibit a balanced parental attitude to the AID child.[18]

B. AID Using Fresh Semen

9.19 In considering lawmaking on the subject of semen mixing it is desirable also to examine the practice of AID using fresh semen. While this practice does not ordinarily involve the mixing together of semen from different donors or from a donor with that of a husband, it typically does involve insemination with the semen of a single but different donor at daily or two-day intervals on a number of occasions during the recipient's menstrual cycle. This has the same effect as semen mixing in that it results in confusion over paternity. The Victorian legislation referred to in paragraph 9.16 may make AID with fresh semen, in the manner just described, a criminal offence. The Act makes no direct reference to mixing but rather proscribes the use of semen "produced by more than one man" in a procedure of artificial insemination". If "a procedure of artificial insemination" is interpreted ,is referring to a single treatment cycle of AI, then an offence will be committed since a single treatment cycle will involve multiple inseminations using fresh semen of single but different donors. Hence, the semen used in "a procedure" will have been "produced by more than one man". It is therefore arguable that in New South Wales, a statutory provision in the same terms as the Victorian Act would have the effect of converting into a criminal offence punishable by imprisonment, not only semen mixing, but AID practice with fresh semen.

C. Considerations for Lawmaking on the Subject

9.20 In view of the matters outlined above, the introduction in New South Wales of a statutory prohibition of semen mixing requires justification both in principle and on the basis of community need or protection. This is particularly so if the prohibition is to be sustained by criminal penalties. The principle that underlies the Victorian statutory prohibition is described in the Victorian Committee's report ot 1982 in the following words:

> Because of the great importance the Committee accords to the interests of the child and its parents in honesty and integrity in the family, the Committee recommends that it shall be unlawful to use donor gametes in IVF in such a way as to confuse those concerned about the genetic background of any child born. This means that procedures such as the mixing of donor sperm..... should be prohibited.[19]

It thus appears that the Victorian Committee based its recommendations on the proposition that accurate information about a child's genetic background should be available. We draw attention to tile fact that the recommendations related to in vitro fertilization, although the subsequent legislation included AI. The Victorian Committee's report did not specifically consider the practice of AID, particularly using fresh semen, no doubt because this was not included in its terms of reference.

9.21 If the purpose of legislative intervention is to assist the AID child by ensuring that accurate information about paternity is ascertainable, the question arises whether this can be achieved realistically by the prohibition of semen mixing. We are not persuaded that this aim can be achieved for a number of reasons. A woman inseminated by AID may have sexual intercourse with her husband or another man before or shortly after the insemination. The pregnancy resulting from such intercourse could achieve the very confusion that a legal prohibition of semen mixing would seek to remove. It is

unrealistic to expect that sexual intercourse of this kind would or could be effectively prohibited by law. For a legislative prohibition to have a real prospect of success it should have the capacity to prohibit and police semen mixing, successive use of semen of different single donors, and sexual intercourse by the recipient for a particular period. This would clearly be impossible to police and difficult to prove. On the face of it, modern blood testing techniques offer a solution to the problem. However, although blood tests have a high capacity to prove paternity, particularly when the number of candidates is small, they could need the assistance of legal compulsion in the context of AID. We believe that compulsory blood testing is not feasible as execution of such a requirement would involve force and bodily invasion.

9.22 We have formed the opinion that the notion of certainty of paternity in relation to AID children, and even in the community at large, is based on assumptions that may not always be justified.[20] In some cases, for example married persons, the law assists the determination of paternity by making presumptions [21] but these are no more than presumptions and do not alter the genetic truth. It could therefore be argued that the desire for certainty of paternity and the desire to help AID children should not be permitted to found criminal laws unless the hypotheses on which they rest can be proved to be true.

9.23 We list briefly a number of conclusions and factors that have influenced our consideration of lawmaking on this subject:

> The deliberate use of donated gametes to cause confusion about a child's paternity is an unacceptable practice.
>
> The reality of AID practice in New South Wales lends little, if any, support to the argument that a statutory prohibition of semen mixing supported by criminal law sanctions is necessary.
>
> We are not persuaded that an effective prohibition of AID using fresh sperm is justifiable on the basis that the prohibition will ensure certainty in attributing paternity.
>
> We have seen no evidence of practice or approval of semen mixing in New South Wales and no evidence of semen mixing in Australia in any of the reports of official Inquiries.
>
> Certainty about parentage cannot be ensured to all AID children because of the nature of AID practice and for other reasons. Certainty about biological parentage cannot be ensured to non-AID children, although the law assists in the case of married persons by making legal presumptions of paternity.
>
> Among overseas reports neither the United Kingdom Report nor the Ontario Report made recommendations on the subject. The United Kingdom Report did not discuss semen mixing, although it discussed and made a recommendation on the frequency of use of the semen of a single donor. The Ontario Report stated that semen mixing, "is rarely used" in Ontario,[22] but did not pursue the matter in its law reform discussion.

9.24 Our conclusion is that no persuasive case has been made for legislative intervention in New South Wales, whether or not supported by criminal law sanctions aimed to proscribe semen mixing or successive use of semen from different single donors in AID or both. However, we do not approve of semen mixing or any action aimed to cause confusion about a child's parentage. We regard both as falling outside the bounds of good medical practice. We see this unintended confusion of paternity as a disadvantage to the practice of AID with fresh semen. The question is whether the disapproval of a practice justifies the introduction of legislation and the use of parliamentary time and government resources to create a statutory offence. We have decided that they would be neither justified nor certain of successful enforcement. We recommend that no action be taken to enact legislation regarding the use of mixed semen from two or more semen donors or the use during one menstrual cycle of a woman of multiple or successive single donations of semen produced by one man. However, the use of mixed semen and any action in AID by a medical practitioner or by medical personnel aimed

to cause confusion about a child's parentage, should be regarded as falling outside the bounds of good medical practice.

IV. SUMMARY OF RECOMMENDATIONS

Testing and Storing Semen

(1) legislative regulation is not called for in relation to testing and storing semen for use in AI.

(2) The medical profession should prepare guidelines for testing and storing sei-nen for use in AI. Bodies such as the Royal Australian Colleges of Medicine and the Australian Fertility Society have the capacity for this.

Limits to Quantity of Semen from One Donor

(3) Legislative regulation is not called for in relation to limiting the quantity of semen from one donor to be used in AI.

(4) The medical profession should prepare guidelines for limiting the quantity of semen from one donor to be used in AI, see (2) above.

(5) AID practitioners should have regard to the risk of innocent consanguineous mating between half siblings born as a result of AID and should accordingly limit the usage of the semen of a semen donor.

The Use of Mixed Semen in AID

(6) Legislative regulation is not called for in relation to the use of mixed semen from two or more semen donors or the use during one menstrual cycle of a woman of multiple or successive single donations of semen produced by one man.

(7) The use of mixed semen as described in (6) above and any action in AID by a medical practitioner or by medical personnel aimed to cause confusion about a child's parentage, should be regarded as falling outside the bounds of good medical practice.

FOOTNOTES

1. See Discussion Paper, ch 8.

2. Information supplied by Professor Louis Waller, Chairman Victorian Law Reform Commission, at New South Wales Law Reform Commission Artificial Conception Division Meeting (30 July 1985).

3. Royal College of Obstetricians and Gynaecologists, *Confidential Enquiry into Extent to which Artificial Insemination by a Donor (AID) is practised in the United Kingdom (up to the end of 1977)* (1978) at 4.11.

4. S L Corson et at, "Donor Insemination" (1983) 12 *Obstetrics and Gynaecology Annual* 283 at 292.

5. Chairman Royal Women's Hospital Reproductive Biology Unit (Victoria).

6. C Wood et at (eds), Artificial Insemination by Donor (1980) at 15. In the United States practitioners have employed standards of analysis called "the rule of 60s" described as follows: The rule of 60s has served well as a general index to seminal quality; at least 60 million per ml of semen, 60 percent good motility, and 60 percent with normal morphology.(See note 4 at 289).

7. C Wood et at (eds), note 6 at 14-16.

8. *Id* at 19-32.

9. United Kingdom Report, para 10.8.

10. G J Stewart et at, ",Transmission of Human T-Cell Lymphotropic Virus Type III (HTLV-III) By Artificial Insemination by Donor" (1985) 2 The Lancet 581 at 583; "AIDS: woman infected by artificial insemination", Sydney Morning Herald, 25 July 1985 at 1. A confidential communication to the Commissioner-in-charge of the Artificial Conception Reference has indicated that one AID child has been born in New South Wales with cystic fibrosis.

11. See Royal College of Obstetricians and Gynaecologists, *Recommendations for Centres Planning to set-up and AID Service* (London, June 1983) and Artificial Insemination (London, March 1979). See also American Fertility Society, *Report of the Ad Hoc Committee on Artificial Insemination* (Alabama, November 1980).

12. Discussion Paper, ch 10.

13. *Id*, paras 10.6-10.8.

14. *Id,* paras 10.9.

15. C Wood *et al* (eds), note 6 at 102.

16. *Id,* ch 11.

17. See paras 2.7, 2.8 above.

18. Discussion Paper, para 11.6.

19. Victorian Report (1983). para 3.37.

20. Discussion Paper, paras 11.11, 11.12; M Curie-Cohen *et al,* "Current Practice of Artificial Insemination by Donor in the United States" (1979) 300 *New England Journal of Medicine* 585 at 589; Ciba Foundation Symposium 17, *Law and Ethics of AID and Embryo Transfer* (1973) at 63, 66.

21. See eg Children (Equity of Status) Act 1976 ss10, 18.

22. Ontario Report at 17.

10. Semen - Commerce and Ownership

I. COMMERCE IN SEMEN

A. Commerce in Human Tissue and the Law

10.1 Part VI of the Human Tissue Act 1983, headed “Prohibition of Trading in Tissues”, applies a general prohibition of sale or supply of human tissue “for valuable consideration” whether the tissue comes from the supplier’s body or not and whether the person from whom it is derived is dead or not. Criminal sanctions are provided by section 32 (a maximum penalty of $4,000 and imprisonment for six months) and contracts or arrangements made in contravention of the section are void.[1] The Human Tissue Act 1983 is the New South Wales adoption of the model legislation on human tissue transplantation presented in 1977 by the Australian Law Reform Commission in its report Human Tissue Transplants.[2] The model legislation has now been enacted, with some State-to-State variations, in all Australian mainland States and Territories, and the provisions relating to trade apply to all human tissues including reproductive tissues. There are however, some limited exemptions from the statutory prohibition and these are described in the following paragraphs.

B. Statutory Exemptions

10.2 Section 32(3) allows “the reimbursement of any expenses necessarily incurred by a person in relation to the removal of tissue in accordance with this Act”. Tissues that have been treated or processed for medical or therapeutic use may be sold, but their original acquisition is not exempt from the trading prohibition.[3] Further, the Minister has power to grant a specific exemption in special circumstances.[4]

10.3 In relation to semen donation, the exemption provisions of section 32(3) are not entirely clear because they extend to expenses “necessarily incurred by a person in relation to the removal of tissue in accordance with this Act”. While it seems plain that semen donation would not normally involve a removal of tissue in contravention of the Act, it is not entirely clear that the removal would be accurately described by the words “in accordance with this Act” since the mechanisms legitimizing removal of tissue generally do not apply to sperm. Even so, it seems plain that the policy of section 32 is to permit reimbursement of a semen donor’s expenses while generally forbidding commerce in that tissue.

C. Present Payments to Semen Donors

10.4 Money payments to semen donors are a feature of AID practice in New South Wales. The payments are invariably made as reimbursement of expenses and the range appears to be $10.00 to $20.00 per ejaculate or “specimen”. We believe that payments of this order are usual throughout Australia and in other Western countries such as England, Canada and the United States.[5] We have been informed by many medical practitioners that they regard the payments as a necessary part of AID practice because donors are usually put to expense and inconvenience in order to donate and also because the payments are a symbolic confirmation to donors that their semen is valued and appreciated. In Chapter 5, particularly in paragraph 5.9, we discussed the worth of semen donation. We have also been informed that many donors refuse to accept the payment. However, AID practitioners consider that prohibition of the payments would adversely affect AID programs by causing a decline in donations.[6]

10.5 We think that current payments for reimbursement of expenses are not objectionable. However, it could be argued that, strictly, uniform payments represent in effect a standard fee and contravene section 32 of the Human Tissue Act 1983.

D. Attitudes of Other Inquiries

10.6 In the Discussion Paper we set out the varying views of other Inquiries in Australia and overseas.[7] It is sufficient to say that they show wide divergence. The United Kingdom Committee in its Report expressed, somewhat reluctantly, its approval both of payment of a fee and the reimbursement of expenses.[8] The Victorian Committee considered "that it would be inhuman to traffic in human tissue", but approved "the reimbursement of donors for any costs..... in making the donation".[9]

E. Other Comments

10.7 Because of the recent enactment of the Human Tissue Act 1983, we do not intend to canvass the moral and practical arguments for and against payment to semen donors. These are well recorded and readily available.[10]

10.8 It is also to be remembered that commerce or trade in semen may be envisaged at two levels. The first is that which involves payment to the donor. The second is the activity of commercial "banks" or organisations such as those reported to operate on a substantial business basis in the United States. Organisations of the latter kind are not yet apparent in Australia and, should they appear, would no doubt attract immediately official attention. Subject to our recommendations, the Human Tissue Act 1983 is in our view sufficient under present circumstances to protect the New South Wales community.

