LECTURE ON REPRODUCTIVE TECHNOLOGY

Victoria University of Technology, St. Albans.

NOVEMBER 4, 1992.

Dr. Christine Ewing

The new reproductive technologies such as in vitro fertilization (IVF) have been a source of intense debate in Australia for more than a decade. It is now 15 years since the birth of the world's first test-tube baby, Louise Brown, in Britain. Her "creators", Patrick Steptoe and Robert Edwards, received world acclaim. More than 5,000 children have been born in Australia through IVF. IVF is now called routine procedure in the treatment of infertility and is supported by Medicare rebates of about $25 million per year, as well as hundreds of thousands of dollars for associated research. The media stories about new developments ("world firsts") in IVF is most often sensationalized and focused on the "success stories" and "miracle babies". However most women who go through IVF will not have a baby.

IVF is by no means a simple procedure. It involves the administration of drugs and hormones to cause superovulation, (i.e., the ovaries produce more than the normal one egg per ovulation cycle), there are blood tests to monitor the timing of ovulation, surgical procedures to collect the mature eggs, there is anxiety and emotional strain. Some IVF clinics encourage women to have at least five attempts to increase the chances of success, and some women go through considerably more than 5 treatment cycles. And how successful is IVF? It is in fact a procedure with a very low success rate. IVF success rates are often described by the clinics in terms of pregnancy per treatment cycle, but not all pregnancies are carried to term. There is a high pregnancy failure rate with a 23% spontaneous abortion rate - about 20% of these are miscarriages beyond the 12th week of pregnancy. Official statistics from the National Perinatal Statistics Unit (NPSU) put the average success rate of IVF at 9 % live births per treatment cycle (NPSU, 1991).

There are potential health risks associated with the use of superovulatory drugs such as chlomiphene citrate (reviewed by Klein/Rowland, 1988). A serious adverse effect of superovulation is ovarian hyperstimulation syndrome, which can have potentially life-threatening consequences if not monitored correctly (Barlow, 1988).

OHSS

Another superovulatory drug, buserelin, works by "desensitizing" the pituitary gland in the brain and blocking the natural production of hormones that induce ovulation. This puts the woman into a state of (reversible) menopause. She is then given other hormones, such as human chorionic gonadotrophin (hCG) to induce the ovulation that has previously been blocked. These types of drug regimes are preferred by the IVF teams because it makes the woman's cycle artificial. Ovulation and egg collection can be timed for convenience - of the medical staff ("never on a Sunday"). Marcia O'Keefe from Melbourne spoke recently on television current affairs programmes of her experience with buserelin and hCG. She was part of an experimental trial with buserelin, and subsequently developed severe and uncontrolled hyperstimulation syndrome. Her abdomen swelled up and her weight increased from 48 kg to 61 kg in 4 days. Marcia was hospitalised - she was extremely ill and her husband thought she was going to die. Four months later Marcia was diagnosed with breast cancer - she believes that the IVF procedures may have played some role in this. Marda was never informed by the IVF clinic staff about hyperstimulation syndrome as an adverse effect.

There are some other medical case reports of women developing cancers following the administration of superovulation drugs and hormones (Klein/Rowland, 1988), although no causal link has been established. Some women have also reported the development of ovarian cysts after superovulation (Klein, 1989). Other effects include nausea, headaches, depression, dizziness and visual problems (Klein/ Rowland, 1988). The potential health risks of superovulation for women are a cause of increasing concern, rather than a diminishing one. Also, the long-term effects of superovulation on women, or on their offspring are not known.

Sydney children with rare forms of cancer

Use of Clomid among Aboriginal women

I recently received an article from an Aboriginal woman living in WA about the administration of both Clomiphene and Depo Povera to Aboriginal women living in remote communities in WA.

I would like to read to you some of the article:

Clomiphene use in remote areas includes the following instances. Aboriginal women from one extremely remote location were transported over a long distance to a larger centre by the nurse. The women were seen there by gynaecologist who visited from the capital city on an infrequent basis. Clomiphene was "freely prescribed" by the gynaecologist. The explanation given to the women was that the drug would "help them get pregnant".

