

Chapter 5

Eligibility for Treatment

CONTENTS

- 58 GUIDING PRINCIPLES
- 61 PROTECTING CHILDREN
- 66 MARITAL STATUS
- 67 INFERTILITY
- 69 DONATED EMBRYOS
- 69 ETHICAL IMPLICATIONS
- 70 CONSENT, COUNSELLING AND INFORMATION
- 70 LEGISLATION AND REGULATORY BODY

RECOMMENDATIONS

1. The *Infertility Treatment Act 1995* should set out the following principles to guide the administration of the Act and the carrying out of activities regulated by the Act:
 - The welfare and interests of children to be born as a result of the use of assisted reproductive technology are paramount.
 - At no time should the use of reproductive technology be for the purpose of exploiting (in trade or otherwise) either the reproductive capabilities of men and women or the children born as a result of the use of such technology.
 - All children born as a result of the use of donated gametes have a right to information about their genetic parents.
 - The health and wellbeing of people undergoing assisted reproductive treatment procedures must be protected at all times.
 - People seeking to undergo assisted reproductive treatment procedures must not be discriminated against on the basis of their sexual orientation, marital status, race or religion.
2. It should be a condition of licence that each licensed clinic establish a clinical ethics committee for the purpose of considering cases where there is a concern that a prospective child will be at risk of abuse or neglect.
3. If, before a woman undergoes treatment, a doctor or counsellor believes that any child that might be born as a result of a treatment procedure may be at risk of abuse or neglect, the doctor should seek advice about whether or not to proceed with treatment from the clinical ethics committee operating within the licensed clinic.

As discussed in the previous chapter, the commission believes that the current eligibility requirements of the *Infertility Treatment Act 1995* fail to protect effectively the best interests of children. In order to address this issue, we recommend:

- a new set of guiding principles
- a process for review by a panel or ethics committee when there is a concern that the health and wellbeing of a child may be at risk
- presumptions against treatment to deal with cases where there may be an unacceptable risk of harm to the child
- removal of the marital status requirement
- clarification of the 'unlikely to become pregnant' criterion.

We also recommend that the requirements for consent, counselling and the provision of information remain and that the regulatory authority retains its licensing and oversight functions.

These recommendations do not depart substantively from the interim recommendations the commission made in *Position Paper One: Access*. We have, however, refined the recommendations in light of comments and suggestions made in submissions in response to the position paper.

Our recommendations seek to strike a balance between allowing patients and clinicians sufficient scope to determine whether assisted reproductive technology (ART) is appropriate in a particular case and making clear statements about community values and standards. We believe that the processes we recommend achieve a fair and workable balance between these two objectives, as well as providing a mechanism for protecting children from the risk of harm.

GUIDING PRINCIPLES

The commission believes there should be clear statements within the legislation to provide a framework for decision-making by people who wish to access treatment, their treating doctors, counsellors, ethics committees and other bodies such as our recommended review panel. The establishment of guiding principles would provide these clear statements. The principles are also flexible enough to enable the Act to be applied in ways that are appropriate to individual cases and developments in emerging technologies and can help avoid the problems associated with prescriptive legislation. At the same time, guiding principles can encourage consistency in how the law is applied in individual cases.

The commission has reviewed the current guiding principles and believes they should be revised. The proposed new principles are:

1. The welfare and interests of the child to be born as a result of the use of assisted reproductive technology are paramount.
2. At no time should the use of reproductive technology be for the purpose of exploiting (in trade or otherwise) either the reproductive capabilities of men and women or the children born as a result of the use of such technology.
3. All children born as a result of the use of donated gametes have a right to information about their genetic parents.
4. The health and wellbeing of people undergoing treatment procedures must be protected at all times.
5. People seeking to undergo assisted reproductive procedures must not be discriminated against on the basis of their sexual orientation, marital status, race or religion.

BEST INTERESTS OF THE CHILD

The principle of best interests of the child reflects the predominant concern expressed by people in public forums, in submissions and at the roundtables conducted by the commission. It reflects the international standard articulated in the *Convention on the Rights of the Child* that '[in] all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration'.¹ It is also consistent with the policy which applies to assisted reproduction in jurisdictions which have legislated to regulate it, such as the United Kingdom, Canada, South Australia and Western Australia.