F. Conclusions

10.9 We have concluded that the legislative policy of prohibiting trade in human tissue as expressed by Part VI of the Human Tissue Act 1983 should not be changed in relation to semen donated or used for AI. On the other hand, the established practice of AID clinics in New South Wales whereby semen donors are paid or given reimbursement for expenses associated with donation should be seen as acceptable and as falling within the policy of section 32(3) of the Human Tissue Act 1983. Our opinion is that while section 32 is generally applicable to semen, section 32(3) does not exempt from section 32(1) semen donated for AID because the exemptions only apply "in relation to the removal of tissue in accordance with this Act." We consider that those words are not apt to describe the procedure of semen donation. Specific legislative exemption is therefore desirable to enable the lawful reimbursement of expenses. We also draw attention to section 32(4), under which the Minister would have power to determine from time to time a standard fee for payment of semen donors while also permitting reimbursement of expenses additional to or beyond that fee. In view of the small amount normally paid for expenses, we think that the setting of a standard fee by the Minister would be a practical and desirable way of controlling this subject. We recommend that the reimbursement of any expenses necessarily or reasonably incurred by a semen donor in relation to the lawful donation of his semen for AID be allowed and that legislation be enacted to ensure that such reimbursement is lawful. We also recommend that the Minister give consideration to setting from time to time a standard fee under section 32(4) of the Human Tissue Act 1983 for payment to semen donors as well as permitting further reimbursement of expenses, to the extent that they exceed the standard fee in a particular case.

II. STORED SEMEN-DOMINION, CONTROL AND OWNERSHIP

A. Property in Human Tissue

10.10 No useful purpose is served, in our opinion, by discussing in this Report the difficult question whether the common law recognises the concept of ownership as applicable to human body materials. There is good authority for the general proposition that the common law does not recognise proprietary rights or interests in human tissues.[11] However, we are concerned with only one kind of tissue, namely donated and stored semen. We believe that the issues of dominion or control over this tissue in the context of AID can best be resolved by specific legislation and not by leaving them to the processes of litigation and judicial determination.

10.11 The issues relating to dominion over semen in the context of AID are probably the same in principle as those relating to donated ova, but are not likely to be seen as of equal significance to those relating to fertilized ova (embryos) in the context of IVF. The power to control, use and dispose of human reproductive tissues in relation to the processes of artificial conception is an important matter in

its own right, whatever may be the general legal principles applicable to proprietary rights in human tissues.

B. Semen Donated for AID

10.12 We take the general view that if a man donates semen unconditionally for use in AID there is no basis for him to assert rights and powers over its subsequent use. This is implicit in the Artificial Conception Act 1984 which precludes him from legal paternity and which implicitly accepts the converse, namely that he will have no duties or obligations to a resulting child.

10.13 Human semen is routinely frozen and stored for future use in AI. We are aware of no medical time limit that must be imposed, although as time passes the effectiveness of donated semen for fertilization declines. In view of the purpose of the donation and the simplicity of its production we recommend that legislation be enacted to the effect that the AI clinic should have the power to determine the use, storage and disposal of semen donated to it for AID. This power should carry some conditions and exceptions, for example, the clinic should be obliged, if a special use or purpose is stipulated at donation, to use it for that purpose although the clinic should have power to refuse to accept semen in the first place.

C. Semen Donated or Stored for a Specific Purpose

10.14 Following the exception envisaged in paragraph 10.13, a man and a clinic should be free to make an agreement setting out the terms applicable to his semen donation for AID and should also be free to reach a discrete agreement for the storage of his semen for his or his wife's subsequent use, for example, where he is about to undergo surgery or chemotherapy, or has a medical condition that might make him infertile.

D. Duration of Storage and Disposal of Semen

10.15 Whatever the purpose of storage, it seems to us that a means of terminating it should be envisaged. As far as semen for AID is concerned, we see no reason to set a time limit on the period of storage. At the same time, we see no reason to oblige a clinic to store semen indefinitely. If a clinic decided to cease storage or close its storage facility it should be free to do so unless it had entered into a contrary agreement.

10.16 The United Kingdom Report made recommendations on the duration of storage of both semen and eggs. It suggested a periodic review by the clinic at five-year intervals. The clinic would be obliged to ascertain the wishes of the donor or depositor for continued storage, donation or destruction. If the donor should die or cannot be traced or fails to give instructions then the power of use and disposal should pass to the clinic.[12] The report made no recommendation on the question of a clinic deciding to discontinue storage.

10.17 The National Health and Medical Research Council guidelines of October 1982 expressly provided for stored human embryos by setting an overall time limit of 10 years or the period "of conventional reproductive need or competence of the female donor" whichever is the longer.[13] The Ontario Report addressed the duration of storage of fertilized ova (embryos)[14] but did not deal directly with time limits in relation to stored semen.

10.18 Our opinion is that an AI clinic should have power to discontinue storage of semen donated for AID and to dispose of it if it so decides. However, we recommend that where an agreement has been made regulating the terms under which semen is to be stored, the clinic should, subject to the terms of the agreement, be under an obligation first to communicate with the donor or depositor and provide a reasonable opportunity for alternative arrangements to be made. We further recommend that the clinic's power of disposal be exercisable if the donor should die or cannot be traced or fails to give instructions.

III. SUMMARY OF RECOMMENDATIONS

(1) The reimbursement of any expenses necessarily or reasonably incurred by a semen donor in relation to the lawful donation of his semen for AID should be allowed and legislation enacted to ensure that such reimbursement is lawful.

(2) The Minister should give consideration to setting from time to time a standard fee under section 32(4) of the Human Tissue Act 1983 for payment to semen donors as well as permitting further reimbursement of expenses to the extent that they exceed the standard fee in a particular case.

(3) On the subject of dominion and control over donated semen and stored semen, legislation should make provision to the following effect:

(a) As a general rule the AI clinic should have the power to determine whether, and in what manner, semen donated to it for AID will be used, stored and disposed of.

(b) The power in (a) should be subject to any agreement made by the donor and the clinic setting out the terms applicable to his semen donation for AID.

(c) If a man and a clinic make an agreement for the storage of his semen for his or his wife's or partner's subsequent use, the clinic should, subject to the terms of the agreement, have power to discontinue storage and to dispose of the semen only after first giving the depositor a reasonable opportunity to make alternative arrangements. The clinic's power of disposal will also be exercisable if the donor or depositor dies, cannot be traced by the clinic or fails to respond.

FOOTNOTES

1. s32(5).

2. Australian Law Reform Commission, Human Tissue Transplants (ALRC 7, 1977) appendix IV.

3. s32(2).

4. s32(4).

5. United Kingdom Report, para 4.27; Ciba Foundation Symposium 17, *Law and Ethics of AID and Embryo Transfer* (1973) at 53,57 citing R M Titmuss, *The Gift Relationship* (1971), and at 101: Ontario Report at 167-169.

6. Discussion Paper, para 9.2.

7. *Id*, para 9.6.

8. United Kingdom Report, para 4.27.

9. Victorian Report, paras 3.10, 3.11.

10. See eg note 2, paras 174-182: Ciba Foundation Symposium 17, note 5 at 53.

11. Note 2, paras 13,168; for a general discussion of the legal position see Russell Scott, The *Body as property* (1981).

12. United Kingdom Report, paras 10.7,10.8.

13. National Health and Medical Research Council, Ethics *in Medical Research* (October 1982) at 27.

14. Ontario Report at 214-217.

11. Registration of Births of AID Children

11.1 Until the Artificial Conception Act 1984, the registration of births of AID children was a matter of considerable concern for law enforcement and for lawmakers. The reason was that it was widely believed that often a consenting husband, in contravention of the law, would register himself as the father of his wife's AID child.[1] The Family Law Council Report cited a 1981 research paper prepared in the Federal Attorney-General's Department which stated:

> . . . the NSW registration authorities have indicated that no registration form presented to them has ever disclosed that the child resulted from AID.[2]

Ample evidence is available that this practice was (and no doubt, is) widespread in Australia and overseas and, on occasions, encouraged by government instrumentalities.[3] Our inquiries of AI clinics in New South Wales have caused us to conclude that recipient couples normally indicate their desire and intention not to disclose to their AID children the circumstances of conception. The reluctance of AID parents to place on public record the fact of their resort to AID may be readily imagined. Nevertheless, it is a criminal offence to furnish wilfully false information with respect to a birth certificate.[4] Similar statutory provisions can be found in other Australian States and overseas.

11.2 The concern that numbers of citizens were deliberately breaking the law, or felt compelled to do so, has largely disappeared since the commencement of the Artificial Conception Act 1984 on 1 August 1984. That Act provides that when a married woman has received AID with her husband's consent and gives birth to a child as a result "the husband shall be presumed, for all purposes, to have caused the pregnancy and to be the father".[5] The birth may be registered accordingly. We refer in Chapter 13 to the Australia-wide enactment of legislation of this kind since August 1984 and to acceptance of the policy on which it is based throughout Western countries both in legislation and in the reports of official inquiries.[6]

11.3 The enactment of this clearly-expressed "status" legislation has now given rise, in some quarters, to the suggestion that its presumptions are not desirable and that it should be amended so as to require the biological facts to be put on official records.[7] A recurrent claim in support of this suggestion for further law reform is that a function of birth registration is to provide "a record for each individual of his or her blood or genealogical connections, of his or her progenitors."[8] We do not accept this claim, and believe it to be incorrect. The birth registry is not, nor is it intended to be, a source of biologically or genetically accurate information. The legislation expresses no such principle. It is further demonstrated by the fact that the births of large numbers of children are, and have over the years been, officially registered "without paternity". In our Discussion Paper we cited official figures which showed that, on average, 4.7 per cent of births in New South Wales were registered in this fashion in 1981-1983.[9] The Ontario Report discusses the same subject and reaches the same conclusion, after giving a variety of circumstances in which the birth register accepts and even encourages the recording of "social reality" in preference to "biological accuracy":

> . . . the act is not really intended to..... establish a true biological record of Parentage. Rather, registration by and large creates a social record of parentage.[10]

A further persuasive example is the general legal presumption that a child born to a married woman is the child of her husband.[11]

11.4 We believe that the policy of the new status legislation and its acceptance of social paternity should be respected. Further, we are not persuaded that the legislative pursuit of biological truth is practical or justifiable under the circumstances of AID practice in New South Wales, and have given our reasons at length in Chapters 8 and 13. We think, on the contrary, that it is arguable that the

Artificial Conception Act 1984 has both clarified and improved the law. It allows AID couples to register births free from the fear of breaking the law and clearly defines the legal status of the typical AID child. We make no recommendation for reform on this subject.

11.5 Two related matters should be mentioned at this point. The first is the registration of' the birth of a child from a widow following her insemination by her deceased husband's stored semen after his death. This is dealt with as a discrete subject in Chapter 12. The second is the reference given to this Commission by the Attorney General on 11 November 1985 to make recommendations for law reform in relation to:

1. Criteria for registration of the surname of a child of married and unmarried parents; registration procedures and acknowledgment of paternity in relation to an ex nuptial child; details to be recorded in relation to births and deaths; provision of certificates omitting potentially embarrassing details appearing in a registration;

2. any related matter.

While we remain of the view that reform of the law is not called for in relation to the matters discussed in this Chapter, we must respond specifically to these terms of reference in a separate report. The recommendations for reform that will appear in that report will flow from our consideration of the specific matters listed in the terms of reference and will not be preempted by this present Report.

FOOTNOTES

1. Discussion Paper, paras 15.6,15.7.

2. Family Law Council Report, para 6.41.

3. Discussion Paper, para 15.6 citing Royal College of Obstetricians and Gynaecologists, *Artificial Insemination* (London, March 1979).

4. Registration of Births, Deaths and Marriages Act 1973 ss57-59; Crimes Act 1900 ss337, 547A.

5. s5(2).

6. Paras 13.15-13.21 above.

7. Discussion Paper, para 15.4; Family Law Council Report, para 6.4. 1 0.

8. Family Law Council Report, pira 6.4.2; United Kingdom Report, para 4.25.

9. Discussion paper, para 15.8.

10. Ontario Report at 70.

11. See generally M Aronson et *al, Litigation: Evidence and Procedure* (3rd ed, 1982) at 504,505.

12. AIH and Posthumous Use of Semen

I. GENERAL CONCLUSION ON AIH

12.1 The Commission has reached the conclusion that direct legislative regulation of the practice of AIH is not necessary and recommends accordingly. The AIH child is conceived from the reproductive tissues of the couple themselves and will be a true child of the marriage. In this respect AIH is clearly comparable to natural reproduction.

II. AIH USING DECEASED HUSBAND'S SEMEN

A. The Problem

12.2 It is possible for a widow to be made pregnant by AI with her deceased husband's stored sperm. Such cases are likely to be rare. We are aware of only two, one occurring in England in 1977 and the other in France in 1984. The latter case received wide international publicity.[1] Despite the rarity which we have assumed in the incidence of such cases, they raise an unexpected problem under the Artificial Conception Act 1984 that calls for serious consideration of amendment of that Act. The problem is one of interpretation, and our conclusion is governed by our understanding that the Act was passed for the purpose of clarifying the status of AID children. The Act provides that where a woman becomes pregnant by means of AI:

> . . . any man (not being in the case of a married woman, her husband) who produced semen used for the artificial insemination . . . *shall for all purposes, be presumed not to have caused the pregnancy and not to be the father* of any child born as a result of the pregnancy.[2]

12.3 If a widow is made pregnant by her late husband's semen by AI and bears a child as a result, this provision may exclude the deceased husband from fatherhood and render the child fatherless. An interpretation that excluded a deceased husband from fatherhood would in our opinion regard the time of insemination as critical. Argument in favour of such an interpretation would emphasise the fact that the woman (widow) did not have a husband at that time and therefore could not he regarded as a "married woman" for the purposes of the subsection. The argument might also suggest that the deceased husband is therefore specifically excluded by the remaining words of the subsection from paternity of the child. On the other hand a court may accept a contrary argument, for example, that the subsection does not apply to such extraordinary circumstances and is intended only to apply to cases where all the parties to the information are alive at the time.