In 1990, at another remote area Aboriginal community three Aboriginal women were prescribed clomiphene for 'fertility problems'. Courses of Clomiphene were prescribed over a period of time by a visiting general medical officer. The nurse stated that to her knowledge there was no investigation of the women's male partners for fertility (problems).

In 1991, at one of Australia's most remote locations a 24 year old Aboriginal woman was prescribed a six month regime of clomiphene.

In these reports nurses stated that women patients were not fully informed of the extent of potential side effects or risks of clomiphene.

Clomiphene is supplied to the remote area health centre from a central pharmacy. The nurse is expected to administer the drug according to medical prescription. In at least one area clomiphene is dispensed from the pharmacy as a 'chronic medication'. One regimen administered to Aboriginal women in remote areas was 50 mg clomiphene tablet daily for five days (days 5-9 of the menstrual cycle), and repeated over a six month period.

A written medical protocol for Aboriginal women promotes clomiphene as 'ovulation induction' that 'can be done in (the) community', The protocol also states that Clomid tablets may help' when women are not ovulating but where their fallopian tubes are the sperm of their male partner are satisfactory.

The woman who gave me this article made a general enquiry about clomiphene use to the head of a pharmacy department. This pharmacist stated that, “Clomid is approved under the Australian Drug Evaluation Committee for release under specific curcumstances. Clomid can only be used by a limited list of gynaecologists who are expert in that field, for patients under their supervision”. The pharmacist added, “Clomid is a fairly potent drug and inappropriate use can give rise to multiple births”, Despite the rules clomiphene was used on Aboriginal women living in remote areas of this state.

Registered nurses in remote areas who were spoken to often relied on medical communications for their knowledge of clomiphene. These nurses were underinformed of the severity of side effects and unaware of the restrictions to the presciption of clomiphene under the Poisons Act in each state and territory. Medical practitioners only visit the remote area community for a fortnightly, or even monthly, clinic. Nurses alone living on site have sole responsibility for administration of clomiphene, and by implication, the observation of woman’s responses to the drug and any suspected adverse drug reactions.

The use of Depo Provera on Aboriginal women in remote areas has been promoted over several years. This is despite information alerting medical prescribers to the adverse side effects, long term inplications, and the Australian Drug Evaluation Committee’s non-approval of Depo Provera as a contraceptive.

Depo Provera is supplied to health centres in remote areas by central pharmacies. A nurse at one remote location stated that while she was employed there 27 women were prescribed Depo Provera by a visiting medical practitioner, but added, “the doctor rarely sees the patient”. The nurse usually has the responsibility for informing the client, obtaining her consent, and administering Depo Provera. Many Aboriginal women receiving Depo Provera were under 30, and some less than 20, years of age.

In 1988 a National Aboriginal and Islander Health Organisation spokeswoman criticised the use of Depo Provera claiming that “It is a form of genocide as far as we’re concerned.” At the same time another woman, director of an Aboriginal health service in Tennant Creek, believed that many Aboriginal women were given Depo Provera without their informed consent, and also claimed that following treatment some women still of child bearing age has never had another child (*The Australian* May 31, 1991, p 16; Australian Government Printing Service, 1989, p. 184).

Back to the other medical implications of IVF

Usually, several embryos (perhaps 3 or 4) are transferred back to the woman's uterus to increase the chance of a pregnancy. This means that there is a higher incidence of multiple births among IVF births. There are also higher rates of premature births and low birth-weight babies who require intensive neonatal care. There is a greater than average use of caesarian section (about 43%), and increased rates of ectopic pregnancies (NPSU, 1991).

Egg collection carried out under general anaesthetic also has risks. In Perth , two women died during 1988 and 1989 whilst undergoing laparoscopy to collect eggs from their ovaries. The death of the second woman in Perth was described as an "unfortunate coincidence" by Dr. Bruce Bellinge, clinical spokesman for the IVF unit (*The Age*, 25.4.88). In evidence given to the coroner at the inquest, it was leamt that the anaesthetist accidentally turned off the oxygen supply to the woman, giving her a dose of pure nitrous oxide - apparently he was distracted by a conversation at the time. A finding of "therapeutic misadventure" was handed down by the coroner in November, 1988 (*The Age*, 29.11.88).

