

SOCIAL IMPLICATIONS OF DEVELOPING MEDICAL
KNOWLEDGE IN THE FIELD OF HUMAN
REPRODUCTION – A CASE OF IGNORING SOME
HUMAN RIGHTS

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Synopsis – The story of Karen is related to focus attention especially on the plight of participants in donor oocyte programmes (and other new reproductive technology programmes) who have grievances not generally heard. The article then analyses Karen's story with the intention of furthering discussion and debate about the priority ranking of considerations between competing and conflicting interest groups in the community. The inadequacies of current legislation in Victoria, Australia (as well as proposed new legislation) are pointed out to show that the social cost of fulfilling the desires of some people to make "test-tube" babies may be too high in terms of the consequent cost to the community (current and future).

KAREN'S STORY

Karen, in her early thirties, is a nurse and married with two children of primary school age. Karen is close to all her family, especially her maternal grandmother.

Karen's grandmother is very supportive of Karen's aunt, Jo, who is married, over 40 years old, but without children. Jo has decided to seek assistance to bear a child from an in vitro fertilisation programme she has heard about.

Jo approaches Karen asking would she donate an egg to be joined with Jo's husband's sperm to form an embryo for placement in Jo. Karen thinks about this. She feels obliged to agree because it is her aunt asking. The family would not look kindly on her rejecting the proposal after all the aunt has done for Karen. Indeed, Karen quickly realises that the family, especially her grandmother, would make her an outcast if she did not help her aunt in this way. All in all, Karen decides there is no harm in acquiescing to her aunt's request. She rests some faith in the thought that the doctors will surely discover Jo is too old to have a child, and, moreover, has been under psychiatric and

doctor's care for nervous disorders, which would cause her to be considered incompetent to rear a child.

Karen therefore allows an appointment with the counsellor at the in vitro fertilisation programme to proceed. She and her husband go along together. They discover a number of points about the procedure and learn about possible side effects consequent upon Karen becoming the biological donor-mother of someone else's child. As part of the preparation, the counsellor advises that there should be some discussion between all concerned about relationships and especially what the child will be told about who is the biological mother or mothers.

Karen raises with the counsellor her concerns about the competency of her aunt to raise a child, given her age and psychological health. The counsellor is surprised to hear Karen's allegations. Karen is in a quandry over all these happenings but decides to think things over a little longer.

That night Jo telephones Karen to enquire how the appointment with the counsellor transpired. Karen is eager to discuss what the child will be told. Her aunt halts the possibility

of any discussion about this. In no uncertain terms Jo declares it has nothing to do with Karen, that there is nothing to discuss: "All I want is your egg."

Karen has a terrible and sleepless night, wondering what she should do. She feels guilty because she has also discovered the true age of her aunt is 49 years. She suspects that Jo must have lied about her age.

The next day, Karen telephones the counsellor to seek relief. All of her fears are relayed to the counsellor. Karen is particularly anxious about keeping her fears and concerns confidential from her aunt as she is certain the repercussions would be devastating.

The in vitro fertilisation programmers maintain Karen's confidentiality. Some 2 weeks later Jo telephones, distressed, to say that the doctor requested her birth certificate, that she admitted her true age, and that, consequently, the doctor considers it not appropriate for her to continue on the programme.

Karen sympathises with her aunt. Karen is relieved too, believing this will be the end of the matter.

However, at a family dinner at Christmas time, her aunt relates to the family her discovery, from the newspaper, of a 50-year-old grandmother, who went on an in vitro fertilisation programme and had the fertilised egg (donated by a 30-year-old woman) transferred to her body.

Some short time later, Jo telephones Karen with the news that another in vitro fertilisation programme will accept her. She has already arranged an appointment with the programme doctor for herself and Karen to attend.

This time there does not seem to be a counsellor to assist. The doctor in charge of the programme is to see Karen and Jo together. Karen has, through the first experience, decided that she definitely does not wish to be involved. However, she is very troubled by now about the repercussions of

her family if they learn of her withdrawal of support. She does not know what to do or to whom to turn. She is still hopeful that this second programme will find her aunt unsuitable, as with the previous programme. Hoping it will all work out as before, Karen contacts the doctor some 2 weeks before the scheduled appointment. Once again, she relays all her fears and concerns. Once again, she particularly stresses her own dilemma in the context of the family expectations of her and that she is not able to refuse to donate her egg. She relays to the doctor considerable family history as the basis for her anxiety. Karen is assured of confidentiality by the doctor: "I will keep this confidential," he says, "I have to."