12.4 In our opinion, amendment of the Act is justifiable to enable biological paternity in a case of this kind to be accepted by the law and recorded in the register of births. It is plain that this is the wish of the parties. Accordingly we recommend that the law recognise the deceased husband as the father of a child born as a result of such a procedure, provided that the woman is his widow and unmarried at the time of insemination and birth, and further that the law allow the register of births to record the deceased husband's paternity in such a case.

12.5 Our conclusion has been reached after considering the legal, temporal, logical and philosophical arguments that may be made to demonstrate that the word "father" is not appropriate for a man who does not exist at the time of conception. However, the sperm does exist and in commonsense not only is there a basis for recognising the deceased husband's paternity but notation of his paternity on the birth register is desirable. There appears to be no other way of creating a credible record that does not contradict itself. We recommend that no other action be taken to enact legislation to regulate or prohibit directly AIH where a widow wishes to use that procedure to become pregnant by her late husband's stored sperm.

B. The Inheritance Question

12.6 Posthumous or post mortem conception raises questions concerning the child's rights, if any, to share in the father's estate. The effect of the recommendation made in paragraph 12.4 will be that a child may be born who will in law be able to regard as his or her father a person who died before his or her birth. From a succession point of view this would mean that, unless the law provided otherwise, the child would be regarded as the deceased's child under the scheme of distribution on intestacy in New South Wales if he were to die intestate; if he left a will, the child would be considered his child in a gift to "children"; and, in either case, the child could make an application for further provision under the Family Provision Act 1982 as his child.[3]

12.7 An obvious practical difficulty with giving full effect to our recommendation arises when the father's estate is wholly or partly distributed at the date of conception or birth. Views differ as to what should happen in this case. The Ontario Report favours legislative intervention and the creation of an entitlement on the part of the posthumously-conceived child to inheritance of a share in the undistributed estate of the father "as if the child were conceived while the husband was alive".[4] On the other hand, the United Kingdom Report unequivocally rejected this proposition, recommending:

> that any child born by AIH who was not *in utero* at the date of the death of its father shall be disregarded for the purposes of succession to and inheritance from the latter.[5] The United Kingdom Report expressed the view that posthumous AIH of a widow, "should be actively discouraged", and that it "could cause real problems of inheritance, and succession".[6]

12.8 In our opinion, the law should not preclude the creation of a specific gift by a man (or any other person) by will in favour of his (or any other person's) posthumously-conceived children. A man who wishes to provide for a posthumously-conceived child should be entitled to make direct testamentary provision to that effect. Complex legal problems such as those that could be posed by the rule against perpetuities should not arise because we are here considering only the unique case of post mortem pregnancy of the deceased's widow.

12.9 Because of the practical difficulties in administration of estates referred to in paragraph 12.7 we propose that the posthumously conceived child should not be entitled to participate in the distribution on intestacy of his father's estate. This will enable the administrator of a intestate's estate to distribute without the need to make enquiry to negative the possibility of the subsequent birth of persons who, because of our recommendations in paragraph 12.4 will be regarded as the children of the deceased. Further comments on intestacy, and comments on testacy of the deceased father, now follow.

12.10 Should children born whilst the deceased's widow remains unmarried be entitled to bring a claim under the Family Provision Act 1982? We have not found this an easy question to determine, and the opinions which are set out in the remainder of this paragraph, as well as the recommendations in paragraph 12.11 are those of a majority of the Commission. Two of the Commissioners hold different opinions and their views are set out in paragraph 12.12. There will be few cases where a child will be born posthumously while his or her mother remains a widow and where his or her father has not made adequate provision in his will. However, experience shows that even the most well-meaning testators can overlook particular needs or by failing to constantly update their will, may leave a will which is no longer appropriate to their family's needs. To deny rights on intestacy, and on testacy (where no provision or inadequate provision is made) but leave no jurisdiction for claims to be made on an estate by a child could mean that a large estate might pass to a charity or a remote relative of the deceased leaving the posthumous child with nothing even where the estate was sufficient to provide adequately for his or her maintenance and advancement in life. We believe that the Court's jurisdiction to entertain such claims should be preserved. An executor or administrator will be free to distribute according to the will or laws of intestacy as soon as the estate is in a position to be distributed. He or she will be protected thereafter from personal liability at the suit of the later-born posthumously-conceived child of the deceased, provided the requisite notice is given under section 35 of the Family Provision Act 1982. Thereafter, the claimant will need to assert the claim directly against those to whom the estate was distributed. While this will be inconvenient, it should be borne in mind that such a situation would only arise in the rarest of circumstances. The claimant will need to satisfy the court both that "sufficient cause" exists for bringing a claim more than 18 months after the deceased's death [7] and that in the final analysis the court should exercise its *discretion* to make an order in his or her favour. The Court's

ultimate discretion to make an order requires it to take into consideration circumstances existing after the death of the deceased and any other matter which it considers relevant in the circumstances[8] and this would, we believe, allow proper adjustment having regard to the position of beneficiaries who may have spent their inheritance before the posthumous claim was known.

12.11 We therefore recommend that legislation should be enacted to reflect our intentions. To some extent this legislation will be declaratory. The legislation should make it clear that as a consequence of the legislation enacted pursuant to the recommendations appearing in paragraph 12.4, a child conceived in the manner under discussion, namely by AIH after the death of his or her biological father, will have the right or power to make a claim under the Family Provision Act 1982. The legislation should also provide that, for the purposes of inheritance or succession to property whether on the testacy or intestacy of the father, the child is not to be regarded as the child of the father except to the extent that the father has made specific provision for the child in his will.

12.12 The Commissioner-in-charge of the reference, Mr Russell Scott and Justice Nygh do not agree with the recommendations in paragraph 12.11 for two reasons. The first is the uncertainty that will attend the distribution of estates because of the possibility of claims being made by children to be conceived in the future. The second is the complexity of the recommendations and the possibility that the public will be confused by them. They consider that a man who has arranged for the storage of his semen should be entitled to make direct testamentary provision for a posthumously-conceived child to share in his estate, and as well should be under the necessity of doing so if the child is to take such a share. Their view is that the interests of all members of the family of the child in question will be best served by certainty and simplicity in the law. Accordingly legislation should provide that a child conceived by AIH after the death of the biological father, should be regarded as a child of the latter for the purposes of the inheritance of property only to the extent that the biological father or any other person has made specific testamentary provision in the child's favour.

III. AID USING DECEASED DONOR'S SEMEN

12.13 By way of a postscript we mention that there is no call for recommendations to be made in relation to the stored sperm of a deceased donor not married to the female AID recipient. In such a case the death of the donor would be irrelevant and subsection 6(1) of the Artificial Conception Act 1984 would specifically exclude the donor from paternity.

IV. SUMMARY OF RECOMMENDATIONS

(1) Direct legislative regulation of the practice of AIH is not necessary.

(2) The law should recognise the deceased husband as the father of a child born as a result of such a procedure, provided that the woman is his widow and unmarried at the time of insemination and birth.

(3) The law should allow the register of births to record the deceased husband's paternity in such a case.

(4) No action should be taken to enact legislation to regulate directly or prohibit directly AIH where a widow wishes to use that procedure to become pregnant by her late husband's stored sperm.

(5) Legislation should provide that, for the purposes of inheritance or succession to property whether on the testacy or intestacy of the father, the child is not to be regarded as the child of the father, except to the extent that the father has made specific provision for the child in his will. Otherwise, that child should have the right or power to make a claim under the Family Provision Act 1982.

FOOTNOTES

1. "The Parpalaix Case and postmortem insemination" (1984) 58 *Australian Law Journal* 627; "A Dead Man Has the Right to Breathe Life into His Wife's Womb and Prove Love is Stronger than Death"

Sydney Morning Herald, 3 August 1984 at 7: “Rush Law on Donating Sperm after Death” *Sydney Morning Herald*, 4 August 1984 at 8.

2. Artificial Conception Act 1984 s6(1) [our emphasis].

3. R F Atherton, “Artificially Conceived Children and Inheritance in New South Wales” (unpublished paper, 1986).

4. Ontario Report at 182.

5. United Kingdom Report, para 10.9.

6. *Ibid.*

7. Family Provision Act 1982 s16.

8. *Id*, s9(3).

13. Record Keeping

I. BACKGROUND

A. Human Infertility and AI

13.1 A person born as a result of AI is typically the child of a married woman whose husband is infertile. For some infertile couples childlessness in marriage is a tragedy. The United Kingdom Committee, discussing infertility, said:

> Childlessness can be a source of stress even to those who have chosen it . . . For those who long for children, the realisation that they are unable to found a family can be shattering. It can disrupt their picture of the whole of their future lives.[1]

When we speak of infertility in marriage, we are not referring to a minor social phenomenon. It is generally accepted in medical and scientific literature that 10 to 15 per cent of all couples of childbearing age are infertile.[2] Most of us are familiar with the statements made in recent years that infertility in Western society is increasing and that the reasons for the increase are not known. Examination of the raw information on annual birth rates provided by the Australian federal government shows a clear decline.[3] In Australia between 700,000 and 1,000,000 persons are now partners in infertile marriages.[4] There exist varied opinions about the significance of infertility in marriage, and the justification of its treatment by medical practitioners. However, infertility is likely to be a matter of considerable sensitivity for those affected by it. This in turn suggests that actions such as medical treatment for infertility, insemination of a wife with the husband's or a donor's semen and the birth of an AI child will also, for some, be matters of considerable sensitivity. The answers to the questions whether AI children should be told the truth about the conception, whether they should have access to all available information on the subject, whether detailed records should be kept and if so by whom, are likely to reflect deep divisions of opinion. There are no more difficult issues than those arising from these and related questions. In this Chapter our attention is principally devoted to AID.

B. Telling the Truth About Genetic Parentage

13.2 The debate about the claim of the AID child to be told the truth about parentage and origin has its source in adoption practice and major changes in thinking that have taken place in recent years favouring the supply of personal information to adopted people in a context of openness and frankness. As a general proposition, openness and frankness are preferable to secrecy and deceit. However, it is sometimes easier to propound a desirable objective than it is to achieve it.

13.3 The Commission's awareness of this fundamental alteration in approach to adoption is derived from its research and from the long professional involvement in this field of one of its Commissioners,[5] to whom we are indebted for advice both on developments and policy formulation. We believe that we have been able to remain abreast of the debate, which is a continuing one. In particular we have considered sensitive and contentious questions such as the supply of information that identifies persons, the transfer to the field of artificial conception of philosophy and principles seen as suitable for use in adoption, and the equation of adopted persons with persons born as a result of the use of donated reproductive tissues. We are aware that the new approach has begun to reflect in adoption legislation such as the United Kingdom Adoption Act 1976 and the Victorian Adoption Act 1984.

13.4 We discussed the issues at length in the Discussion Paper[6] and analysed the factual differences between the circumstances of children in a typical adoption and those in typical cases of AID and IVF. The fact is that the typical adopted child has no biological relationship to the adopting parents, while the typical AID child is borne by its biological mother under arrangements to which her husband is a willing party from conception, and is raised by her and her husband. The typical IVF and AIH child is

born to and raised by both its biological parents. Once again we emphasise that despite the inevitable use of expressions such as “AID child” and “IVF child” we refer to all persons, whatever their ages, born following these procedures of artificial conception and do not confine our comments to infants.

C. Two Crucial Questions

13.5 Our research and inquiry has led us to the view that two questions have particular significance in AID, namely:

> should Information that identifies a party to AID be made available to another party or another person without the first party’s consent?
>
> by whom should AID records be kept?

The answers to these questions are likely to disclose the fundamental differences of opinion referred to in paragraph 13.1. These differences appear to have resulted in an alignment on one side of people who believe that a donor’s claim to anonymity and confidentiality and a recipient couple’s claim to decide what to tell their AID child should have effect, and on the other side of people whose perception of the welfare of the AID child causes them to take the view that the child should be given a “right to know”, by means of enforceable legal rights to information that can override all contrary claims.

II. ACCESS TO AI RECORDS

A. The Debate

13.6 Whether information recorded by AI clinics and practitioners should be made available to AI children (or other interested persons) is a matter of real contention. Our inquiries of New South Wales clinics led us to the conclusion that AID parents do not, as a rule, inform their children of their AID origins.[7] We found, however, that the clinics normally provide counselling on this subject and advise patients to make their own decision.

13.7 The two sides of the debate may be illustrated by reference to the contrasting recommendations that have been made recently by two Australian official reports and two overseas reports.