In the majority of cases, IVF offers a false hope - most women who undergo IVF in the expectation of having a child and who have endured the physical and emotional risks of the procedures will in the end be disappointed. Dr Renate Klein, of Deakin University interviewed 40 women who dropped out of IVF programmes in Melbourne. They spoke of both their physical and emotional experiences, and some of the accounts clearly depict their feelings of exploitation, loss and despair (Klein, 1989). One woman said:

> When I was told after the third attempt that my eggs weren't good enough and that I should give up, I was shocked and utterly devastated. I remained deeply depressed for more than a year and I was suicidal a lot of the time. I felt such an abysmal failure, a barren women unable to give my husband a child.

IVF was originally used for women with blocked Fallopian tubes, since in such cases there was no way in which her egg could be fertilized in her own body following ovulation. However the indications for IVF have expanded way beyond that and many women now on IVF programmes are not themselves infertile. A significant number of women on IVF are there because of male factor infertility, i.e., their partner's infertility. In some of these cases, eggs are fertilized by a procedure called microinjection where a single sperm is injected into an egg. Some women on IVF have unexplained (idiopathic) infertility.

In Britain, IVF is now being used clinically as a form of prenatal diagnosis, for couples who have a risk of passing on conditions such as cystic fibrosis. Using a technique called embryo biopsy, embryos are genetically screened before they are implanted back into the woman's uterus. shift away from infertility using IVF for genetic survey.

This procedure has developed as a result of experimentation and research using human embryos. The debate about embryo experimentation often focuses on concerns that embryos are human beings or potential human life. However, embryos can only be obtained by fertilizing eggs taken from women who have been superovulated, and therefore embryo experimentation relies on this continuing supply of eggs. Any discussion of the ethics of embryo experimentation should take place in this context of how women's eggs are obtained (Ewing, 1989).

Victoria was the first locality in the world to enact legislation to regulate reproductive technology procedures for the so-called treatment of infertility, and also to regulate experimentation on human embryos.

One technique being developed for screening embryos for genetic abnormalities is called embryo biopsy. It involves removing one cell from an early embryo of say 8 cells and analysing the genetic material from that cell to determine whether the embryo is carrying genetic or chromosomal aberrations. The remainder of the embryo is presumably able to develop normally. The intention of embryo biopsy is to test for genetic defects in human embryos, before transferring them to "patients" on IVF programmes (Pirrie, 1989). Embryo biopsy is a way of performing quality control tests on embryos prior to implantation and I believe that underlying rationale is a eugenic one. Embryo biopsy is a method of genetically screening which embryos are implanted and therefore which babies

are born. The outcome of a pregnancy where a biopsied embryo is used for implantation will only be known when the woman gives birth to the child. The only way to test whether a biopsied embryo will develop normally is to follow its development *in utera* This constitutes experimentation on the woman. It is unethical to offer such an experimental procedure to a woman even though she may have given her consent. It is also an experiment on the potential child.

Femaleness as a genetic defect

The first tests on early human embryos that involved determining the sex of the embryo by analysing the chromosomal makeup of one cell that had been removed from the embryo. While scientists have maintained that the sexing of embryos applies to cases of sex-linked genetic disease, clearly it offers the opportunity for selection of embryos solely on the basis of sex. Dr. John West, from the Edinburgh team which developed the first test for sex determination of human embryos said that it would not be ethical to use the test for sex determination, but he admits, “we couldn’t prevent the technique from being used in that way” (Johnston, 1987: 547). There is no clause under the current Victorian Infertility Act that would prevent the screening of embryos solely for the purpose of sex determination, followed by implantation of such embryos into women. Sex determination of embryos solely for that purpose is then the point at which femaleness becomes a genetic defect. Here we should be mindful of the fact that IVF technology developed in Australia and other Western countries has been exported around the world, often through private companies. For example there are IVF clinics in countries such as India. We already know that in some countries, female foetuses are aborted in their thousands. Following the introduction of amniocentesis into India in 1975, it rapidly became a commercially available test used almost exclusively for sex determination, followed by selective abortion of female foetuses. It is estimated that 78,000 female foetuses were aborted in India between 1978 and 1983 (Forum Against Sex Determination and Sex Pre-Selection, Bombay, India). This practice, combined with the long legacy of female infanticide, has lead to an alarming decrease in the ratio of females to males in India. I could only see that the use of embryo biopsy would streamline such a process, and indeed embryo biopsy has put forward as a superior alternative to amniocentesis followed by selective abortion. There are many male preferring societies, including Western societies, and female feticide is practiced in Western countries too, albeit disguised. A newspaper report from Sydney in 1988