The doctor advises Karen to telephone "at the last minute" to excuse herself from the scheduled appointment and from there he will see her aunt alone. This Karen does.

Later, on the day of the appointment, Karen telephones her aunt to apologise for not attending the doctor's appointment. Her aunt's husband answers the telephone and immediately asks why she will not donate her egg? "The doctor said you do not want to give us your egg anymore."

Thereafter, Karen is not permitted to speak with either her aunt or her grandmother. The family is in turmoil and hostile. She is not able to explain to them that she has not stated she will not give her egg.

Karen is furious at this turn of events, particularly the denial of an opportunity to be present when the doctor told her aunt the in vitro fertilisation procedure must stop because of Karen's noncooperation (i.e., her apparent refusal to donate an egg). Karen telephones the doctor but is further shocked by his rejection of her allegations. He says he did not know Karen felt this way. He says further that, because Karen feels her aunt would not make a capable mother, she should not be the egg donor. The doctor does not like what Karen has to say. Finally, he advises, "Just keep out

of it." No further assistance is offered to Karen by the doctor or the in vitro fertilisation programme. There is no acknowledgement by the doctor that he breached confidentiality, no apology, and, more importantly, no attempt to alleviate Karen's problem with her family.

Karen has since struggled to cope with the bitter recriminations of her family, especially of her grandmother, who wrote to her concluding, "We do not want to see you again." All of Karen's fears have been spelled out. She is an outcast from the family she cared so much about.

This story is not related merely to demonstrate the inadequacies of the current approach to regulation of human rights in the medical, procedures that alleviate infertility for the few.

This is a true story, with no proper mechanism currently available for alleviating the pain and suffering engendered by family members caught up as Karen was, and with no prospect for avoiding a similar unhappiness should a similar situation arise in any of the in vitro fertilisation programmes being conducted in Victoria.

In the following I want to discuss the unequal ranking of priorities between competing and conflicting interest groups in the community and to highlight the lack of choice that is the reality in many women's lives. The story of Karen is related to show that there are many considerations attached to the acceptability of new reproductive technologies. The powerful and frightening rider that doctors and scientists may conduct experiments on the "leftover" embryos must also be given close scrutiny. It may be that the social cost of fulfilling the desires of some people to make "test-tube" babies is too high in terms of the consequent cost to the rest of the community (current and future).

It is certainly of great concern that arbitrary focus is directed to the participants in these new reproductive technologies. Trite though it

may sound, it bears repeating that the first and most important people immediately and directly affected by the new reproductive technologies are undoubtedly the women patients, be they the oocyte donors (in this instance Karen), the "transferees" (here Jo is the "transferee," to use the dehumanising jargon of the Victorian lawmakers), or women who require preliminary surgery so that their own eggs may be collected once they have been superovulated. The procedures applied to all these women patients, who often undergo surgical operation under anaesthetic, contrast sharply, for example, with the procedure for sperm donation.

These women, along with women as a social group, are most important, or ought to be, because they are the ones required to make self-sacrifices and undergo physical suffering, as well as cope with the consequences following any birth. It is their bodies that will be taken from their control, tampered with, invaded, and subjected to the drugs prescribed. They are also the bodies within which the women will continue to live (all going well) afterwards. One of these women (the oocyte donor) will become a kind of "relinquishing mother," especially once the child born realises the fact of double parentage. One of these women will become, in all likelihood, the most important person, at least in the early life, of another: the child born should the procedure work.

There must be acknowledgement of the failure rate of the new reproductive technologies in producing live babies.¹ It is not within the ambit of the article to take the matter further. Indeed, I am focusing here on the effects of these technologies *before* pregnancy commences.