The commission has adopted the expressions 'welfare and interests' and 'paramount' as they are consistent with other Victorian legislation dealing with children such as the *Adoption Act 1984*² and the *Children and Young Persons Act 1989*.³

The commission has made recommendations concerning access to ART (see Chapter 5) which are intended to provide a process for giving effect to this guiding principle.

NON-EXPLOITATION

The principle of non-exploitation of children and parents is intended to make it clear that it is not acceptable to exploit the reproductive capabilities of men and women, or the children born as a result of ART, in trade or otherwise. The principle is consistent with section 380 of the Infertility Treatment Act which prohibits commercial trading in human eggs, human sperm or human embryos. It is also relevant when considering section 59 of that Act which prohibits commercial surrogacy arrangements.⁴ A similar provision appears in the guiding principles of Canada's *Assisted Human Reproduction Act 2003*.⁵

CHILDREN'S RIGHT TO INFORMATION

This principle enshrines children's rights to information about their genetic parentage and is consistent with the *Convention on the Rights of the Child*. We discuss this principle and the importance of telling donor-conceived children about their origins further in Chapter 15.

HEALTH AND WELLBEING

People wishing to utilise ART to achieve a pregnancy and subsequent birth of a child should not be exposed to unnecessary risks. The principle that the health and wellbeing of people undergoing ART should be protected draws attention to the nature of the treatment procedures which are provided to a patient. Women should not be subjected to treatment procedures which place them at a higher level of risk than is necessary to achieve a pregnancy.

Clinics are required to comply with the Reproductive Technology Accreditation Committee's (RTAC) code of practice⁶ and the National Health and Medical Research Council's (NHMRC) ethical guidelines.⁷ This principle is consistent with these requirements and is also closely linked to the provisions in the Infertility Treatment Act which require the provision of information to, and counselling and informed consent of, donors and patients. This serves to protect the health and wellbeing of people undergoing ART.

- 1 *Convention on the Rights of the Child*, UN GAOR, 44th sess, UN Doc A/44/736 (1990) Article 3(1).
- 2 *Adoption Act 1984* s 9.
- 3 *Children and Young Persons Act 1989* s 87.
- 4 Issues surrounding payment for surrogacy arrangements are addressed in Chapter 18.
- 5 *Assisted Human Reproduction Act 2003* (Canada) cl 2.
- 6 Reproductive Technology Accreditation Committee, *Code of Practice for Assisted Reproductive Technology Units* (rev ed, 2005).
- 7 National Health and Medical Research Council, *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (2004).

RECOMMENDATIONS

4. Clinical ethics committees should be empowered to make decisions about whether treatment should be provided to a person or couple where there is a concern that a prospective child will be at risk of abuse or neglect.
5. Clinical ethics committees should include a child development expert, a psychologist or psychiatrist with expertise in prediction of risk of harm to children and a doctor with experience in assisted reproductive technology.
6. Clinical ethics committees should develop their own procedural guidelines and processes, and should have regard to the guiding principles of the Infertility Treatment assisted reproductive technology.
7. Clinical ethics committees should be able to convene quickly to ensure cases are dealt with expeditiously.
8. Clinical ethics committees should be provided with training and support.
9. The Infertility Treatment Authority should review the operation of clinical ethics committees after five years.
10. Where a clinical ethics committee decides that a person or couple should not be treated:
 - (a) the person or couple may apply to the Infertility Treatment Authority review panel to have the decision reviewed
 - (b) a clinic must not treat that person or couple unless the committee's decision is reviewed by the Infertility Treatment Authority review panel and the panel decides that there is no barrier to treatment or decides that subject to compliance with certain conditions, there is no barrier to treatment.
11. Where a clinical ethics committee decides that there is no barrier to a person or couple being treated, a clinician should not be compelled to provide treatment.