B. The Victorian Report

13.8 The importance of this report lies in the fact that, together with other reports of the Victorian Committee, it led to the enactment in November 1984 by the Victorian parliament of Australia’s first statute regulating the practices of AI, AID and IVF.[8] The Victorian Report itself was limited to IVF, but many of the principles which it enunciated were extended by the Parliament to AI. No official inquiry into AI or AID was held in Victoria. The basic principle propounded by the Victorian Report on the subject here in question was put as follows:

> Whether or not a person pursues her or his origins, It should be possible for everyone to discover them..... There is..... a substantial and growing view that the values of honesty and integrity are crucial to the creation of a happy family . . . [9]

Pursuant to this proposition, the legislation has created a government register into which must be put comprehensive details of all gamete donors, AID pregnancies, recipients, resulting children and all abnormalities in those children.[10] The provision by the hospital of the information to the register is compulsory and is supported by a criminal sanction.[11] Access to information in the government register by children born as a result of AID procedures was envisaged by the report but it did not recommend the supply of information that would identify a donor. The legislation in its present form provides only for the supply of non-identifying information.[12] We examined the Victorian Report and the legislation (then a Bill) in our Discussion Paper and expressed some reservations about its underlying principles and assumptions in relation to the supply of information through a central government register.[13] These reservations extended to the assumption that legislative intervention of

this kind is justifiable as a support for the stated social value of “honesty and integrity” and that statutory compulsion is an acceptable route “to the creation of a happy family”.[14] We expressed doubts (also discussed earlier in this Report) whether it is justifiable for the law to assume that the AID child under normal conditions of practice, is necessarily the child of the donor and drew attention to the lack of factual information about AI practice in the Victorian Report (due, obviously, to the limits of the terms of reference).

13.9 It seems to us that parents may be honest and open with their children and yet decide that it is not in the children’s interests to be given all information regarding their origins. The issues are whether the parents should be left to exercise discretion in the light of the circumstances and whether it is the role of the law to intrude. If legislation is to compel the recording and the supply of specified genetic information without regard to individual circumstances, the legislation must be based on some other principle than “the values of honesty and integrity”.

C. The Family Law Council Report

13.10 The Family Law Council was created to advise the federal Attorney-General on matters relating to family law under the Family Law Act 1975 (Cth). It decided in early 1984 to examine, via a sub-committee, the matters dealt with in its report. This is not the place to discuss the constitutional limits on the reach of the Family Law Act. However, it should be borne in mind that the Act and the power of the federal government are limited, to use non-technical language, to children of married persons and do not extend to all children.[15] The main recommendation of the report, which was published in July 1985, is that a body should be established and named the *National Council on Reproductive Technology* with the function of monitoring medical research and practice related to reproductive technology and advising governments and the public accordingly.[16] However, the report itself contains many recommendations for federal and state lawmaking including keeping of, and access to information and records in relation to children born as a result of the use of donated gametes.[17]

13.11 The Family Law Council Report’s recommendations on the present subject proceed from the following statement of principle:

> The practice, experience and research of the past 20 years in adoption emphasize the following as essential to the healthy social and psychological development of children in their families:
>
> > honesty and openness in family relationships .....
> >
> > access to medical and/or identifying information and records where required..... in terms of the child’s/adult’s needs and rights;

and are based on the paramountcy of the welfare and interest of the child/adult.[18]

The recommendations following this statement of principle are applied or transferred to persons born following the use of donated gametes in artificial conception, and include the following:

> That, in recognition of the importance of access to knowledge and information of genealogical origins, legislation and practice provide for access to such information by the child/adult:
>
> > that such information be of a non-identifying nature prior to the child reaching 18 years of age; and
> >
> > that identifying information be available for adults over 18 years of age.[19]

13.12 It is significant that this report is the only one we have seen that recommends the creation of a statutory right in favour of an AID child to obtain identifying information about parentage. It is also important, before proceeding to the two overseas reports, to set out some facts as we have them:

> The AID child is not in an equivalent position to the typical adopted child for reasons already stated.[20] However, advocacy of a legal right to identifying information about a donor equates adoption with AID.[21]
>
> The Adoption Act 1984 (Vic) is the only statute enacted in Australia that provides a legal right for an adopted person to have access to identifying information about biological parents.[22] We are informed that no other State or Territory will provide such information against the wishes of a biological parent.[23]
>
> We should add that since the publication of our Discussion Paper, the Marshall Review Report has been published by the Minister for Youth and Community Services on the subject of adoption in New South Wales. That report recommends that adopted persons on reaching 18 years should have access to their original birth certificates. It further recommends that "policy be developed..... to release additional relevant identifying information from adoption records . . ." [24]
>
> No other Australian Inquiry nor any overseas Inquiry has suggested the creation of a legal right of access to identifying information in artificial conception.
>
> In England and other places where a statutory right has been given to the adopted person to obtain a copy of his or her birth certificate, it does not follow that the certificate will contain details of the biological father.[25]

D. The United Kingdom Report

13.13 The United Kingdom Report pays regard to the principle of the welfare of the AID child, but does not use that principle as a starting point. The following extracts clearly show the report's approach:

> [T]here is a need to maintain the absolute anonymity of the donor.....[26]
>
> [O]ur general view is that anonymity protects all parties not only from legal complications but also from emotional difficulties.[27]
>
> AID has tended to be surrounded with secrecy. This secrecy amounts to more than a desire for confidentiality and privacy, for the couple may deceive.... the child is well... However, while we agree that it is wrong to deceive children about their origins, we regard this as an argument against current attitudes, not against AID in itself.[28]
>
> [T]he [AID] child should have access to the basic information about the donor's ethnic origin and genetic health and [non-retrospective] legislation [should] be enacted to provide [a] right of access to this [upon reaching the age of eighteen years.[29]

The United Kingdom Report does not discuss or recommend access to identifying information about parentage in artificial conception. In our view the foregoing excerpts show the reason. England is regarded as the pioneer of legislation giving access to information about an adopted person's biological parentage, yet that legislation gives access to the birth certificate, not to identifying information as such. Triseliotis, the adoption expert who is credited with causing the enactment of the English legislation, commented as follows:

> My research studies have shown that approximately 98% of adopted people are satisfied with non-identifiable information passed on to them by their parents. For the tiny minority who are not satisfied and set out on a quest, the reasons are mostly associated with secrecy and evasion pursued by the adoptive parents, or with some other serious identity crisis.[30]

The United Kingdom Report declined to deal with the question of a central register of births by artificial conception and recommended that the matter be studied later.[31]

E. The Ontario Report

13.14 The Ontario Commission thoroughly discusses all aspects of this subject from the creation of records, their content and retention, to the difficult questions of access and confidentiality. The Commission is firmly of the view that full records of the parties to AID should be created so that a linkage can be made if health considerations require it. It insists with equal firmness upon preservation of the confidentiality of records and the anonymity of the parties between themselves.[32] As for access to the records by the AID child, the report reaches conclusions that are in clear contrast with the two Australian reports. It should be stated that, unlike the United Kingdom Report, those conclusions are reached after lengthy discussion of the issues. Thus:

> Before we deal specifically with access to medical records, we wish to raise the critical threshold question concerning whether a child should be told of his biological origins . . . [W]e agree in principle with the view expressed in a Report of the Royal College of Obstetricians and Gynaecologists in the United Kingdom that "the decision to disclose to the child the nature of its parentage should at the present time remain with the 'legal' parents" . . . Each family situation is different, so that a general hypothesis-that, for example, secrecy is deceitful and fundamentally unhealthy-while perhaps reasonable and compelling in the abstract, cannot be translated into meaningful statutory directive.[33]
>
> [A]fter a child has, in fact, discovered that he or she was artificially conceived..... the Commission recommends that the decision concerning access to medical records by the parties involved-the woman, her husband or partner (if any), the child, and the donor should be left to individual members of the medical profession. However, *under no circumstances should any doctor or other person disclose information that could in any way identify the parties involved*.[34]

F. Our Comments on the Debate

13.15 Plainly, there are differences between the philosophy and social principles underlying the two Australian reports and those underlying the United Kingdom Report and the Ontario Report. There appears also to be a difference of approach concerning the desirability of legislative intervention in this aspect of domestic life. We find ourselves unable to agree with the conclusions of the Family Law Council Report on access to identifying information, or with the Victorian Report and legislation on the method of recording information. There are several reasons for this, which we outline in the succeeding paragraphs.

13.16 We agree that openness, integrity and honesty in all relationships, including family relationships, are desirable. However, there is nothing original or unusual in that proposition. In our view, it is not justifiable to use such proposition as a reason for enacting legislation. In the words of the Ontario Report, used in relation to the decision to disclose to the child the nature of its parentage, "the decision..... does not lend itself..... to legislative resolution".[35] There is another aspect of the "openness" proposition that concerns us, namely our belief that the ideal of openness in family relationships should extend to many more matters than biological parentage. For example, a child might be seriously affected by a parent's lies or deceit concerning past criminal behaviour, past marriages, serious illness or financial instability. Why should the law select this one area of *possible* lack of openness as meriting legislative intervention?

13.17 Secondly, the factual difference between the parental circumstances of the AID child and the typical adopted child has already been twice referred to in this Chapter. We are aware that some people say that an AID child can suffer serious identity problems in relation to paternity alone, despite the "halving" of the problem as applied to an adopted person. Nevertheless, we believe that this factual difference is significant and has not been addressed in the Australian reports that rely on the adoption parallel.

13.18 Thirdly, there is an assumption behind the Victorian approach, to which we have already referred in this Chapter and in Chapter 9, namely that the semen donor, under present conditions of AID

practice, may be assumed with certainty to be the genetic father of the child in question. We doubt that justification exists for this assumption.

13.19 Fourthly, neither of the Australian reports (nor any other report that we have read) attempts a balancing of its recommendations with an important matter of principle, namely the claim of competent adult parents to personal autonomy and liberty to make their own decisions in relation to reproduction and family matters, including the welfare of their children.

13.20 Fifthly, both Australian reports assume that the acquisition of accurate genetic information about parenthood is so important that legislation to underwrite it is necessary. Neither contains any discussion of the merits of this assumption nor, in particular, of those cultures and communities that have not taken this view of the importance of the genetic link. Examples may be readily given from Maori, Polynesian and Aboriginal culture of circumstances where social parenthood is accepted as at least equal to biological parenthood. We are aware of the notion of "genealogical bewilderment" in sociological literature, but believe that the imperative of "biological truth" should have been argued because the proposition was used as a foundation for recommendations for legislation.

13.21 Our final reason is the inconsistency of the policy espoused by the two Australian reports and the "central register" provisions of the Victorian Infertility (Medical Procedures) Act 1984 with the legislative policy of the 1984 status legislation relating to children born as a result of the use of donated gametes. The Artificial Conception Act 1984 and the Status of Children (Amendment) Act 1984 (Vic) both reject biological parenthood and replace it with social parenthood in AID. The husband who consents to the use of donated semen for his wife's pregnancy, the "social father", is presumed to have caused the pregnancy and to be the father for all legal purposes. This legislation goes further than adoption legislation on this point. The Family Law Council Report saw some of the problems which the status legislation raises for its own recommendations on "the right to know" biological facts and recommended that the Australian States and Territories should amend their status legislation (and also their birth registration laws) to reflect the report's views on biologically accurate record keeping.[36] We do not regard this as an acceptable approach. The Victorian and New South Wales status legislation of 1984 followed some five years of consideration by the Standing Committee of Attorneys-General. Its policy on paternity is not only now common throughout Australia, but has been adopted or recommended throughout the Western world, beginning with the Uniform Parentage Act of 1973 in the United States and including the United Kingdom, Canada, the Council of Europe (for all European nations), New Zealand and South Africa..

G. Submissions from the Public

13.22 Twenty-six of the written submissions on AI held by the Commission expressed views on the creation and keeping of records. Six of these stated their support for the supply to AID children of identifying information about semen donors and one appeared to favour it without saying so specifically. However, 14 specifically advocated restriction to non-identifying information, and the remainder were concerned with other aspects of record keeping. Of the 22 persons and organisations who made oral statements and submissions to the Commission at its public hearing on 16 April 1985, 19 discussed the question of access to records. Five favoured the supply of identifying information about donors to AID children as a legal right, while 15 favoured restriction to non-identifying information.

H. Conclusions

13.23 We have concluded that insufficient reason exists for creating legal rights in favour of any person for access to recorded identifying information about semen donors or any other party to AID. Accordingly, **we recommend that no person should have a legal right of access to information that may identify a party to AID, and no record keeper may divulge such information, unless the person who is the subject of the information formally consents.** As for non-identifying information or identifying information to the supply of which the person to be identified consents, we believe that access may be granted for "good cause". Under existing legal procedures and the law of evidence, access to any records can normally be ordered by the courts for the purposes of legal proceedings. We see no need to interfere with this. **We recommend that a statutory entitlement should be created**

whereby AID recipients, AID children, semen donors and any other person, upon showing "good cause" may have access to recorded non-identifying information either by agreement with the record keeper or, failing agreement, upon the decision of a person or body nominated by the Minister for Health. The majority of Commissioners envisage that "good cause" will involve the health and welfare of a party to AID. However, Justice Peter Nygh is of the view that "good cause" should be defined more restrictively, to refer only to information necessary for the physical well-being of the AID child. **We further recommend that the supply of information should not necessarily confer a right of access or inspection of the records themselves.** Our conclusions on the question of a central register of information are in paragraph 13.30.

III. CREATING AND KEEPING AI RECORDS

A. In General

13.24 We now turn to creating and keeping records, the extent of the records, the persons to whom they should relate, the persons who should keep them and the duration of retention. Firstly, the Commission has decided in principle that appropriate information about the parties to AI should be recorded. The principal purpose of recording and keeping information should be to secure the good health and welfare of parties to AI, in particular the semen recipient, the resulting child and the semen donor. AID records could relate to the recipient woman, her husband or partner (if any), the resulting child and the semen donor. Before dealing with feasible procedures for creating records, the question should be asked whether the law already requires records to be created. In the following paragraph, we suggest that the law requires records to be created, on the assumption that AI is classified as a medical practice. If our recommendations in Chapter 4 are implemented, the systematic practice of AI will be confined by the law to medical practitioners. It can therefore be expected that records will be made and kept about AI "patients".