From public discussions and the various reports made in the media, as well as legislative writings, one could be excused for focussing on the scientists, doctors, and the "greater cause" itself, to the exclusion and detriment of consideration of the women

subjects (and the children born). This focus is supported by the way many in our society demand women must be. Consequently, the women themselves are caught in a tight bind by what they are taught, how they are taught to see themselves, and the expectations placed upon them to accord with being acceptable members of the community. As Robyn Rowland has explained (Rowland, 1987; see also Scutt, 1990):

For women, motherhood is deemed to be the true fulfillment of femininity. For many women, internationally, it brings little power in real terms, but for many, it is the only power base from which they can negotiate the terms of their existence. Women learn to like themselves in the motherhood role because it allows them experiences of love and power not easily found in other situations. The ideology of romantic love also deems that it is a woman's greatest desire to present her husband with his offspring. These kinds of ideological pressures to "choose" motherhood create a strong need in women. This ideology and this need are re-inforced by the economic structure, for example, within capitalist countries, the consumption of goods is focussed within the family unit.

These binds of ideology and practice are further strengthened by the supervisory role men demand over women's bodies. Already there is a dangerous precedent in Victoria for continuing this supervision and control. The "Menhennitt ruling" of the Supreme Court of Victoria in 1969 (*R. v. Davidson*, 1969) requires a doctor to assess and decide upon a woman's request for an abortion. More recently, there has been a push to make the foetus a person in its own right—that is, an adversary of the woman in and of whose body it grows. Even now, once a foetus is "viable," legal abortion is totally reliant upon the pronouncement of the doctor. Women could

lose the access they have to abortion by default if younger and younger foetuses become viable through technical assistance (Cannold-McDonald, 1991).²

As well as a dearth of discussion about women's rights generally in this area, there has been little concentration on the people perforce involved in the process (i.e., the donors, their families, the extended families of both gamete donors, and transferees). This paper seeks to further discussion about the ambit of legislation covering "infertility treatment," as it has been named, in Victoria. The lawmakers have, to date, instituted a system of regulation which only ensures that subjects of the new technologies, people like Karen, have no easy access to opportunity to call for questioning of the activities of doctors, scientists, and institutions conducting treatments and experiments.

The Infertility (Medical Procedures) Act 1984 of Victoria and the current Infertility Treatment Bill³ effectively write people like Karen *out* of the law. Karen may have a legal recourse in the court system by suing the doctor for his negligent behaviour in breaching the confidences she placed in him and thereby causing her damage. This is risky litigation. Remember, the doctor refuses to acknowledge Karen's version of their telephone conversation. There were no witnesses. There would also be difficulties with an action against the doctor for breaching the doctor-patient relationship, as it may well be successfully argued there was no such relationship at the point when Karen telephoned the doctor. In any event, these legal actions will not remedy the damage done; Karen will still be ostracised by her family.

Karen may wish to ensure the doctor cannot act again as he has. She may complain, ensuring the Minister for Health is apprised of what happened to her. Pursuant to the Infertility Treatment Bill, section 11:

The Minister may suspend or cancel the license of a doctor . . . if he or she is

satisfied the institution has:

- o failed to comply with the provisions of the Act⁴
 - o failed to comply with a condition of the license.
- (emphasis added)

Karen may find the Minister replying to her concerns by saying she/he will not interfere with the practice of the doctor or the doctor's license, since section 11 only empowers her/him to act if the institution (at which the doctor practices) has acted improperly, not the doctor. The Minister may also reply that, while the doctor's behaviour is poor, she/he does not consider it, in any event, sufficiently reprehensible to intervene, since it is not behaviour that would jeopardise the doctor's license. The Minister may even point out to Karen that Karen's telephone conversation was too early in the procedure to contravene section 7.5, which merely says:

Before treatment commences, an approved counsellor must have counselled the woman and her husband. If a donated gamete or a donated embryo is used an approved counsellor must also have counselled:

- o the woman and her husband, the donor of any gamete that is to be transferred or is to be used to form the embryo and of any embryo that is to be transferred; and
- o the spouse of any donor who is married.⁵

The Minister may see the first telephone conversation as merely a preliminary conversation.

Either of the above decisions of the Minister may be the subject of an appeal to the Administrative Appeals Tribunal for review of the decision (section 42 of the Bill, section 31 of the Act). Yet Karen may first have to apply to the Supreme Court seeking a prerogative writ forcing the Minister to formulate an actual

decision, because an appeal to the Administrative Appeals Tribunal is dependent upon the Minister actually making a decision.