NON-DISCRIMINATION

Australia has ratified the *International Covenant on Civil and Political Rights* and the *Convention on the Elimination of all forms of Discrimination Against Women*. Central to these treaties is the principle that people should not suffer discrimination on the basis of their sex, marital status, race, colour, political or other opinion, birth or other status. The *Convention on the Rights of the Child*, also ratified by Australia, requires parties to protect children from discrimination on the basis of the status, activities, expressed opinions, or beliefs of the children's parents (Article 2).

The principle of non-discrimination is consistent with the inclusive values upon which our community prides itself, and has been implemented in federal and state anti-discrimination laws and in Victoria's recently implemented *Charter of Human Rights and Responsibilities Act 2006*. All legislation in Victoria must now be compatible with the rights contained in the charter, including the right to enjoy human rights without discrimination and the effective protection against discrimination.⁸

Within the charter the term discrimination has the same meaning as in section 6 of the *Equal Opportunity Act 1995* which lists attributes on the basis of which discrimination is prohibited, including marital status, sexual orientation, personal association and impairment. After some deliberation, the commission decided not to include impairment or disability as one of the grounds on which discrimination in relation to access to ART should be prohibited. This is because in some cases there is a nexus between disability and risk of harm to a child (for example, some forms of severe mental illness). Such a nexus does not exist in relation to marital status or sexual orientation. This does not mean that people with a disability or impairment should be refused treatment, but that in some cases a different approach is justified. Such an approach should involve making enquiries about any potential risk to the health and wellbeing of a prospective child.

The commission believes that non-discrimination is not simply an important end in itself, but that its observance in law and practice helps to shift community attitudes and to promote the health and wellbeing of all members of our society.

The following comment made in a submission identifies the impact that discrimination in the area of ART can have on children:

What are the effects on children who have same-sex parents when they hear discussions about whether gay people are fit to be parents? ... VicHealth talks about three key areas that are important in determining whether we're mentally healthy or not, and they are: social connectedness, freedom from discrimination and violence, and economic participation. In terms of freedom from discrimination and violence it talks about opportunity for self-determination and control of one's life as being really important in supporting our mental health. So whether it's the single mums or lesbian mums or gay couples or the yet to be born children or existing children who hear about this kind of discussion, we are potentially damaging their mental health when we're suggesting there's somehow something wrong with their family unit.⁹

The elimination of discrimination in this area will also promote the health and wellbeing of children born to single women and people in same-sex relationships in a direct way, by allowing more women to have access to the benefits and safeguards offered through the licensed clinic system.

PROTECTING CHILDREN

REGULATORY MODELS

Submissions received and consultations conducted during the course of this reference demonstrated that most people believe that the best interests of children born through ART should be the paramount consideration in the carrying out of ART. The commission has given considerable thought to the ways the law should support this objective. We considered three possible ways that rules governing access to treatment could safeguard the health and wellbeing of children.

The first approach would be to rely solely on the principle that the best interests of children are paramount and to leave it to clinics and people seeking treatment to decide how this should be translated into practice. This approach would treat assisted reproduction in a similar way to conventional conception and the legislation would not prescribe who may have access to ART. Proponents of this approach argue that eligibility criteria should not apply to people accessing ART services, in the same way that the state does not interfere in the decision of other members of the community to become parents without assistance.¹⁰ The submission made by ACCESS, a national support group for infertile people, stated:

*If society believes that instituting a 'fitness to parent' code is necessary to protect the best interests of the child, then the same criteria should be applied equally to fertile people, regardless of the method of conception. To do otherwise would be to treat infertile people as a sub class in society.*¹¹

This approach is also based on the difficulties of predicting whether a person will be a good parent, or whether a child who has not yet been conceived will be at risk of harm. Arguably, these difficulties make it unjustifiable to restrict access to treatment on the basis of the health and wellbeing of the child because decisions on this matter inevitably reflect personal value judgments.