B. Who is the Patient?

13.25 Who is (or are) the patient (or patients) in AI? Is it legally compulsory for a medical practitioner to create and keep records about patients? On the basis that AI is a proper subject of medical practice, we are of the view that in the typical case that arises for treatment, where a heterosexual couple experience infertility, both the partners are patients. The male will have a condition such as oligospermia or azoospermia that calls for expert medical advice and treatment, and the female will receive the insemination. Both will be counselled. However, there does not appear to be any statutory requirement in New South Wales compelling the creation of medical records.[37] This may be contrasted with the law of Ontario where:

> . . . seventy-seven pieces of legislation, including regulations, [deal] with the reporting, collection, storage, use, dissemination, confidentiality, retention, or disposal of health information.[38]

The creation of medical records in Australia is, however, required by the Code of Ethics of the Australian Medical Association. Rule 6.1.2 of the Code provides:

> Every patient has a right to expect a complete and thorough examination into his condition and that accurate records will be kept.[39]

We conclude from this ethical rule, and our belief that medical practitioners habitually create and keep records of patients and their treatment, that good medical practice requires that these steps be taken. It follows that the common law could be expected to recognise this practice and impose a legal duty to follow it, breach of which may amount to negligence. The next question is whether the semen donor and the AID child are "patients".

13.26 We discussed in Chapter 8 the question whether semen donors are "patients" of the clinics or medical practitioners to whom their semen is given. Our inquiries of New South Wales clinics disclosed that all clinics which use frozen sperm create and keep coded, confidential systems of donor information and all give confidentiality and anonymity to donors.[40] The donor records are kept for

varying periods, from a reasonable time after a donor ceases to be a donor and the results of his donation are known, to “indefinitely”. We are therefore satisfied that regard for the welfare of the parties to AI has caused the establishment in New South Wales of the practice of record-keeping in relation to semen donors, despite the lack of clarity and definition of this relationship with the medical profession. Even so, we have reached the conclusion that it is desirable for the matter to be clarified by an official statement requiring records about semen donors to be kept, and our recommendations reflect this conclusion. The Ontario Report expressed the same view but was able to deal with the matter more directly because of the existence in Ontario of extensive statutory requirements for patient” record keeping:

> [W]e recommend that the relevant statutes, regulations, and professional rules be amended to make it clear that gamete donors are patients for the purposes of record keeping.[41]

13.27 Strictly speaking, the AID child as such is not a “patient”. Obviously the parents of the child, or one of them, could create that status contractually with the clinic. The Ontario Report suggests that the child may have a special status that attracts duties owed by the clinic:

> Indeed, it might well be professional misconduct where a physician failed to maintain records required for the conscientious and professional care of persons, other than patients, to whom legal, fiduciary, or ethical duties are owed. These other persons could include artificially conceived children, who, *while not patients*, have frequently been said to be persons to whom physicians owe at least ethical duties. Thirdly, under traditional negligence law, there would likely be a legal duty of appropriate record keeping owed to patients and others, including children, who foreseeably might be prejudicially affected by the failure to keep such records.[42]

C. Conclusions

13.28 We recommend that all clinical records relating to AI and AID and to the parties to AI and AID shall be retained by the practitioner or clinic who provides the service. We further recommend that the extent of the records and their contents and the methods to be used to assist in preserving confidentiality and anonymity, should not be prescribed by legislation because they are essentially matters for good medical practice. Minimum requirements for patients’ records are prescribed by legislation in some jurisdictions, for example Ontario and England.[43] Our view is that regulations are the appropriate means of prescribing such matters and we believe that under the Medical Practitioners Act 1938, the Minister already has power to make such regulations. However, at this stage we do not recommend the preparation of regulations, believing that the existence of power to make them is sufficient. We would prefer to see attention given to this subject by the medical profession itself, by organisations such as the Australian Medical Association, the Royal Australian College of Obstetrics and Gynaecology and the Fertility Society of Australia, either severally or jointly. Rules or regulations on this subject should pay regard to the need for confidentiality, privacy and anonymity of the parties[44] and to possible requests on those subjects by the parties. We further express the view that regulations should take into account the realities of medical practice and should not place impractical obligations on any person. For example, it is not unusual for women to seek AID from a public hospital clinic as a specialist service on referral from their medical advisers. In such cases the women may leave the clinic after insemination or after pregnancy and the clinic will not learn about the birth of a child unless special arrangements are made. Therefore, while we agree with the practice of recording details of children born as a result of successful inseminations, there must be a limit on the clinics’ duty and the extent to which they should be obliged to “follow up” patients or seek information that is not readily available. The Infertility (Medical Procedures) Act 1984 (Vic) makes specific concessions on this subject.[45] Attention is also drawn to the Ontario Report:

> [W]e recommend that there should be no positive duty on artificial conception practitioners to take steps to ascertain whether conception and birth have taken place or to ascertain the medical status of any child.[46]

IV. WHO SHOULD KEEP RECORDS?

13.29 Having recommended that AI records should be compulsorily created and kept, we now recapitulate some of the results of our inquiries. These show that AI in New South Wales is practised mainly in organised clinics in public hospitals and that AI is now rarely practised by individual medical practitioners.[47] The reason is that patients suitable for AI are normally referred to one of the specialist clinics. We identified eight AI clinics in New South Wales, six of which are in major public hospitals. We have been supplied with no evidence or suggestion of any misbehaviour or abuse on the part of any AI clinic or any medical practitioner in relation to records or the failure to keep records.

13.30 Because of the recent Victorian legislation, the Infertility (Medical Procedures) Act 1984, the question arises of a central register of AI information. We have already described the Victorian experience on this subject, which has no counterpart, so far as we are aware, in North America or the United Kingdom. We emphasise that the Victorian legislation resulted from a report on IVF, although the central government register proposed will also contain details of parties to AID. As far as New South Wales is concerned, we see no case for the establishment of a central register of AID information. If our earlier recommendations are accepted, specific legislation and supporting regulations or guidelines will ensure the creation and retention of detailed records. AImost all of these will be held in public hospitals. The remainder will be held in private clinics which will not only be governed by the legislation, but conducted by medical practitioners already controlled by the Medical Practitioners Act 1938. A central register would, in our view, be a duplication of record keeping that will already have been done as a statutory obligation. We cannot see justification for it, or for the expense and resources necessary to conduct it. Accordingly, **we recommend that there be no establishment of a central register to contain details of AI, AID or any of the parties involved.**[48] **The records should be kept by clinics and practitioners.**

V. DURATION OF RECORD RETENTION

13.31 We believe that a direct obligation on AI clinics to retain AI medical records on a permanent basis should not be imposed by statute. There should be a procedure whereby the obligation may be terminated and the records disposed of (or destroyed). We note that under the various Ontario statutes relating to medical records, individual medical practitioners are required to keep normal “patient” records “for a period of six years after the date of the last entry in the record or until the practitioner ceases to engage in the practice of medicine, whichever first occurs”.[49] Public hospitals in Ontario are obliged to keep medical records for 50 years.[50] The introduction of a fixed statutory period of retention is, in our opinion, not required in New South Wales. Our advice is that the inheritance by an AID child of a disease or abnormality will be known or apparent at birth or very shortly thereafter, except in the rarest of circumstances.[51] Such circumstances, if they do occur, are likely to result from human error or ignorance as much as scientific or medical error, for example, the semen donor is unaware that he carries a transmissible abnormality. We recommend that there be no fixed time limit for retention of records but that a procedure be provided whereby a record keeper may apply for permission or authority to dispose of records or transfer them to an acceptable custodian. A suitable source of such permission would be an Advisory Committee envisaged in Chapter 15 or a person or body nominated by the Minister for Health. The procedure should be broadly specified by statute and, if thought desirable, could include some principles of a general kind to assist decision making, and to guide potential applicants on the nature of the considerations that will justify an application. We are reluctant to make recommendations that add to the burdens and work-load of courts or involve expense and undue formality.

VI. RECORD KEEPER’S DUTY TO INFORM A PERSON AT RISK

13.32 In our Discussion Paper we devoted a separate chapter to the question whether a record keeper should be placed under a legal obligation or duty to seek out and advise parties to AI whose health is found to be at risk.[52] This possibility, which could arise from an unexpected abnormality or disease appearing in a donor or an AID child, has given concern to some Inquiries into artificial conception[53] and has been extensively discussed in this Commission. In order to ascertain whether our concern was well based or not, we sought the advice of a noted geneticist, Dr Gillian Turner of the Prince of Wales Children’s Hospital, Sydney, on the likelihood of the transmission of disease or abnormality by AI procedures.[54]

13.33 Dr Turner made the point that we have previously discussed, namely that taking a thorough and accurate history of a semen donor is an important step that would reveal and eliminate most risks.[55] She confirmed that there are very few conditions or diseases that can be transmitted by sperm that will not be revealed by taking a donor's history.[56] The risks are caused by donors who ought to know that they carry a disease or who deliberately provide false information or who simply are unaware that they carry disease.[57] However, Dr Turner made the telling point that the maintenance of records is likely to benefit the health of donors and their other offspring rather than AID children, because the AID children will have been born with their inherited characteristics. After considering the matter, we have concluded that the risks involved do not call for a specific legislative or statutory obligation. We are satisfied that any clinic or medical practitioner made aware of a risk or danger of this kind would normally take steps to advise the person at risk. Procedures to be followed are not a suitable subject for legislation, because every case will be governed by its own facts. The nature of the risk and the disease, and the sensitivity of the information should be taken into account when determining the most appropriate method of dealing with the problem. Our conclusion is that the decisions are essentially for the medical profession, and the profession must carry the discretionary power to determine what to say, when to say it and even whether to say it. Although we believe that in principle, a party who is at risk should be told, we recommend that no action be taken to create or impose by legislation, an obligation or duty on the part of the record keeper to seek out and advise a party to AI that he or she is under a risk to health. We also note that there could be circumstances in which a record keeper may be considered to be under a duty, based on existing common law principles, to communicate information.

VII. RETROSPECTIVITY OF LEGISLATION

13.34 In the event that the recommendations in this Chapter are accepted, consideration must be given to retrospectivity of the legislation. We have indicated that clinics and medical practitioners already follow the practice of recording information about the parties to AI and AID. It can therefore be expected that extensive records will be in existence when the legislation commences to operate. The legislation would confer on some persons rights of access to recorded information, and record keepers might be entitled and in some cases obliged to disclose information. Should those rights and obligations affect information already recorded?

13.35 The desirability of retrospective operation of a statute will depend on the circumstances. Parliament has power to enact legislation with retrospective effect if it chooses. The Artificial Conception Act 1984 directly provides for retrospective application by including in its ambit pregnancies occurring and children born both before and after its commencement.[58] No doubt the reason for this is that the statute is intended to confer benefits upon certain persons and protect their interests. Retrospectivity should not, in such cases, be objectionable. However, different considerations could arise in relation to newly created statutory rights, duties and obligations. A person who was a semen donor under an understanding or arrangement about anonymity made when the law was different, may well have a good ground of complaint concerning the compulsory supply of identifying information. However, as far as non-identifying information is concerned, we are of the view that application of the legislation to existing records is justified on the ground that it is intended to foster the welfare and health of AID children and other parties. We recommend that legislation conferring rights of access to certain recorded information apply to existing records.

VIII. SUMMARY OF RECOMMENDATIONS

Access to AI Records

(1) No person should have a legal right of access to information that may identify a party to AID and no record keeper should divulge such information, unless the person who is the subject of the information formally consents.[59]

(2) Information about any party to AI or AID that does not identify a person may be made available "for good cause" by a record keeper. In the event that agreement cannot be reached on "good cause" the matter should be determined by a person or body nominated by the Minister for Health. "Good cause"

should be defined or indicated by legislation and should be based, in principle, on the health and welfare of a party to AI or AID.

(3) The supply of information should not necessarily confer a right of access to or inspection of the records themselves.

Creating and Keeping Records

(4) All clinical records relating to AI and AID and to the parties to AI and AID shall be retained.

(5) The extent of the records, and their contents and the methods to be used to assist in preserving confidentiality and anonymity, are matters for good medical practice and should not be prescribed in a statute.

Who Should Keep Records

(6) Records should be created and kept by AI clinics and practitioners. There should be no establishment of an official or other central register.

Duration of Record Retention

(7) Records should be retained until such time as permission is lawfully given to dispose of all or some of them under principles and procedures envisaged by paragraph 13.31.

Record Keeper's Duty to Inform a Person at Risk

(8) No action should be taken to create or impose by legislation an obligation or duty on the part of a record keeper to seek out and advise parties to AI whose health is found to be at risk.

Retrospectivity of Legislation

(9) Information lawfully supplied pursuant to (1) and (2) above may include information recorded at the time the relevant legislation takes effect.

FOOTNOTES

1. United Kingdom Report, para 2.2.

2. S Cahill and S Suchy*, The Infertility Resources Handbook* (1981) at 13; A Stanway, *Why Us?* A Common-Sense *Guide for the Childless* (1980) at 12. See also Russell Scott, "Test Tube Babies, Experimental Medicine and Allied Problems" (1984) 58 *Australian Law Journal* 405 at 407, footnote 16.