revealed that foetuses of a sex unwanted by the parents were being aborted following chorion villus biopsy tests (West (ed), 1988). Similarly, in Britain there have also been reports of selective termination of foetuses following amniocentesis based on learning their sex (Hulten, et al. 1987).

The idea that IVF can be used to produce "quality" babies has implications for disabled/differently abled people who already exist. It implies that their lives are of less value and that technology can prevent such people from being born. This will ultimately intensify the stigma attached to disabled people. Ironically, the majority of disabilities are not genetic or congenital in origin. Couples who carry hereditary disorders can participate in the IVF programme in order to have embryos screened for abnormalities and this implies that IVF is a cure for disability. If these technologies were to become further entrenched, people who carry hereditary disorders could be pressured into using IVF combined with embryo biopsy - otherwise, they may be labelled irresponsible. Thus these technologies reflect the values of our society which does not seek to deal with the issue of disability, but rather eliminate it.

Maturation of immature eggs

Immature oocytes which are matured *in vitro* can be fertilized and then used in experiments. Experiments on the maturation of human ova cells *in vitro* are being undertaken in IVF units in Australia. In this process, immature egg cells would be taken from an ovary and matured in culture in the laboratory (one ovary containing several hundred thousand immature eggs). Once this technique has been 'perfected', ovaries, or pieces of ovarian tissue, will suffice to produce large numbers of mature eggs for fertilization, to be then used for experimentation, or fertilized and then implanted in women. This would allow control by scientists over human reproduction in an unprecedented way - even ovulation would no longer be seen as relevant to the reproductive process. The production of such large numbers of eggs and, potentially, embryos would allow virtually limitless screening of embryos for 'defects', or the production of unlimited numbers of embryos to be used in other kinds of experimentation.

A couple may see as the opportunity to have their embryos genetically screened before implantation, but the implications of these techniques go beyond the individual case. We also have wider social responsibilities to consider. The IVF technology being developed in Australia is being exported to many other countries. The recent announcements that Monash University plans to set up IVF clinics in Asian countries brings some very sobering implications with it. How will IVF and embryo biopsy be applied in countries like China, where as Dr. Hetzel from Infertility Medical Centre has said: "If you could guarantee sons in China you would be a billionaire"?

Commercialization of IVF

MONASH UNIVERSITY TO SET UP IVF CLINICS IN ASIA

Monash University's Infertility Medical Centre is negotiating to supply IVF technology to Asian nations in what may be the beginning of a multimillion dollar export trade (Deborah stone, *The Age*, March 22, 1992).

The centre's chief executive, Dr. Robert Hetzel said he expected that the first clinic would be operating within a year, probably in Japan, Taiwan or Korea. The clinics would operate independently using local doctors, donors and management but would depend on Australia for the development of new techniques. The centre currently has a Japanese clinical research fellow, Dr. Keijiro Azumo here for a two year study of common factors which dispose to successful embryo implantation in women.

Dr. Hetzel will visit Taiwan, Korea. Malaysia, Japan, Indonesia, Hong Kong, and possibly China within the next few months to decide where the initial drive should be concentrated. All profits will go to the Infertility Medical Centre which is owned by Monash University and the Centre for Early Human Development. Dr. Hetzel said there were clearly enormous business opportunities for the export of medical technology to Asia and a definite demand for infertility services.

The export of IVF technology from Australia began in 1986 with the establishment of IVF Australia, an North American-based company which uses technologies developed through Monash University. That venture is now the biggest IVF business in the United States, providing 1500 treatments at 6 centres and reaping hundreds of thousands of dollars for Australian research. Dr. Hetzel said Asia was a potentially larger market than the US, and could also provide valuable joint research and university ventures.