This is broadly the position taken in the recently published report of the United Kingdom (UK) House of Commons Science and Technology Committee Inquiry into Human Reproductive Technologies and the Law.¹² The report is critical of regulatory approaches which place the welfare of the child at the centre of decisions about access to ART. It concludes that the current welfare of the child provision in the UK *Human Fertilisation and Embryology Act 1990* 'discriminates against the infertile and some sections of society, is impossible to implement and is of questionable practical value in protecting the interests of children born as a result of assisted reproduction'.¹³

The second approach is to treat assisted reproduction in a similar way to adoption of children and to require people to be assessed according to a set of criteria aimed at ascertaining whether they will be good parents. People who wish to adopt children must be approved as fit and proper to parent.¹⁴ Applicants must undergo a medical examination and police record check and are assessed according to a range of factors to establish their capacity to provide a secure and beneficial emotional and physical environment for the care of a child.¹⁵ TangledWebs, a group concerned with the impact of ART on people who are conceived with donor gametes, supported use of a similar process to control access to assisted reproduction.¹⁶ TangledWebs argues that prospective parents should be vetted by the Department of Human Services, not by the medical profession, and that the assessment process should be directed primarily to the capacity of applicants to meet the specific needs of donor-conceived children.

The third approach is to implement a fair and transparent process that enables a clinic to investigate concerns about risks to children on a case-by-case basis and according to identifiable and established risk factors.¹⁷ This is the approach preferred by the commission. Such a process would apply only in certain circumstances, and would acknowledge that most people who seek ART services should not be treated any differently from people who conceive without assistance.

8 *Charter of Human Rights and Responsibilities Act 2006* s 8.

9 Submission CP 59 (Ian Seal).

10 Submission CP 192 (ACCESS).

11 *Ibid.*

12 House of Commons Science and Technologies Committee, *Human Reproductive Technologies and the Law*, Fifth Report of Session 2004–05: Volume 1 (2005).

13 *Ibid.* 51.

14 *Adoption Act 1984* s 13.

15 *Adoption Regulations 1998* rr 35, 35A.

16 Consultation, 12 November 2004. It should be noted that the principal policy goal of TangledWebs is to cease the entire practice of donor conception.

17 See, eg, Danya Glaser, 'Emotional Abuse and Neglect (Psychological Maltreatment): A Conceptual Framework' (2002) 26 *Child Abuse & Neglect* 697.

RECOMMENDATIONS

12. A licensee should not treat a person without the approval of the Infertility Treatment Authority review panel if the licensee is aware that the person seeking treatment and/or his/her spouse or partner (if any):
 - (a) has had charges proven against them for a sexual offence as defined in clause 1 of Schedule 2 to the *Sentencing Act 1991* or
 - (b) has been convicted of a violent offence as defined in clause 2, Schedule 1 to the *Sentencing Act 1991* or
 - (c) has had a child protection order (but not an interim order) made in respect of one or more children in their care under a child welfare law of Victoria or any equivalent law of the Commonwealth or any place outside Victoria (whether or not in Australia).
13. In order to determine whether a presumption against treatment applies, clinics should require people seeking treatment to make a statutory declaration as to the existence or otherwise of facts or circumstances giving rise to a presumption against treatment.
14. A review panel should be established to decide whether or not a person or couple is eligible for treatment where:
 - one of the presumptions against treatment in Recommendation 12 applies or
 - a person or couple seeks review of a clinical ethics committee recommendation that they not be treated because of a concern about the health and wellbeing of any child that might be born as a result of a treatment procedure or
 - a person or couple seeking treatment does not satisfy the requirements in Recommendation 28.

Several submissions received in response to Position Paper One expressed strong reservations about legislating to empower institutions and individuals to exclude people from treatment, and therefore from parenthood.¹⁸ For example one person wrote:

*The issue of becoming a parent is an extremely complex one, and for many years (through forced sterilisations, child removals, and discriminatory social policy) decisions have been made by privileged white people (usually men) about who should or should not be a parent. For this reason, I have grave concerns about legitimising the refusal of treatment procedures to women where concerns exist about the health and wellbeing of potential children.*¹⁹

Notably, many proponents of this view acknowledge that there will at times be cases which present clinicians with a dilemma about whether or not treatment should be provided, even where access to treatment is unregulated. The UK Science and Technology Committee proposed that ‘these should be resolved by recourse to local clinical ethics committees’.²⁰ Kristen Walker argues that if the law is to exclude certain people from treatment ‘this should not simply be at the discretion of the doctor—there should be legislative guidance’.²¹