3. Australian Bureau of Statistics, *Year Book Australia* 1980 (ABS Cat No 1301.0) at 105.

4. In 1982 there were approximately 3.5 million married couples in Australia. Assuming 10 to 15 per cent of those couples to be infertile, the incidence of persons who were partners in infertile marriages may be estimated at between 700,000 and 1,000,000: Australian Bureau of Statistics, Australian Families 1982 (ABS Cat No 4408.0) at 13.

5. Eva Learner, Part-time Commissioner, Manager of Human Resources in Staff Development (Bidura Remand Centre). See also Marshall Review Report.

6. Discussion Paper, ch 12.

7. *Id*, para 12.8.

8. Infertility (Medical Procedures) Act 1984 (Vic).

9. Victorian Report (1983), paras 3.29,3.30.

10. ss 19,21.

11. s 19.

12. s22.

13. Discussion Paper, paras 12.9-12.12.

14. *Id*, para 12.12.

15. The Commonwealth of Australia Constitution Act 1901 (Cth) s5l(xxi), (xxii).

16. Family Law Council Report, para 6.1.10.

17. *Id*, paras 6.3.11-6.3.13.

18. *Id*, para 6.3.2.

19. *Id*, para 6.3.1 1.

20. See para 13.4 above.

21. Family Law Council Report, paras 6.3.2, 6.3. 1 0.

22. ss 92(2), 93.

23. Discussion Paper, ch 12, footnote 5.

24. Marshall Review Report at 42,43,52 and 53.

25. Discussion Paper, para 12.3.

26. United Kingdom Report, para 4.22.

27. *Id*, para 3.2.

28. *Id*, para 4.12.

29. *Id*, para 4.21.

30. J Triseliotis, “Recent Developments in Adoption” (unpublished article, April 1980) at 13.

31. United Kingdom Report, para 13.9.

32. Ontario Report at 186.

33. *Id* at 187,188.

34. *Id* at 189,190 [our emphasis].

35. *Id* at 188.

36. Family Law Council Report, paras 6.2,6.4.

37. The medical practitioner may be guilty of “misconduct in a professional respect” if he or she does not make and keep medical records. See Medical Practitioners Act 1938 ss27,30.

38. Ontario Report at 78.

39. Australian Medical Association, *Code of Ethics* (1984 ed) at 11.

40. Discussion Paper, para 12.16.

41. Ontario Report at 185.

42. Id at 184 [our emphasis].

43. See G Sharpe and G Sawyer, *Doctors and the Law* (1978) at 116,117. The minimum extent of a medical record under Ontario legislation requires a practitioner to:

(a) keep a legibly written or typewritten record in respect of each patient..... setting out,

(I) the name and address of the patient,

(II) each date the [practitioner] sees a patient,

(iii) a history of the patient,

(iv) particulars of each physical examination of the patient by the [practitioner],

(v) investigations ordered by the [practitioner] and the results of the investigations,

(vi) each diagnosis made by the [practitioner] respecting the patient, and

(vii) each treatment prescribed by the [practitioner] for the patient;

(b) keep a day book, daily diary or appointment record setting out the name of each patient seen or treated or in respect of whom a professional service is rendered by the [practitioner].

See also C R A Martin, Law *Relating to Medical Practice* (2nd ed, 1979) at 1 12,113. In the United Kingdom, under the auspices of the National Health Service established by the National Health Service Act 1946, Terms of Service contained in National Health Service (General Medical and Pharmaceutical Services) Regulations 1974 lay down duties which require general practitioners to:

Keep records of illness of patient[s] and..... treatment of them, in prescribed form, [and to] forward them to [a] Committee when called for.

44. See Ch 15 below.

45. s19.

46. Ontario Report at 187.

47. Discussion Paper, paras 1. 11 - 1.15.

48. In support, see Ontario Report at 184-185.

49. Ontario Report at 80.

50. *Id* at 8 1.

51. Letter to Advisory Committee from Dr G Turner dated 12 August 1983.

52. Discussion Paper, ch 13.

53. See eg Ontario Report at 186.

54. Discussion Paper, paras 13.4,13.5.

55. *Id*, para 13.4.

56. *Ibid.*

57. Paras 5.14, 5.15 above.

58. s4(1).

59. A much more restricted view of the information that should be made available was that contained in the United Kingdom Report, para 4.2 1, which recommended restriction to “basic information about the donor’s ethnic origin and genetic health” to be made available to an AID child after reaching the age of 18.

14. Legal Liability of Medical Personnel, Donors and Recipients

I. INTRODUCTION

14.1 In this Chapter we address the question whether special legislative provisions should be enacted to impose duties upon AI practitioners, medical personnel, semen donors or recipients and their husbands. In relation to medical personnel, a related question asks whether they should be given specific legislative immunity or relief from legal liability if they act in good faith and without negligence when performing an act or duty imposed in relation to AI by the recommendations in this Report.

II. THE LEGAL POSITION

A. Relationships Created by AI

14.2 The relationships created by the practice of AID are numerous, as are the potential sources of complaint and damage. The former include those of doctor and patient, doctor and semen donor, doctor and spouse of patient (and spouse of donor), doctor and AI child (and AID child), parent and AID child, donor and recipient, and donor and AID child. This Chapter is concerned with civil liability and not with the creation of criminal or statutory offences which have been already dealt with in Chapter 5. For practical purposes we are concerned with the law of negligence although many disputes could arise that involve other common law principles such as those relating to trespass, battery and contract.

14.3 Our broad conclusion is that the existing common law and the judicial system should be left to deal with matters of civil liability. Although there appear to be no rules or principles of common law directed specifically to the liability of AI practitioners, there exist general duties, privileges and obligations applicable to the parties to AID and their relationships as is the case with other aspects of medical and professional practice and human relationships. The normal processes of litigation should be followed until inadequacy can be demonstrated.

14.4 In this context, some circumstances call for separate reference. These, in our opinion, are the following:

- actions for damages which have made their appearance with courts of common law countries in recent years and have been called “wrongful birth” claims and “wrongful life” claims;
- the legal relationship of doctors with semen donors;
- the protection of medical personnel.

B. Wrongful Birth and Wrongful Life

14.5 A typical claim for damages for wrongful birth will be made by a parent against a medical practitioner who has negligently carried out a sterilization operation or an abortion with the result that the claimant has become the parent of an unexpected or unwanted child. Success, if it results for the claimant, will come from application of the principles of the law of negligence or contract.[1]

14.6 The claim for damages for wrongful life[2] is a claim by a child for compensation for having been born at all. Such a claim has its origin in a negligent act by a medical practitioner as a result of which the child is born with disease or defect, for example, a child born with mental abnormalities because of a doctor’s negligent failure to diagnose rubella in the pregnant mother and advise her of the desirability of an abortion. The English courts have, to date, rejected such claims on public policy grounds, stating that it is unacceptable to give a person damages on the basis that the person would have been better off never to have been born at all. It is possible that Australian courts may take a similar view of such

claims, although it is to be noted that in the United States and Canada, claims of this kind have developed much further than in England.[3]

14.7 We have mentioned these claims because it is possible that they may increase and that related kinds of claim could appear. This could arise from rapid developments in recent years in the medical treatment of infertility and of embryos and fetuses *in utero*, as well as the obvious adaptability of the common law. In Australia, a court has already confirmed the legal liability of a negligent medical practitioner to a defective child born eight years after the negligent behaviour.[4]

14.8 This leads to the conclusion that the principles upon which the doctor's liability is based may be equally applicable to parents and to donors. We are aware of no Australian case in which a child has sued parents for damages resulting from breach of a duty not to cause birth defects. However, there appears to be no reason why such a claim could not be made and succeed. It is possible, by means of the same reasoning, to envisage a claim for damages by an AID child against its parents and the medical personnel involved in its conception, on a ground comparable with "wrongful life" or "dissatisfied life",[5] namely that they have caused the child to be born as a kind of social freak.[6] The Ontario Report came to a similar conclusion.[7]

14.9 Although the law in this area is obviously developing we do not regard any legislative initiative as necessary. The law is best left to the courts for determination. In the words of the Ontario Report:

> . . . the challenges presented by wrongful life and related claims cannot and should not be resolved within the four corners of a report on human artificial reproduction.[8]

We recommend that no action be taken to enact legislation to impose specific legal liability upon medical personnel, semen donors or parents to pay compensation for damages or injury resulting from AI or AID.

C. The Legal Relationship of Doctors with Semen Donors

14.10 In discussion of the legal liability of medical personnel in AI and AID one apparent anomaly arises, namely the relationship between the AI practitioner (or clinic) and the semen donor. The anomaly is "apparent" because although some people may believe that the donor is a patient, it seems plain that he is not.[9] However, it is reasonable to suggest that in some circumstances the donor is entitled to the same duties of confidentiality and anonymity as a normal medical patient. Because of these considerations and our analysis in paragraphs 8.6 to 8.13 we have recommended that the donor should be treated as though he is a patient for the purpose of record keeping[10] and that the law should impose upon AID practitioners and clinics the same obligation to observe confidentiality and give anonymity in relation to semen donors as medical practitioners have to patients.[11]

D. The Protection of Medical Personnel

14.11 If statutory obligations and duties are placed upon AI practitioners pursuant to this Report is it necessary or desirable to confer direct statutory protection from liability upon a person who acts in good faith to comply with the statute? Assume that an AID practitioner interviewed and tested a semen donor pursuant to a statutory requirement, but obtained diseased semen because the donor lied. Assume also that the practitioner acted in good faith and without negligence. Does he or she require specific statutory protection? We do not believe so. An act done in good faith and without negligence should be protected on ordinary common law principles. A statutory statement is unnecessary. Hence, we recommend that no action be taken to enact legislation to confer exemption from liability upon medical personnel who act in good faith and without negligence when performing an act or duty imposed by legislation in relation to AI or AID.

III. SUMMARY OF RECOMMENDATIONS

(1) No action should be taken to enact legislation to impose specific legal liability upon medical personnel, semen donors or parents to pay compensation for damages or injury resulting from AI or AID.

(2) No action should be taken to enact legislation to confer exemption from liability upon medical personnel who act in good faith and without negligence when performing an act or duty imposed by legislation in relation to AI or AID.

FOOTNOTES

1. *Sciuriaga v Powell* [1980] CA Transcript 597; *Udale v Bloomsbury Area Health Authority* [1983] 1 WLR 1098. The law on this subject is by no means settled. In a recent English decision, *Thake v Maurice* [1984] 2 All ER 513 Pain J accepted a claim for breach of contract relating to a filed vasectomy and awarded damages for the support of the resulting unplanned child to the age of 17. The plaintiff claimed that the defendant surgeon had given a collateral warranty that the surgery would make him irreversibly sterile, and that as a result he was induced to have the operation. This case is to be contrasted with previously reported claims for wrongful birth, which were founded in negligence. The decision was overturned on appeal: [1986] 1 All ER 497. The Court of Appeal held that as medicine was not an exact science, a doctor could not be regarded as guaranteeing the result of any operation or treatment. However, the plaintiffs were entitled to damages for distress, pain and suffering. See also Discussion Paper, paras 18.6-18.8, 19.3 and 19.4.

2. *McKay v Essex Area Health Authority* [1982] QB 1166. For some American decisions on “wrongful life” see J N Turner, “Family Solidarity in the Brave New World” (1982) 7(3) Australian Child and Family Welfare 16.

3. Ontario Report at 194-197.

4. *Kosky v The Trustees of the Sisters of Charity* [1982] VR 961.

5. Ontario Report at 195.

6. Discussion Paper, paras 19.3,19.4.

7. Ontario Report at 197.

8. *Ibid*. The developing nature of this area of law may be further illustrated by the report in October 1985 of an action in California by a woman who had been treated with infertility drugs and thereafter gave birth to seven babies from the same pregnancy, three of whom lived. She and her husband claimed damages of $4.5 (Aust) million from the medical practitioners who prescribed the drugs, alleging negligence and “wrongful death” by reason of bringing about the pregnancy: “Parents sue over too many babies” *Sydney Morning Herald,* 10 October 1985 at 9.

9. Paras 13.25, 13.26 above.

10. Para 13.28 above.

11. Para 8.13 above.

15. An Advisory Committee on AI

I. THE PROPOSED REGULATORY BODY

15.1 We expressed the view in our Discussion Paper that there is much to recommend the establishment of an official Advisory Committee on AI.[1] The committee that we favoured was one of limited membership, comprising mainly medical experts, possibly with one or two members who could provide advice on the law and on government policy. Its functions would be principally to work promptly with AI practitioners, helping with interpretation and application of broad statutory provisions and "good practice" recommendations, as well as recommending guidelines for good practice and collecting accurate information about AI in New South Wales.

15.2 We put a second option, which envisaged an Advisory Committee of a more general kind with a wider interdisciplinary membership. It would have a larger brief, extending to monitoring, advising and licensing along the lines recommended by recent Australian and overseas Inquiries.[2] Such a committee could be intended to maintain an overview of all aspects of artificial conception and not be limited to AI. We intend to give further attention to this subject in our reports on IVF and surrogate motherhood, including the practicality of such committees. Although the Commissioner-in-charge of this reference was, possibly, the original advocate in Australia of such a monitoring approach,[3] we believe that the costs and benefits to the Australian community of a plethora of state and federal monitoring and advisory committees on human reproduction and perhaps all biomedical advances must be carefully considered. It would not necessarily serve the public interest to create numbers of similar organisations with wide membership and little power as a substitute for dealing directly with the hard issues raised by the new biomedical technology.