Many aspects of Karen's complaint, however, are not matters that could be the subject of any decision the Minister might make. Therefore, she might usefully be directed to the Standing Review and Advisory Committee on Infertility (hereafter referred to as "the Committee") established under the Infertility (Medical Procedures) Act. Once again, her pursuit for recognition of and protection of human rights would be thwarted. The subject of her complaint is not strictly something the Committee concerns itself with either.

Is there nowhere in the law that we may look for direction on these issues of human rights? It could be thought that a valuable experience upon which to draw is that of procedures for the adoption of children, an adoption being a social, psychological, and legal process by which a child is given a new family relationship to the exclusion of the child's original family. This effectively maintains the appearance of society divided neatly into nuclear family units. Yet the experience was so wholly unsuccessful for a great many people, principally relinquishing mothers and many adopted children themselves, who were traumatised by loss of identity as well as the shame which secrecy of the procedure engendered. The adoption procedure has, more recently, undergone major changes. Now in Victoria, adoption is a measure of last resort and used only when there is some special reason why a child's relationships cannot be regularised by way of guardianship, custody, and access orders made under the Family Law Act (1975).⁶ These orders openly recognise the whole social circle of biological mother, biological father, and child, as well as the social parents and family of the child. Identifying information about all parties involved in an adoption is now available for many people. In the past 15–20

years it has been regarded generally as a progressive leap forward that all relationships (going both ways) are openly acknowledged. Very few adoptions where there is no connection to relatives of the child at all now occur in Victoria, and these may be arranged only through an adoption agency authorised by the Department of Community Services Victoria. It is an offence to place a child with nonrelatives with a view to adoption unless the authorised avenues are followed.

These issues are also relevant to the concerns Karen demonstrated by wishing to canvass with her aunt what a child born would be told. There is no avenue pursuant to the legislation for Karen to have raised those issues and concerns.

Since the government was able to bring such relief and sense of identity to one section of the community by rationalising adoption laws, it is excruciating and frustrating to witness the treatment of infertility and the avoidance of hereditary and/or congenital disorders by the use of in vitro fertilisation and related techniques, and by donor insemination, which at the same time merely replace the earlier adoption sagas and traumas of individuals.

An emphasis on individuals with a fertility-related problem and an unmet desire to have a child denies the change to the collective process of reproduction for all people – especially women as a social group.

If the doctor had the aunt's best welfare as a priority, why didn't he take the discussions initiated by Karen any further than a telephone call? Karen was dismissed by the doctor as obstructive to the end goal – his end goal. She appears to have been summarily dismissed by the doctor once he judged her not to be a ready source of eggs. "All I want is your egg," the aunt's words, could just as well have been the words of the doctor. Both wanted Karen as the donor of the vital gametes. Both were unwilling to give (or recklessly careless about giving) Karen anything in return, while

effectively taking so much more than merely "an egg"!

A host of questions are raised by Karen's predicament. Many of the questions are not related to the medical procedures that are regulated by the regulations and licensing conditions provided in the Infertility (Medical Procedures) Act or the Infertility Treatment Bill. Does this mean that Karen's concerns are to be viewed as not legitimate or not worth pursuing? Is it to be accepted that family dynamics are a private concern and not subject to rules which might hinder a "greater cause"? Do we, as a society, simply ignore people like Karen and her family, who dare not comply silently with a popular pursuit? Do we abandon attempts to weed out ethical from unethical activities because it is too onerous? Do we content ourselves with piecemeal attempts at addressing the gross errors, as they occur? For example, the Infertility Treatment Bill proposes (in grey writing which indicates that there is not unanimous agreement on the proposal):

Section 7.9:

. . . there must be reasonable correlation between the age of the donor and the recipient . . .

This is referable to the publicity about the success of a 50-year-old grandmother in having an embryo transfer using the gamete of a 30-year-old woman (as related to Karen at the family Christmas dinner by her aunt).

By expanding our view to the gross effect and unveiling the hidden agendas, the exploitation of a desire becomes plain – that is, the desire of the infertile woman⁷ and the desire of the doctor/scientist. Both desire the creation of a child, albeit for vastly different reasons.

Undoubtedly, it has been the recognition of a need to curb the worst excesses of this exploitation of desires that moved the Victorian government to legislate first in 1984.