ETHICS COMMITTEES

For the reasons outlined above and in Chapter 3, the commission has decided that some degree of external regulation of access to treatment is warranted. However, we believe it would be inappropriate to implement an adoption model for determining access to ART because assessment in the adoption context is related to the needs of an existing, and possibly particularly vulnerable, child for whom the state is responsible. An assessment process as rigorous as that used for adoption would also be unnecessarily onerous in the context of ART. We believe that counselling already fulfils an important educative function and plays a significant role in preparing parents for the needs of donor-conceived children (this issue is addressed in Chapter 5).

Our consultation process indicated that clinics do encounter cases where they are unsure whether to treat a patient because of concerns that a potential child may be at risk.²²

Some people involved in the provision of ART services expressed the need to have clear

processes or avenues for denying treatment to a person or couple seeking ART when there is a concern about the health and wellbeing of a potential child. For example, a person or couple who otherwise meet the current eligibility criteria may have a physical or psychiatric illness, an intellectual disability, or some other problem that raises a doctor’s concern about their capacity to care for a child. While some people with these conditions may be excellent parents, in cases where a doubt arises there should be a process for decision-making which allows proper assessment of the risk to any child who may be conceived. Doctors and counsellors need a mechanism for determining whether or not to treat the person or couple which is transparent, procedurally fair and allows each case to be evaluated on its own merits.

The commission recommends that a formal system be established to:

- provide guidance and support to doctors and counsellors who are unsure about whether there is any likelihood of harm to a prospective child
- allow the clinic to seek expert advice from people with relevant disciplinary expertise in assessing risks to children, so decisions are based on factors relevant to the health and wellbeing of the child, rather than purely on medical factors or personal value judgments
- implement a decision-making process that is transparent, procedurally fair and consistent.

We therefore recommend that where a doctor or counsellor believes that a child may be at risk of abuse or neglect the matter should be referred to a clinical ethics committee. Each clinic licensed to provide treatment services should establish a clinical ethics committee for the purpose of considering cases where there is a concern that a prospective child will be at risk of abuse or neglect. The establishment of a clinical ethics committee should be a condition of licence for clinics to ensure the ITA can monitor compliance with the requirements we recommend.

The proposed process will ensure that decisions about access to treatment are not based on discriminatory assumptions about the parenting capacity of particular groups of people (for example people with a psychiatric condition). Where a doubt arises about the capacity of a person to care for a child, it will allow case-by-case evaluation to occur in a way which takes account of the health and wellbeing of any future child. The committees would be obliged to have regard to the guiding principles of the Act, including the principle of non-discrimination.

In proposing the use of a clinical ethics committee, the commission aims to build on a process that already exists in some hospitals and is currently being set up in others. Our proposal is consistent with the requirement in the NHMRC's ethical guidelines that clinical ethics committees be used when difficult decisions need to be made concerning whether or not to proceed with a treatment procedure.

Currently, most ethics committees operating in hospitals act as advisory bodies and do not make decisions which individual doctors must follow.²³ In our view, because the proposed ethics committees would have as their central consideration the health and wellbeing of children, and not merely the best interests of the patient seeking treatment, they should have a decision-making capacity. That is, if the committee decides that treatment should not be provided to a particular patient because of concerns about risk of harm to a potential child, the clinic or doctor should not be permitted to treat that person. Clinicians should not, however, be compelled to treat a person even where the ethics committee has decided there is no barrier to treatment. This is consistent with the principles that govern general medical practice. Clinical ethics committees are usually made up of people who have experience and/or expertise in resolving dilemmas such as these or who have clinical experience in the area. However, because the primary purpose of referring the matter to the committee is to deal with a concern about a prospective child, the committee should include a child development expert, a psychologist or psychiatrist with expertise in the prediction of risk of harm to children, and a doctor with experience in ART.