II. OUR APPROACH TO AI REGULATION

15.3 We envisage an amount of direct statutory regulation of AI, but also put forward suggestions for broad statutory guidelines or statements of principle on a number of subjects and on many issues, we suggest that there should be no statutory regulation at all. Our proposals involve considerable reliance upon the medical profession and a policy of keeping statutory legal rules and traditional criminal sanctions and penalties to a minimum.

15.4 In the Discussion Paper we set out in some detail the reasons for our approach. These included:

> our satisfaction, after personally visiting each clinic in New South Wales and inquiring into its methods and results, that high professional standards have been maintained, satisfactory success rates achieved, and abnormalities in resulting children kept at a rate that is not higher, and may be lower, than with children born as a result of normal sexual intercourse;
>
> the absence of evidence of any practice in relation to AI on the part of hospitals or the medical profession that would be considered unacceptable to the community at large;
>
> evidence of community approval of AID as a treatment for infertility in marriage, and of community confidence in the practice of AI by the medical profession, particularly in public hospitals, as disclosed by the surveys conducted for the Advisory Committee on Human Artificial Insemination;
>
> the absence of evidence or reason to conclude that detailed legal regulation, licensing, statutory controls, sanctions and punishments are called for in New South Wales or are likely to produce better results in AI than have been produced by the medical profession itself. With the exceptions recommended in this Report we see no reason why AI should be subjected to detailed legal control any more than other normal aspects of medical practice;

our inability to suggest any benefit to New South Wales that would balance the cost of creating and policing a system of detailed regulation; and

the fact that all public hospitals offering AI have ethics committees capable of advising on ethical questions affecting medical practice within the hospital.

15.5 There are aspects of AI that are unusual. One is that AI is not therapeutic in the normal sense, but aims to produce the conception of a child. The tissue involved (semen) has a reproductive capacity. Another is that the subject evokes strong public feeling. Further, we believe that medical practitioners might sometimes welcome assistance with difficult decisions on the matters which we recommended should be left to them. Examples are the question of admission to AID programs (see Chapter 6) and screening and testing semen donors and semen (see Chapters 9 and 10). There is also the possibility that developments could change the significance of subjects that at present call for no legal resolution, such as sex predetermination and semen mixing. These considerations suggest to us that the scheme of regulation in this Report would be aided, or strengthened, by an official Advisory Committee.

15.6 We have, however, reached the conclusion that the creation of an Advisory Committee should not be recommended solely in relation to AI. The issues raised by in vitro fertilization and other forms of artificial conception, as well as surrogate motherhood, should also be considered before the final decision is made because those activities are also likely to call for the establishment of such a committee. If, as now seems likely, a substantial number of advisory committees are established by state and federal governments a need for co-ordination and co-operation will arise. This possibility reinforces our opinion that the final decision on a New South Wales Advisory Committee should be deferred until our reports on IVF and surrogate motherhood are completed.

FOOTNOTES

1. Discussion Paper, paras 23.3-23.6.

2. See eg Family Law Council Report, paras 7.8.2-7.8.5; United Kingdom Report, para 13.3: Queensland Report at 46-49.

3. See Russell Scott, “Legal Implications of In Vitro Fertilization and Embryo Transfer”, paper delivered at ANZAAS Congress (Sydney, May 1982).

Appendix A - Draft Legislation

I. Artificial Conception (Amendment) Bill 1986
II. Human Tissue (Amendment) Bill 1986

III. Children (Equality of Status) Amendment Bill 1986

I. ARTIFICIAL CONCEPTION (AMENDMENT) BILL 1986

NEW SOUTH WALES

TABLE OF PROVISIONS

ARTIFICIAL CONCEPTION (AMENDMENT) BILL 1986

NEW SOUTH WALES

A BILL FOR

An Act to amend the Artificial Conception Act 1984 with respect to human artificial insemination.

See also Human Tissue (Amendment) Bill 1986: Children (Equality of Status) Amendment Bill 1986.

BE it enacted by the Queen's Most Excellent Majesty, by and with the advice and consent of the Legislative Council and Legislative Assembly of New South Wales in Parliament assembled, and by the authority of the same, as follows:

Short Title

1. This Act may be cited as the "Artificial Conception (Amendment) Act 1986".

Commencement

2. (1) Sections I and 2 shall commence on the date of assent to this Act.

(2) Except as provided by subsection (1), this Act shall commence on such day as may be appointed by the Governor and notified by proclamation published in the Gazette.

Amendment of Act No.3, 1984

3. The Artificial Conception Act 1984 is amended in the manner set forth in Schedule 1.

SCHEDULE 1

(Sec. 3)

AMENDMENTS TO THE ARTIFICIAL CONCEPTION ACT 1984

(1) Long title-

After "artificial means;", insert "to regulate artificial insemination;".

(2) Part 1, heading-

Before section 1, insert:

PART 1

PRELIMINARY

(3) Section 2 **(Commencement)**-

Section 2 (2)-

Omit ", and a reference in this Act to the commencement of this Act is a reference to the commencement of the provisions of this Act, except those sections".

(4) Part 2, heading-

Before section 4, insert:

PART 2

ARTIFICIAL CONCEPTION- PRESUMPTIONS AS TO FATHERHOOD

(5) Section 4 **(Application of Part 2)**-

(a) Section 4-

Omit "this Act" where firstly, fourthly and fifthly occurring, insert instead "this Part".

(b) Section 4 (1)-

After "section 5" wherever occurring, insert ", 5A".

(6) Section 5A-

After section 5, insert:

Fertilisation procedure: presumption as to status of child of widow 5A. (1) A reference in this section to a fertilisation procedure is reference to-

(a) the artificial insemination of a woman; or

(b) the procedure of implanting in the womb of a woman an ovum produced by the woman and fertilised outside her body.

(2) Where-

(a) the husband of a married woman dies;

(b) the woman, after his death, undergoes a fertilisation procedure in accordance with his previous consent;

(c) the semen used for the fertilisation procedure was stored semen produced by the deceased husband;

(d) the woman becomes pregnant as a result of the fertilisation procedure and a child is born as a result of the pregnancy; and

(e) the woman does not become a married woman after his death and before the birth of that child,

the deceased husband shall be presumed, for all purposes, to have caused the pregnancy and to be the father of that child.

(3) An executor or administrator may distribute the assets of the testator or intestate without making any inquiries as to whether the testator or intestate has or may become the father of a child in the circumstances referred to in subsection (2).

(4) The presumption of law that arises by virtue of subsection (2)

is irrebuttable.

(5) In proceedings in which the operation of subsection (2) is relevant, a deceased husband's consent to the carrying out of a fertilisation procedure in respect of his wife shall be presumed, but that presumption is rebuttable.

(7) Section 6 **(Artificial conceptions: presumption as to semen donors)**-

(a) Section 6 (1)-

Omit ", in the case of a married woman,".

(b) Section 6 (3)-

After section 6 (2), insert:

(3) A reference in subsection (1) to the husband of a woman includes a reference to the deceased husband of the woman unless she becomes a married woman after his death and before the birth of the child concerned.

(8) Parts 3, 4-

At the end of the Act, insert:

PART 3

ARTIFICIAL INSEMINATION

Interpretation

7. (1) In this Part-

"artificial insemination" means the artificial insemination of a woman, but does not include, except in section 10, the procedure of implanting in the womb of a woman an ovum (whether or not produced by her) fertilised outside her body.

(2) For the purposes of this Part, the parties to any artificial insemination are-

(a) the donor of the semen used in the artificial insemination;

(b) the woman artificially inseminated;

(c) any child born as a result of the artificial insemination; and

(d) in the case of a married woman, her husband at the time of the artificial insemination unless he did not consent to the artificial insemination.

(3) In this Part, a reference to a donor, in relation to semen, is a reference to the person who produced the semen.

Practice of artificial insemination only by or under supervision of medical practitioners

8. (1) A person shall not carry on the practice of artificial insemination unless-

(a) the person is a medical practitioner; or

(b) the practice is carried on under the supervision of a medical practitioner.

Penalty: $2,000 or imprisonment for 6 months, or both.

(2) For the purposes of this section, a person carries on the practice of artificial insemination if-

(a) the person carries out a procedure of, artificial insemination for fee or reward; or

(b) the person advertises or holds himself or herself out as being prepared to carry out a procedure of artificial insemination.

Assessment by medical practitioners

9. (1) A medical practitioner shall, before carrying out a procedure of artificial insemination or authorising the carrying out of such a procedure, give due consideration to the following matters:

(a) whether, in respect of the woman concerned and any

partner-

(i) they are infertile; or

(ii) their children are likely to be affected by a genetic abnormality or disease;

(b) the welfare and interests of any child born as a result of the artificial insemination;

(c) the home environment and the stability of the household in which any such child would live;

(d) whether or not counselling is desirable;

(e) a prospective parent's physical and mental health, age and emotional reaction to artificial conception.

(2) A medical practitioner who contravenes this section is, for the purposes of section 27 (1) (c) of the Medical Practitioners Act 1938, guilty of misconduct in a professional respect.

Certificates from donors of semen relating to medical suitability of donors

10. (1) A person shall not obtain or receive any donor's semen intended for use for artificial insemination (other than for use for the artificial insemination of the donor's wife) unless the donor has,

at the time the semen is obtained or received, signed a certificate in or to the effect of the prescribed form relating to the medical suitability of the donor and had the signature witnessed by a prescribed person.

Penalty: $200.

(2) A person shall not use any donor's semen for artificial insemination (other than for the artificial insemination of the donor's wife) if the semen was obtained or received solely for another purpose unless the donor has, at the time or at any time after the semen is obtained or received and before it is used, signed a certificate in or to the effect of the prescribed form relating to the medical suitability of the donor and had the signature witnessed by a prescribed person.

Penalty: $200.

(3) Where a donor is required by this section to sign a certificate and have the signature witnessed and the donor is, by reason of illiteracy or physical incapacity, incapable of signing the certificate, the donor shall be deemed to have signed the certificate and had the signature witnessed in accordance with that requirement if-

(a) in the case of a donor who is illiterate but not physically incapable of signing- the donor makes his mark on the certificate and a prescribed person witnesses the making of the mark and certifies on the certificate that, before the mark was made, the nature and effect of the certificate were explained to the donor; or

(b) in the case of a donor who is physically incapable of signing- a person authorised to do so by the donor has signed the certificate on the donor's behalf and a prescribed person witnesses that signature.

False or misleading statements by donors of semen

11. A donor of semen shall not-

(a) knowingly sign, for the purposes of section 10, a certificate which contains any statement which is false or misleading in a material particular; or

(b) knowingly make any other statement (whether or not in writing) relating to the medical suitability of the donor which is false or misleading in a material particular.

Penalty: $5,000 or imprisonment for I year, or both.

Prohibition on trading in semen

12. (1) A person shall not enter into a contract or an arrangement for the sale or supply, for valuable consideration, of semen produced by that or any other person.

Penalty: $2,000 or imprisonment for 6 months, or both.

(2) Subsection (1) does not apply to or in respect of a contract or an arrangement providing only for-

(a) the payment to a donor for each donation of semen of an amount that does not exceed the maximum amount for the time being fixed by the Minister under subsection (3), or

(b) where no order is in force under subsection (3)- the reimbursement of any expenses necessarily incurred by a donor in connection with the donation of semen.

(3) The Minister may, from time to time by order published in the Gazette, fix the maximum amount that may be paid to a donor for each donation of semen.

(4) Where the expenses necessarily incurred by a donor in connection with a donation of semen exceed the maximum amount for the time being fixed by the Minister under subsection (3), the maximum amount so fixed shall, in respect of that donation of semen, be increased by the amount of that excess.

(5) A contract or an arrangement entered into in contravention of this section is void.

Control over donated semen

13. Semen donated to a person for use in artificial insemination may, subject to any agreement between the person and the donor, be used, stored or disposed of by the person in such manner as the person thinks fit.

Duty of confidentiality owed to all parties to artificial insemination

14. (1) A person who obtains information about any artificial insemination owes to all parties to the artificial insemination the same duty of confidentiality in respect of that information as a medical practitioner owes to a patient who is such a party in respect of information obtained in the medical practitioner's professional capacity.

(2) The duty of confidentiality owed by a medical practitioner to a patient who is a party to artificial insemination in respect of information obtained in the medical practitioner's professional capacity extends to all other parties to the artificial insemination, whether or not they are patients of the medical practitioner.

Disclosure of information about artificial insemination

15. (1) A person shall not disclose to any other person any information whereby the identity of any party to artificial insemination (whether living or dead) may become publicly known.

Penalty: $5,000 or imprisonment for I year, or both.

(2) Subsection (1) does not apply to-

(a) the disclosure of information with the consent of the person (not being a child) to whom the information relates;

(b) the disclosure of information among persons engaged in the administration or enforcement of this Part, if the disclosure is made in the course of their official duties;

(c) the disclosure of information among persons engaged in the administration of any hospital or other place where artificial insemination procedures are carried out or records relating to artificial insemination or the donation of semen are kept, if the disclosure is made in the course of their official duties;

(d) the disclosure of information for the purposes of medical research; or

(e) the disclosure of information required or authorised to be made by an order of a Judge of any court or a Magistrate in connection with any legal proceedings or the report of those proceedings.

(3) Nothing in subsection (2) authorises the further disclosure of information disclosed in accordance with that subsection unless that further disclosure is authorised by that subsection.

(4) In subsection (2) (a), "child" means a person who is under 18 years of age and who is not married.

Keeping of records relating to artificial insemination

16. (1) A person who carries on the practice of artificial insemination (within the meaning of section 8) shall, subject to the regulations, keep clinical and other records relating to the parties to artificial insemination.

Penalty: $200.