Social Issues; Donation of Gametes

There are also social and human issues raised by the use of donor gametes in reproductive technology programmes. The experience with adoption has shown that for many adopted people, access to information about their natural parents is of great

importance as it is connected with issues of identity, belonging, acceptance and loss. The use of donor gametes seems to offer infertile couples an uncomplicated solution but it creates confusion about who are the parents. Some women who have had children, conceived using donor eggs, have a continuing sense of infertility. There are concerns that the trauma created by the secrecy surrounding adoption in the past may be repeated in the case of children boom as a result of the use of donor gametes due to the lack of public records that donor eggs or donor sperm were used. In Victoria records of gamete donors are required to be entered into a Central Register in the Health Department, however as yet the register remains blank.

The Act provides clauses which seek to record the use of donated gametes for creating children, but the legislation is wholly inadequate in the area of allowing any access to this information. In this respect, it is out of step with legislation in related areas such as adoption. Since 1984, adopted people, natural parents, adoptive parents and certain other categories of relatives have been able to apply for identifying information about other parties. Knowledge of this information is of great importance as it is connected with issues of identity, belonging, acceptance and loss. The regime of closed adoption, which sought to bury these issues through secrecy, has been shown to have failed to solve these problems -instead it has preserved and exacerbated them. For instance, closed adoption has undermined the degree to which adoptive parents have been able to come to terms with their role as adoptive parents and to work out how this relates to the role of the other parents. This issue can remain in limbo for many years until it becomes critical should the adopted daughter or son be reunited with the natural family. The degree to which a person's infertility can be 'alleviated' (in the words of the Act) by the opportunity to parent a child who is not their own genetic offspring is highly variable.

These human issues are disguised in programs which use donor gametes (both donor insemination and IVF), as they medicalise the process of conceiving a child. The technologies create divisions between kinds of parents. They fragment and multiply the number of parents of one child. This may not be considered unethical by itself. What is unethical is the attempt, implicit in the Act, to distort the truth and deceive a person conceived using donor gametes that they are in fact the "natural" child of their legal parents. The government participates in this deception in its preparedness to issue a birth certificate which contains no indication of the person's genetic origins, despite the fact that the state is maintaining this information in other departments.

Lack of information is certainly not in the child's best interests. It only serves the interests of the program, as there is more chance of procuring donors if the donor's identity is kept secret. This situation may seem to offer the infertile couple an uncomplicated solution to their fertiltity problems but it only forestalls facing the reality that there are other parents to their child and these people may have to be acknowledged at some future stage.

3.1 Record keeping of the origins of gametes.

Provision has been made under Section 19 of the Act for record keeping of gamete donations, but there are currently no records yet received by the Health Department Victoria's central register. The accuracy of such records is already open to doubt. For instance, sperm donors are allowed to donate at the Royal Women's Hospital without providing proof of identity (personal communication, Amanda Samuels). **The Health Department of Victoria must insist that the records are submitted to the central register without further delay. It should also issue a code of practice to practitioners at AID and IVF clinics to ensure that accurate information is obtained. This must also apply to general practitioners who are carrying out artificial insemination procedures in private consulting rooms.**

Whilst individual institutions have set maximum limits on the number of live births which result from the use of the sperm of a single donor, there is nothing to prevent a donor from giving sperm at a number of institutions. As Gp's are allowed to carry out donor insemination , the potential for one donor fathering very large numbers of children exists in the current system. Even if the maximum of fifteen children to one donor (not including his acknowledged children) is complied with, the possibility of consanguinous relationships between these children, who are most likely to be in the same age range, is quite high. The potential for distress caused by this situation should figure in the committee's deliberation.

SPERM LIQUIDITY CRISIS

Clinics in. Melbourne practicing donor sperm insemination claim that the numbers of sperm donors are declining because of proposed amendments to the Victorian IVF legislation which would allow children born of such assisted conception techniques to have access to identifyting information about donors (Suzanne McDonnell, *The Sunday Age*, May 17, 1992). The number of sperm donors in Victoria has declined from 200 to 40, according to spokespeople from Victorian IVF clinics. Clinics at the Royal Women's Hospital and Monash Medical Centre have a six to eight month waiting list for donor sperm. There is two year wait for donor eggs.