There is currently a scarcity of guidance and support for clinical ethics committees, as opposed to research ethics committees. The NHMRC has issued ethical guidelines for research involving human participants that require all human research projects to be vetted by ethics committees.²⁴ There is considerable infrastructure and guidance for the operation of human research ethics committees, including requirements about membership, procedures and reporting.²⁵ No such framework exists for clinical ethics committees; there is actually no legislative requirement in Victoria for hospitals to establish clinical ethics committees.²⁶

Accordingly, we recommend that the clinical ethics committees develop their own procedural guidelines and processes; members should be provided with training and support, possibly by the Department of Human Services. The committees should have regard to the guiding principles of the Infertility Treatment Act when making decisions about each case before them, and they should be able to convene quickly to ensure cases are dealt with expeditiously. The ITA should review the operation of the committees after five years.

We have also recommended that people wishing to undergo ART treatment should have recourse to an independent decision-making body, established under the auspices of the ITA, if they disagree with a decision which has resulted in the denial of treatment. The composition of this body is discussed below.

UNACCEPTABLE RISK

In rare cases, a person seeking treatment or their partner may have previously behaved in a way which suggests there may be an unacceptable risk of harm to any child born. For example, a person or their partner may have had a child previously removed from their care by child welfare authorities, or may have committed serious sexual offences or offences involving serious violence. If this occurred many years ago, or the person's behaviour was caused by the circumstances which existed at that time, there may be no risk it will be repeated. For example, people who are convicted of offences involving violence when they were young may be excellent parents in later life.

However, if the behaviour occurred recently, or if there are other factors which suggest an unacceptable risk to the health and wellbeing of the child, the commission's view is that the person should not be assisted to conceive. The present law does not provide any mechanism for determining whether there is an unacceptable risk of harm. Nor does it provide any process for deciding whether a person should be treated if a doctor or counsellor becomes aware of these issues.

Some people argue that no restrictions of this kind apply to people who become parents without assistance and that the same approach should apply to assisted reproduction. If the child is at risk of harm after they are born an application can be made for a child protection order.

- 18 For example, submissions PP1 107 (Elizabeth Wheeler), PP1 141 (Rachel U'Ren), PP1 145 (James Magel), PP1 251 (Fertility Access Rights), PP1 319 (Women's Health West).
- 19 Submission PP1 107 (Elizabeth Wheeler).
- 20 House of Commons Science and Technologies Committee, *Human Reproductive Technologies and the Law*, Fifth Report of Session 2004–05: Volume 1 (2005), 51.
- 21 Kristen Walker, 'Should There Be Limits On Who May Access Assisted Reproductive Services? A Legal Perspective' in Jennifer Gunning and Helen Szoke (eds), *The Regulation of Assisted Reproductive Technology* (2003) 123, 129.
- 22 Access roundtables 14 October 2004 and 9 February 2006.
- 23 Consultation with Dr Les Reti, Chair of the Royal Women's Hospital Clinical Ethics Advisory Group, 1 August 2006.
- 24 National Health and Medical Research Council, *National Statement on Ethical Conduct in Research Involving Humans* (1999).
- 25 See National Health and Medical Research Council, *Human Research Ethics Committees (HRECS)*, <www.nhmrc.gov.au/ethics/human/hreecs/index.htm> at 22 February 2007.
- 26 Correspondence received by the commission by email from Dr Peter Saul, convenor of the Clinical Ethics Special Interest Group of the Australasian Bioethics Association, 8 June 2006 and Dr Lynn Gillam, University of Melbourne, 10 July 2007.

RECOMMENDATIONS

15. A person whose case is being heard by the review panel shall have:
 - the right to be heard
 - the right to be represented by a lawyer
 - the right to call evidence.
16. The review panel should otherwise determine its own processes and procedures.
17. In making its decisions the review panel should have regard to the guiding principles of the Act.
18. If the review panel decides that a person or couple should not be treated, a clinic must not treat that person or couple.
19. If the review panel decides that a person should not be treated unless he or she (or a partner) meets certain conditions, a clinic must not treat that person (or couple) until those conditions have been met.
20. Where the review panel decides there is no barrier to treatment, or there is no barrier to treatment once certain conditions have been met, the decision of the panel must be conveyed to all licensed clinics in Victoria and to the person (or couple) seeking treatment. In such circumstances a clinic will not be compelled to treat the person (or couple).
21. The review panel should comprise five members, including:
 - a lawyer with experience in the conduct of hearings and knowledge of relevant areas of law, to sit as chair of the panel
 - a person with expertise in child development and welfare and the prediction of risk of harm to children
 - a person with expertise in the clinical medical practice of assisted reproductive technology
 - a psychologist or psychiatrist with expertise in families
 - a person with knowledge of the ethics of clinical medical practice.