Victoria has all along been at the forefront of the new reproduction industry developments in Australia.

Priority ranking of consideration in the application and purpose of legislation is confused in the Act (and the Bill). Section 2⁸ clearly relegates rights and interests that compete with “infertile couples be(ing) assisted in fulfilling their desire to have children” to a secondary position. Section 1 provides for “General Application and Purpose” of the Act. This section is plainly meant to facilitate only the various medical procedures for obtaining and “transferring”⁹ oocytes, oocytes and sperm, or embryos; to facilitate availability of unused gametes and embryos for experimental purposes; and to prohibit commercial surrogacy motherhood arrangements.¹⁰

The Bill was formulated (as was the Act before it) by the Standing Review and Advisory Committee on Infertility (referred to in this article as “the Committee”) in a report to the Victorian Minister for Health on matters related to the “Review of Post-Syngamy Embryo Experimentation.” It is thus *only* in the Bill itself that any pretence at regulation of the field is attempted.

The Bill provides that the Minister “may” license doctors, scientists, and institutions;¹¹ however, the control mechanism intended by this system lacks the vital element of scrutiny at almost every point in the legislation. For example, while the word *may* actually conveys the meaning that, equally, the Minister may not grant the license, there is no mention of what factors she/he might properly consider to assist her/his decision. Of more concern, the Bill provides no avenue for the Minister to hear any complaints or objections that might be laid should a complainant become aware that an application for license has been made.

There is no public notification provision that an application for license has been made. This is grossly disparate from the position subsisting in town planning, for example.

There, an entire division of the Administrative Appeals Tribunal hears objections to planning decisions of Town Councils as to land use.

The Minister is presumably assisted by the reports of the Committee to her/him. The Committee is appointed and wholly controlled by the Minister (section 25 of the Bill). But the Committee has no power to investigate complaints made about the suitability of applicants for license. Neither has the Committee the power to conduct formal investigations of queries, issues, or complaints made about acts or omissions of license holders. Nevertheless, the Committee will often be in the best position to know when the Act has been breached (as well as any information that the Minister should be mindful of) as is assumed by the odd wording in section 27 of the Bill, which provides:

The Committee must . . .

- o report to the Minister any breaches of the Act or the Regulations *which come to its notice*, (emphasis added)

The Committee is not directed to take part in recommending legal action against offenders “which [who] come to its notice.” The reality since 1984 has in fact been that prosecutions for breaches of the Act do not occur (although breaches of the Act are known and are in the public arena – e.g., advertising for “surrogate” mothers has occurred although banned by the Act).¹² It is doubtful, therefore, that the Minister is placed in a position to properly decide who shall and who shall not be licensed, and who might have their license suspended or cancelled. The standard of proof is that the Minister must be “satisfied” of a failure to comply with the Act or Regulations. Here again, questions arise. Is recklessly careless behaviour by a doctor towards a proposed patient so as to cause her damage sufficient to satisfy the Minister that the doctor’s license should be suspended or cancelled? By not confronting these forms of

behaviour the legislators appear to condone it.

Of more concern is the limitation on the powers of the Committee to broaden in the future the investigation and recommendations it has begun. The Committee clearly sees its role for itself as much more limited than engaging in authoritative activity on broader issues, such as those that Karen's story raises. The only powers that the Committee has relegated to itself are contained in Section 26 of the Bill:

The Committee may

- keep records of and collect information about, the causes, treatment and circumstances of human infertility and about research authorised by the Act and also about similar records, information and research in other places.
- Regulate its own proceedings.
- Advise the Minister at any time on its composition, its operations and its activities.

The Committee obligations are listed in Section 27 and do not extend to taking any direct responsibility for further development of the law to clarify and pronounce on the social implications of the activities the Committee witnesses. The catchall phrase at the conclusion of section 27 provides the Committee "must":

- Report annually to the Minister on . . . any further information the Committee considers helpful to the community understanding of infertility *and its consequences*, the procedures authorised by this Act and the manner in which they are being conducted, (emphasis added)

The context in which the emphasised words appear tend to restrict their interpretation to exclude social implications, at least to a

significant degree.