The Victorian Infertility (Medical Procedures) Act 1984 requires that information about donors and their progeny be kept in a Central Register maintained by the Health Department of Victoria. The register remains blank. Amendments to the Act unanimously endorsed by the Standing Review and Advisory Committee on Infertility propose that chidren born as a result of the use of donor gametes should have access to identifying information about donors on reaching the age of 18. Dr. John McBain from the Royal Women's Hospital described the proposed amendment as "do-good nonsense" that will further discourage donors. Ms Robyn Johnston a sdnetist at Monash Medical Centre said: "Some men are worried they are going to have children knocking on their door in future."

John Forbes (not his real name) is a regular sperm donor and says the most unpleasant aspect is finding the motivation to perform the deed in the uninspiring surrounds of the donor cubicle at Epworth Hospital. "I guess you could say the conditions could be less Spartan. There's a couch, a TV.... and a little of stockpile of..... well, you know ..... um .....well thumbed magazines." Prior to donating sperm, men must abstain from ejaculation for three days. They receive a payment of $25 for each donation which is meant to cover the costs of travel to and from the clinic. Apart from all that, John says: "Donating sperm is a lot more fun than donating blood."

IVF has also been used in surrogacy arrangements. Feminists, relinquishing mothers, adoptees, social workers, policy makers and others have argued against surrogacy because it exploits women for their reproductive capacities and because it makes commodities of children. In 1990, state and federal health and welfare ministers unamimously rejected proposals put forward by the now defunct National Bioethics Consultative Committee to legalize surrogacy, on the grounds of potential harm that would be caused to women and children.

IVF technology has made possible what is sometimes called "total surrogacy" where eggs are taken from the ovaries of a woman (who cannot give birth herself), the eggs are fertilized and then the embryos transferred to another woman who carries the pregnancy and gives birth. Thus it is possible for a woman to give birth to a child that is not genetically related to her. IVF practitioner Professor John Leeton has argued that IVF-assisted surrogacy reduces

the bonding between the birth mother and the child because her egg isn't used to create the embryo. However this definition promotes an idea that the "genetic mother" is the "real" mother, and entirely negates the experience of pregnancy and birth as having any significance in bonding between mother and child. Like any other kind of surrogacy, IVF surrogacy should not be encouraged or legalized - no amount of semantics can change the fact that surrogacy is the deliberate creation of children who are born to be given away. Advocacy groups for adoptees and relinquishing mothers have emphasised the human trauma that has been caused in the past when children were relinquished because of economic hardship, social stigmas, or other reasons. To deliberately undertake this by medicalising the practice of surrogacy (as a means of providing childless couples with babies) is a social experiment.

WHAT DOES IVF COST?

The cost of one IVF cycle varies from clinic to clinic. The most commonly quoted charges vary from $2,500 to $3,000 for one IVF cycle. New Medicare allocations for reproductive technology procedures announced in the 1990 Federal Budget allow additional rebates for assisted conception techniques, including pathology, ultrasound examinations, treatment counselling, and embryology laboratory services. The out-of-pocket expenses for clients may range from $0 to $600, depending on the techniques used and whether clients have private health insurance. Where superovulation is used, Medicare rebates are not available after six IVF or GIFT cycles. However, there is no limit where ovarian stimulation is not used ("natural" cycle) or in those cycles involving transfer of frozen embryos.

In addition, women may incur considerable expense through loss of work time, and for travel and accommodation.

WHAT DOES IT COST THE COMMUNITY?

In terms of the cost to the community, the 1990 Federal Budget Medicare announcements allocated an extra $6 million to these procedures during 1991. This must be considered as additional to the $17 million or so spent on IVF through Medicare rebates alone in 1987

($30 million was the total cost of IVF in 1987). The cost of IVF through Medicare in 1991-1992 is estimated at $25 million. There are many other hidden costs such as the intensive hospital care required for the very small infants that are often delivered from multiple pregnancies. In addition, sizeable grants are allocated to research projects associated with IVF programmes by bodies such as the National Health and Medical Research Council and the Australian Research Council.