The commission disagrees with this view. Assisted reproduction is regulated and supported by the state and we therefore believe that the state has a responsibility to identify cases where there is an unacceptable risk of harm. There should be a process for decision-making about where the past behaviour of prospective parents suggests there may be an unacceptable risk of harm. This process should provide a transparent and fair way of making decisions about treatment. There is a substantial body of research on the parental factors which place children at risk of harm.²⁷ This information should be taken into account when assessing whether a person is eligible for treatment. This will require clinics to put in place procedures to identify whether any of the proposed risk factors exist.

Our recommendation creates a presumption against treatment where women seeking treatment and/or their partners have:

- had charges proven against them for a sexual offence²⁸
- been convicted of a violent offence as defined in clause 2, Schedule 1 of the *Sentencing Act 1991*²⁹
- had a child protection order made in relation to one or more children in their care.³⁰

The presumption against treatment of people in these categories will ensure that careful investigation is undertaken before treatment is provided. We recommend that where this presumption applies to a person or her partner, treatment should be refused unless an ITA review panel finds that there is no unacceptable risk to a child who is conceived through assisted reproduction.³¹ The review process will ensure that a person whose circumstances have changed materially since the offending conduct will not be unfairly excluded from treatment.

The presumption relating to people who have committed sexual offences is based on research which shows that some people convicted of serious sexual offences are subsequently convicted of further sexual offences,³² and a small proportion of sexual offenders are convicted of offences against both adults and children.³³ According to this view, the commission believes that the presumption against treatment of anyone who has been convicted of a sexual offence is justified because it takes a cautionary approach which minimises the risk of harm to a child conceived through assisted reproduction.

The presumption against people who have been convicted of a violent offence also extends beyond people who have been convicted of violence against children. Again, there is research indicating that sexual and other forms of violence often coexist in families³⁴ and that children brought up in a household with a violent parent are at risk of emotional and psychological harm, even if they were not assaulted themselves.³⁵

During our consultation process we were told that clinics sometimes encounter cases where a woman who seeks treatment has already had one or more children removed from her care. Child protection orders are made by the Children's Court under the *Children and Young Persons Act 1989* after detailed consideration of the needs of the child, and having regard to the need to ensure that intervention into family life should be to the minimum extent that is necessary to secure the protection of the child.³⁶ The commission views the making of a child protection order as a serious matter which may indicate that there is an unacceptable risk of harm to a child conceived as a result of ART. We therefore recommend the introduction of a presumption against treatment of people who have had a protection order made in respect of one or more children in their care. Again, the presumption is reviewable, ensuring that people whose circumstances have changed since the making of the order are not excluded unfairly.

Recommendation 12 emphasises the priority to be given to the health and wellbeing of children, but recognises that decisions to exclude a person from treatment should be subject to proper review and consideration, by an independent expert body.

The commission considered the various ways of identifying cases where a presumption against treatment could arise. The available methods are to:

- require all patients to undergo a criminal record check or a process similar to the 'working with children check'³⁷
- require all patients to make a statutory declaration about whether they have been convicted of relevant offences or had a child removed from their care
- require clinics to make independent inquiries about all patients' histories, for example by contacting their family members and general practitioners
- seek out relevant information during counselling sessions.