Nevertheless, the Committee will actually be uniquely placed to form a good community-represented view of which of the competing and conflicting priorities of community interests ought to take precedence, and the reasons why it should be so. This will not only be because of the Committee's access to information formally, but also because of the very membership of the Committee, should the Bill be accepted into law unaltered. Section 25 provides:

The Committee must consist of:

- A person qualified in philosophy.
- A doctor.
- A person who has clinical experience in treating infertility by in vitro fertilisation and related techniques.
- An embryologist.
- Two people affiliated with religious bodies.
- A social worker.
- A lawyer.
- A teacher.
- A person involved in health education or experienced in the prevention of infertility.
- A person who has participated in an infertility program under this Act. [Note: It does not stipulate though whether that person has been a successful or unsuccessful participator in terms of whether they left the program with or without a child born]
- A person with experience and expertise in the field of child welfare.
- A person born as the result of a treatment regulated by the Act.

As far as possible, the Committee should include people representing the views of the family, the child and the community.

(Some members of the Committee wish the last sentence to be deleted from the Bill.)

From the work (and expanded work if that was pursued) of the Committee, a body of expertise would be available for use by a Tribunal or Review Panel, who could hear the concerns and claims of people in the wider community.

Is a Minister of the government a person necessarily qualified to make decisions on these sorts of questions in any event? Would it not be fairer to all concerned and for the community that the Minister equip and direct the judicial arm of the government to arbitrate on the conflicts, as has traditionally been the case when competing community interests are to be resolved? While the construction of the accountability sections of the Bill mean that the doctors, scientists, and institutions are directly accountable to the Parliament,¹³ realistically, people like Karen are obstructed in airing their concerns and grievances. Members of the community opposed to the ethical looseness of the enthusiasts as regards medical knowledge and its development at any price are thwarted in extrapolating principles and guidelines for future conduct, and the community does not benefit from its experiences.

It could be argued that no better form of accountability is available than that by Parliament. However, this could only be so if the annual reports to Parliament, and any reports on the Committee's approval of a research project,¹⁴ included *all* matters of concern to all participants in the medical procedures and associated activities of the reproductive technologies. There is no guarantee of this. There is no guarantee that the Minister will ever hear of the grievances and concerns Karen raised or the shortcuts the doctor makes in his search for a source of eggs.

Given that the correct supervision of the in vitro fertilisation programmes in Victoria is thwarted by the system of Ministerial oversight (in both senses of the word), the only protection against abuses within the

programmes is, realistically, the mandatory counselling that all participants in these programmes undergo. Some of the shortcomings of the legislative directions related to counselling have already been mentioned.

Ideally, the counselling is intended to equip participants with information and knowledge that will enable them to make informed choices about whether or not they wish to consent to the medical procedures proposed. Karen relied on the counsellor made available to her. The second programme apparently did not have the same system in place. The doctor there obviously considered that a counsellor would not be of any more use to Karen than his own advice and judgment. It will never be known whether Karen's anxieties would have been handled more competently by a counsellor if she had been simply directed to one by the doctor.

There are two issues here. Firstly, the mandatory counselling sections in the Bill (6.3, 6.6, 7.4, 7.8, 8.3, and 9.2) do not set out the content of the counselling. "Matters in relation to which counselling is required before infertility treatment can be given" (section 43 of the Bill, section 32 of the Act) are the subject of regulations attached to the Act (or Bill once it becomes law). As such, the content may be changed from time to time with comparative ease and with limited supervision by Parliament. This limitation on certainty of what counselling will cover reduces the value of the counselling system and also places greater significance on the calibre and politics of individual counsellors and institutions.

Section 13 of the Bill provides for the Minister to hold all power with respect to who "may" be approved as a counsellor. No criteria are set out to guide the Minister's decision to give or withhold her/his approval, or vary or cancel an approval, which she/he may do at any time. No avenue is provided for objection to the application of a person to be approved as a counsellor (should it become known that

such approval is being sought, as there is no public notification provision). Similarly, there is no avenue provided for other aspects of the counsellor's input – for example, discussion or conflict resolution as between counsellors and doctors or institutions. There is, furthermore, no prescription or proscription of behaviour to which counsellors are required to comply in order to be and to remain acceptable as approved counsellors.