There is concern about these comprehensive rebates being allocated to procedures that are still largely experimental, and in the majority of cases, unsuccessful. It raises questions about equitable allocation of resources and funds, when the government has allocated a total of $17 million for the implemenation of the whole of the Women's Health Policy over a period of four years.

REVIEW OF VICTORIA'S REPRODUCTIVE TECHNOLOGY LEGISLATION

The Victorian Standing Review and Advisory Committee on Infertility (SRACI), chaired by Professor Louis Waller, issued its third and final report on the review of post-syngamy embryo experimentation in November 1991. The third report was issued in the form of the Infertility Treatment Bill (Plain English Version) with recommendations for the amendment of the current Infertility (Medical Procedures) Act 1984.

However, the 8 members of SRACI did not reach consensus on some of the proposed amendments to the legislation. All members endorsed the 1987 amendment to the legislation which allows destructive non-therapeutic experimentation on fertilized eggs before the point of syngamy (syngamy is defined as when the pronuclei of the egg and sperm fuse, about 22 hours after the sperm enters the egg). But three members do not support the extension of destructive experimentation on spare or untransferred embryos up to a 14-day development stage. The whole committee supports a proposal that *de facto* couples should be eligible to use IVF and related procedures, but three members do not support this where donor eggs or donor sperm are used. All members support a licensing system for institutions performing donor insemination and IVF and related procedures, and for individual doctors performing donor insemination. Three members propose that all doctors and scientists who are performing procedures regulated by the Act should be individually licensed. Certain activities in relation to surrogacy arrangements carry criminal sanctions under the present law (giving or receiving payment, advertising for a surrogate mother) but members of SRACI are equally divided on the prohibition of legal and medical assistance to facilitate surrogacy arrangements. Ail SRACI members support a proposal that children bom as a result of the use of donor gametes may obtain on reaching the age of 18 information about the gamete donor from the Central Register. Under the current regulations, a Central Register containing the names of gamete donors (where children have been born as a result of the use of such gametes) should be kept by the Health Department of Victoria. However, as reported in a previous FINRRAGE newsletter (November, 1991) the register remains blank.

The recommmendations of SRACI have now been referred to the Victorian Parliamentary Social Development Committee (SDC), which consists of parliamentarians from the Labor, Liberal and National Parties. The Committee is chaired by Mrs Margaret Ray, MP. Ultimately the Victorian Parliament will decide on the final form of the legislation. Claims of bias in the SDC's review have arisen because to date it seems that their inquiry has been restricted to interviewing couples

participating in IVF programmes (Mark Forbes, *Tlie SundayAge*, April 12, 1992). Apparently the state Ombudsman Mr Norman Geschke is preparing a case in favour of surrogacy for the Committee. The Equal Opportunities Commissioner, Moira Rayner is also believed to be investigating discrimination claims by two sisters who have been refused access to the IVF programme for the purposes of a surrogacy arrangement.

There are also questions about the terms of the SDC's inquiry (Rosemary West, *The Age*, May 8, 1992). The Victorian Health Minister, Mrs Maureen Lyster has asked the committee to inquire only into those matters where all members of SRACI were not in agreement. Four members propose that offering medical or legal assistance to facilitate surrogacy arrangements should be an offence but four members do not support the inclusion of such a clause in the new bill. Mrs Ray said that IVF surrogacy is still "on the agenda". Mrs Marie Tehan, Shadow Minister for Health said she would be concerned at any attempt to legalize IVF surrogacy through the SDC's inquiry.

Further Reading:

Robyn Rowland. 1992. Living Laboratories: Women and Reproductive Technologies. Sun Australia.

Susan Powell and Helen Stagoll (eds.). 1992. When You Can't Have a Child: Personal Stories of Living with Childlessness. Allen and Unwin.

Manufacturing Babies: What Reproductive Technologies Mean To Women. *The 1992 edition of this booklet, written by Christine Ewing and published by the National Women's Consultative Council is available free of charge from the National Women's Consultative Council, 3-5 Nationa! Circuit, Barton. ACT. 2601*

Christine Ewing is a research scientist. She is a feminist who has been active on issues about reproductive technology and infertility for some years, and has published a number of articles on IVF, embryo experimentation, genetic engineering and surrogacy.