(2) Without affecting the generality of subsection (1), the regulations may-

(a) provide for the keeping of certificates given under section 1 0; and

(b) provide for the disposal or transfer of records.

Access to non-identifying information relating to artificial insemination

17. (1) In this section, "non-identifying information" means information relating to artificial insemination, but does not include information whereby the identity of any party to artificial insemination might become publicly known.

(2) A person is entitled to be supplied with non-identifying information in any records relating to artificial insemination if-

(a) the person has good cause to be supplied with the information; and

(b) the information is supplied by agreement with the person having custody of those records or by direction of an authorised officer.

(3) For the purposes of this section, a person has good cause to be supplied with non-identifying information if the person who agrees to supply the information or the authorised officer who directs that the information be supplied is satisfied that the supply of the information is in the interests of the health and welfare of a party to artificial insemination.

(4) In this section-

"authorised officer" means a person for the time being authorised by the Minister for the purposes of this section;

"records" includes records made before the commencement of this section.

PART 4

MISCELLANEOUS

Proceedings for offences

18. Proceedings for an offence against this Act or the regulations shall be dealt with summarily before a Local Court constituted by a Magistrate sitting alone.

Regulations

19. (1) The Governor may make regulations, not inconsistent with this Act, for or with respect to any matter that by this Act is required or permitted to be prescribed or that is necessary or convenient to be prescribed for carrying out or giving effect to this Act.

(2) A regulation may create an offence punishable by a penalty not exceeding $500.

(3) A provision of a regulation may-

(a) apply generally or be limited in its application by reference to specified exceptions or factors;

(b) apply differently according to different factors of a specified kind; or

(c) authorise any matter or thing to be from time to time determined, applied or regulated by any specified person or body;

or may do any combination of those things.

II. HUMAN TISSUE (AMENDMENT) BILL 1986

NEW SOUTH WALES

TABLE OF PROVISIONS

HUMAN TISSUE (AMENDMENT) BILL 1986

NEW SOUTH WALES

A BILL FOR

An Act to amend the Human Tissue Act 1983 to omit provisions relating to the donation of semen as a consequence of the enactment of the Artificial Conception (Amendment) Act 1986.

BE it enacted by the Queen's Most Excellent Majesty, by and with the advice and consent of the Legislative Council and Legislative Assembly of New South Wales in Parliament assembled, and by the authority of the same, as follows:

Short Title

1. This Act may be cited as the "Human Tissue (Amendment) Act 1986".

Commencement

2. (1) Sections I and 2 shall commence on the date of assent to this Act.

(2) Except as provided by subsection (1), this Act shall commence on the commencement of the Artificial Conception (Amendment) Act 1986.

Amendment of Act No. 164, 1983

3. The Human Tissue-Act 1983 is amended in the manner set forth in Schedule 1.

SCHEDULE 1

(Sec. 3)

AMENDMENTS TO THE HUMAN TISSUE ACT 1983

(1) Section 4 **(Interpretation)**-

(a) Section 4 (2A) (a)-

Omit "and semen".

(b) Section 4 (2B)-

After section 4 (2A), insert:

(2B) In this Act, a reference to tissue does not include a reference to semen.

(2) Section 6 **(Interpretation)**-

Omit ", semen".

(3) Part IIIA, heading-

Omit "OR SEMEN"..

(4) Section 21A-

Omit the section, insert instead:

Interpretation

21A. In this Part, a reference to a donor, in relation to blood, is a reference to the person from whose body the blood has been removed.

(5) Section 21B **(Application of Part)**-

Section 21B (2)-

Omit the subsection.

(6) **Section 2lC (Certificates by donors)**-

(a) Section 21C (1), (2)-

Omit the subsections, insert instead:

(1) A person shall not remove any donor's blood intended-

(a) for the purpose of its tranfusion; or

(b) for the purpose of its use, or the use of any of its constituents, for therapeutic purposes, or for medical purposes or scientific purposes,

unless the donor has, at the time of the removal of the blood, signed a certificate in or to the effect of the prescribed form relating to the medical suitability of the donor and had the signature witnessed by a prescribed person.

Penalty: $200

(2) Where blood has been removed solely for a purpose referred to in section 21B (1), a person shall not subsequently use the blood for any purpose other than a purpose referred to in section 21B (1) unless the donor has, at the time of or at any time after the removal of the blood and before the use of

the blood, signed a certificate in or to the effect of the prescribed form relating to the medical suitability of the donor and had the signature witnessed by a prescribed person.

Penalty: $200.

(b) Section 21C (3)-

Omit "or a person of a prescribed class" wherever occurring.

(7) Section 34 **(Act does not prevent specified removals of tissue, etc.)**-

Section 34 (2)-

Omit "or the obtaining or receipt of semen".

III. CHILDREN (EQUALITY OF STATUS) AMENDMENT BILL 1986

NEW SOUTH WALES

TABLE OF PROVISIONS

CHILDREN (EQUALITY OF STATUS) AMENDMENT BILL 1986

NEW SOUTH WALES

A BILL FOR

An Act to amend the Children (Equality of Status) Act 1976 as a consequence of

the enactment of the Artificial Conception (Amendment) Act 1986.

BE it enacted by the Queen's Most Excellent Majesty, by and with the advice and consent of the Legislative Council and Legislative Assembly of New South Wales in Parliament assembled, and by the authority of the same, as follows:

Short Title

1. This Act may be cited as the "Children (Equality of Status) Amendment Act 1986".

Commencement

2. (1) Sections 1 and 2 shall commence on the date of assent to this Act.

(2) Except as provided by subsection (1), this Act shall commence on the commencement of the Artificial Conception (Amendment) Act 1986.

Amendment of Act No. 97, 1976, s.18A (Effect of Artificial Conception Act 1984)

3. The Children (Equality of Status) Act 1976 is amended by inserting in section

18A after the matter "section 5" wherever occurring the matter "or 5A".

Appendix B - Internal Research Papers

1. Supplying False Information on Birth Certificates in Relation to AID.	December 1983
2. Comment on W Wadlington, "Artificial Conception: The Challenge for Family Law" (1983) 69 *Virginia Law Review* 465.	January 1984
3. AID Numbers.	February 1984
4. Comment on A Jensen, "Record-keeping in Relation to Artificial Insemination by Donor," paper prepared for Advisory Committee on Human Artificial Conception.	February 1984
5. Wrongful Birth and Wrongful Life: Medico-legal Responsibility in Obstetrics.	March 1984
6. The History of Human Artificial Insemination.	March 1984
7. Statement of Legislation Affecting AID in Australia.	April 1984
7A. Death, Donor Tissue and Jurisprudence	April 1984
8. Bioethics: Experimental Medicine: Legal Implications.	April 1984
9. Comment on Comparison of Australian and Overseas Committees' Views on Issues Affecting Artificial Insemination.	July 1984
10. Artificial Insemination by Donor: Record-Keeping.	December 1984
11. Regulating Artificial Conception: Will the Law Do Better than the Doctors?	May 1985
12. Informed Consent.	August 1984
13. Moral Status of the Embryo.	February 1985

14. Legal Issues in IVF.	March 1985
15. Transmission of Diseases and Defects.	May 1985
16. Doctor's Right to Refuse or Discontinue Treatment.	June 1985
17. Current Statistics on Infertility and Difficulties in Their Analysis.	July 1985
18. Eligibility Criteria for Selection into IVF Programs (Apart from Marital Status).	July 1985
19. Eligibility for IVF and Marital Status.	July 1985
20. Microsurgery and IVF.	August 1985
21. Lawmaking and the Tradition called Surrogate Motherhood	September 1985
22. The Paramount Welfare of the Child	August 1985

Appendix C - Table of Statutes

Australia
Commonwealth

Commonwealth of Australia Constitution Act 1901	2.6, 13.10
Family Law Act 1975	2.6, 2.7, 2.9, 3.10, 13.10
Family Law Amendment Act 1983	2.6
Marriage Act 1961	2.6
Marriage Amendment Act 1985	2.6
Racial Discrimination Act 1975	6.7
Sex Discrimination Act 1984	6.7

New South Wales

Adoption of Children Act 1965	3.10
Anti-Discrimination Act 1977	6.5, 6.7
Artificial Conception Act 1984	2.6, 2.9, 4.1, 5.7, 6.3, 7.6, 7.8, 9.18, 10.12, 11.1, 11.2, 11.4, 12.2, 12.13, 13.21, 13.35
Children (Equality of Status) Amendment Act 1984	2.8, 9.22, 13.21
Crimes Act 1900	11.1
De Facto Relationships Act 1984	3.14
Family Provision Act 1982	12.6, 12.10, 12.11
Human Tissue Act 1983	5.18, 8.2, 10.1, 10.2, 10.3, 10.5, 10.7, 10.8, 10.9
Human Tissue (Amendment) Act 1985	5.2, 5.14, 5.17
Medical Practitioners Act 1938	5.11, 6.6, 6.14, 13.25, 13.28, 13.30
Public Hospitals Act 1929	5.11, 6.10
Registration of Births, Deaths and Marriages Act 1973	11.1

Queensland

Transplantation and Anatomy Amendment Act 1984	5.15

South Australia

Family Relationships Act Amendment Act 1984	2.12, 6.8
Sex Discrimination Act 1975	6.7, 6.8

Tasmania

Status of Children Amendment Act 1985	2.13

Victoria

Adoption Act 1984	13.3, 13.12
Infertility (Medical Procedures) Act 1984	2.10, 2.11, 4.1, 5.18, 6.4, 7.4, 7.12, 8.3, 9.16, 9.19, 13.8, 13.21, 13.28, 13.30
Equal Opportunity Act 1977	6.7
Equal Opportunity (Discrimination Against Disabled Persons) Act 1982	6.7
Health Act 1958	5.15
Infectious Diseases (Donors) Regulations 1985	5.15
Status of Children (Amendment) Act 1984	2.9, 2.12, 2.13, 13.21

Western Australia

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Blood and Tissue (Transmissible Diseases) Regulations 1985	5.15
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Australian Capital Territory

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Blood Donations (Acquired Immune Deficiency Syndrome) Ordinance 1985	5.15

Northern Territory

Status of Children Amendment Act 1985	2.13

Overseas

Canada

Canadian Charter of Rights and Freedoms, being Part I of the Constitution Act, 1982	6.7, 6.8

Appendix D - Table of Cases

Appendix E - Select Bibliography

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Appendix F - Schedule Of Organisations And Persons Who Made Submissions

I. Written Submissions to this Commission.
II. Written Submissions to the Advisory Committee on Human Artificial Insemination.

III. Oral Submissions to this Commission at Public Hearing.

I. WRITTEN SUBMISSIONS TO THIS COMMISSION

S1 Social Issues Committee, Anglican Diocese of Sydney

S2 Australian Huntington's Disease Association

S3 Concern

S4 Foundation Genesis

S5 Hobbes, Mrs

S6 IVF Friends (1)

S7 IVF Friends (2)

S8 Knights of theSouthern Cross

S9 National Council of Women

S10 People Concerned about Adoption

S11 Presbyterian Women's Association (1)

S12 Presbyterian Women's Association (2)

S13 Privacy Committee (NSW)

S14 Sinclair, Mrs E

S15 Steigrad, DrS

S16 Tonti-Filippini, Mr N

S17 Wall, Mrs J (1)

S18 Wall, Mrs J (2)

S19 Wilkey, Dr I

S20 Women's Electoral Lobby (SA)

S21 Woolridge, Ms

S22 Confidential (mother of AID child)

S23 Confidential (donor)

S24 Council of Churches

S25 Women's Action Alliance

S26 Presbyterian Church of Australia

S27 Craig, Dr S

S28 Dubow, Y

S29 Council for Civil Liberties

II. WRITTEN SUBMISSIONS TO THE ADVISORY COMMITTEE ON HUMAN ARTIFICIAL INSEMINATION

(PERMISSION TO USE GRANTED)

SAl Apple, Rabbi R

SA2 Australian Medical Association (NSW)

SA3 Church & Nation Committee, Presbyterian Church in NSW

SA4 Country Women's Association (NSW)

SA5 Don, Dr R and Johnson, Dr T

SA6 Family Life Movement of Australia

SA7 Fertility Society of Australia

SA8 Foundation Genesis

SA9 Friedman, Dr S

SA10 Hill, Dr J

SA11 Confidential (doctor, USA)

SA12 Jakobovits, Sir I

SA13 Mason, Dr B

SA14 Matthews, Dr C

SA15 Right to Life Association (NSW)

SA16 Social Issues Committee, Anglican Diocese of Sydney

SA17 Social Responsibilities Commission, Anglican Church of Australia

SA18 Uniting Church of Australia

SA19 Women's Electoral Lobby (NSW)

III. ORAL SUBMISSIONS TO THIS COMMISSION AT PUBLIC HEARING

PH1 Robertson, Dr S

PH2 Woolridge, Ms S

PH3 McDonald, Ms M

PH4 Brown, Ms M

PH5 Johnson, Dr T

PH6 Moore, Ms P

PH7 Coombs, Miss J

PH8 Jordan, Ms A

PH9 Smith, Mrs M

PH10 Burton, Dr B

PH11 Claxton, Dr R

PH12 Steigrad, Dr S

PH13 Tonti-Filippini, Mr N

PH14 Dawson, Dr E

PH15 Mayger, Mr J

PH16 Scott, Mrs K

PH17 Scott, Mr P

PH18 Wall, Ms J

PH19 Brinsmead, Dr M

PH20 Smith, Ms C

PH21 Leong, Mr J