Infertility is not purely a medical problem that can be dealt with in isolation from the community at large. The infertile couple, and the woman “transferee” in particular, cannot be attended in isolation from, for example, members of their close social and family circles. Human rights and dignities ought not necessarily be made to rank second to the desire to produce a child or develop medical knowledge.

One cannot ignore the fact that the enthusiastic doctors and scientists have an overwhelming interest in providing hope and incentive to people to have them participate in the new reproductive technologies, and in silencing any opponents, so that the supply of “leftover” gametes and embryos will be available to continue research and experimentation.¹⁵

The Infertility Treatment Bill 1991 will continue a gross injustice if it is not extended to cover all considerations relevant to the whole community and to the people who are affected by all the consequences of the new reproductive technologies.

ENDNOTES

1. The international “failure rate” (meaning no child is born) of in vitro fertilisation is between 90 and 95% – see *Under the Knife: Surgery in Infertility Treatment and IVF* by Renate Klein.

2. Leslie Cannold-McDonald is a Researcher at the Centre for Human Bioethics at Monash University, Melbourne, Victoria.

3. The Infertility (Medical Procedures) Act 1984 (as amended) is the current law in Victoria in this area. The Infertility Treatment Bill 1991 is not the law. A Bill

becomes law once it is passed by Parliament and is proclaimed as an Act of Parliament. In this paper, the Bill is referred to and quoted in preference to the Act, as it is anticipated that, in the not too distant future and after further debate over the various sections of the Bill, the Bill will be formulated into final draft and passed, superseding the current Act.

4. The failure Karen would especially seek to rely upon would be breach of the counselling conditions attached to the license of the doctor and the institution at which he was practising.

5. There is disagreement within the Committee who drew up the Infertility Treatment Bill as to how onerous approved counselling obligations might be. Some in the Committee advocate deleting the first sentence in this section, for example. It should also be noted the section does not provide for separate counselling of wife and husband.

6. Victoria has given the Australian Commonwealth Government the power to make orders in relation to children born outside marriage. Accordingly, almost all children are now covered by the Family Law Act (1975) (as amended). Until such relinquishing of States' powers, children born outside of marriage were the subject of States' laws only.

7. It should be noted that the desire of the infertile woman is not always because it is she who is actually infertile; instead, her husband could be. Many women on Victorian IVF programmes are there as a result of their male partners' infertility problems, reports FINRRAGE (Australia) in their 1990 submission to the Committee. See also Scutt, 1988, pp. 189, 199, and 244.

8. This section, entitled “Guiding Principles,” lists the principle quoted here following as the first one.

9. Section 46 of the Bill is the definitions section. The word *transfer* is defined to mean “place in a woman.” Dehumanising jargon effectively denying the reality that operations actually affect women physically and otherwise should be shunned.

10. Section 1 of the Bill provides (inter alia):

“The Act prohibits *certain* surrogate motherhood arrangements and creates a number of offences” (emphasis added).

11. Section 3 of the Bill provides for applications for a license. Section 4 provides for the Minister to license doctors. The Committee is in disagreement over whether or not scientists in the field should be licensed. Scientists are mentioned in this paper because the author believes that scientists ought to be required to hold a license on the ground that scientists hold the same power as do doctors and institutions. Section 5 provides for the Minister to license an institution.

12. See section 30(2). This section also provides the penalty of \$5,000 fine or imprisonment for 2 years.

13. Section 28 of the Bill sets out the Minister's obligations to inform Parliament.

14. Section 24 of the Bill provides:

The Minister must appoint a Standing Review and Advisory Committee on Infertility to. . . consider and if it thinks fit approve research on human oocytes in the process of fertilisation and on embryos that it thinks should be permitted under section 8 and 9. (Section 8 – Conditions of license to inseminate human oocyte for research are provided in this section. Section 9 – Conditions of license to do research on an untransferred embryo at or after syngamy [this section is yet to be finalised].)

15. Note section 8, which provides:

The following conditions apply to a license to inseminate a human oocyte for research prior to syngamy [not all Committee members agree that "prior to syngamy" is appropriate]:

8.2 The oocyte and the sperm must be from married people who are undergoing treatment for infertility or to avoid the birth of a child with a serious congenital or hereditary disorder.

Similar provisions concern conditions of license to do research on untransferred embryos at or after syngamy.

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