The commission is of the view that the most appropriate way to ascertain whether any of the presumptions apply is to require prospective patients to sign a statutory declaration. We acknowledge the limitations of this approach, in particular the risk that people may make false declarations. In South Australia, where statutory declarations are required before treatment can be provided, the regulatory body (the South Australian Council on Reproductive Technology) has recommended the requirement be abolished on the grounds that the system is open to abuse, is ineffective in protecting children and creates excessive paperwork for clinics.³⁸

However, the commission is reluctant to recommend the alternative mechanisms because we believe it would be both onerous and ineffective. A police check would be overly invasive as it might reveal convictions that are irrelevant to the health and wellbeing of children, and might not record spent convictions or convictions over 10 years old. Using a process like the working with children check, which is administered by the Department of Justice, would be oppressive and bureaucratic and would go too far in the direction of the state dictating who can or cannot have children. The commission was also concerned not to place the responsibility for conducting background checks on clinic staff, by requiring them to make third party enquiries about patients or to use counselling sessions to interview patients about their criminal records.

On balance, therefore, the commission has decided that requiring a person to make a statutory declaration in respect of the matters giving rise to a presumption against treatment is the most appropriate mechanism available.

REVIEW PANEL

The commission recommends that a review panel be established to determine whether treatment should be provided where:

- a presumption against treatment applies to a person/couple seeking treatment or
- a clinical ethics committee has decided that treatment should not be provided.

The review panel should be an independent body with decision-making functions which receives administrative and secretariat support from the ITA. The guiding principles of the Act should apply to decisions to be made by the review panel. The legislation should prescribe the following procedures to be applied:

- the right to be heard
- the right to be represented
- the right to call evidence.

- 27 See, eg, Victorian Department of Human Services, *An Integrated Strategy for Child Protection and Placement Services* (September 2002); The Allen Consulting Group, *Protecting Children: The Child Protection Outcomes Project: Final Report for the Victorian Department of Human Services* (September 2003); Victorian Office for Children, 'Risk Assessment: Policy Advice and Practice Guidelines for Protective Workers' (1996) in *Protecting Children: Volume 3—Policy Advice and Practice Guidelines: Part 2*, 26–32, available at <office-for-children.vic.gov.au> at 19 February 2006.
- 28 As defined in clause 1, Schedule 1 of the *Sentencing Act 1991*. This definition includes equivalent offences committed in the past and in jurisdictions outside Victoria.
- 29 This definition includes a range of serious offences, including murder, manslaughter, causing serious injury intentionally, intentionally causing grievous bodily harm, and common law kidnapping, but excludes summary offences and common law assault. It also includes offences committed outside Victoria.
- 30 Under the *Children and Young Persons Act 1989* s 85(1)(a).
- 31 A similar review panel operates in South Australia: see Reproductive Technology (Code of Ethical Clinical Practice) Regulations 1995 (SA) pt 3, Schedule.
- 32 It is important to note that rates of sexual recidivism are low relative to other offence types, and that sub-groups of sex offenders reoffend at different rates: Australian Institute of Criminology, *Recidivism of Sexual Assault Offenders: Rates, Risk Factors and Treatment Efficacy* (2004) 36–7.

- 33 For example, a 2002 United Kingdom study by Roger Hood, Stephen Shute, Martina Feilzer and Aidan Wilcox of 174 male sex offenders found that '[s]exual reoffending was largely homologous, with 62 per cent of rapists reoffending against adults only and 71 per cent of child molesters repeating their offences against children only. While the results show a degree of specialisation, a sizeable proportion of each group nevertheless switched between child and adult victims': reported in *ibid*, 35.
- 34 Marie Hume, 'The Relationship Between Child Sexual Abuse, Domestic Violence and Separating Families' (Paper presented at the Child Sexual Abuse: Justice Response or Alternative Resolution Conference, Adelaide, 1–2 May 2003), National Child Protection Clearinghouse, *Exploring Family Violence: Links Between Child Maltreatment and Domestic Violence* 13 (2000).
- 35 Victorian Department of Human Services, *Child Protection and Family Violence: Guidance for Child Protection Practitioners (Incorporating the use of Intervention Orders)* (2005); Australian Domestic & Family Violence Clearinghouse, *Domestic Violence in the Context of Child Abuse and Neglect*, Topic Paper (2003); Patrick Parkinson and Catherine Humphreys, 'Children Who Witness Domestic Violence—The Implications for Child Protection' (1998) 10(2) *Child and Family Law Quarterly* 147. The Family Court has relied on this research: see *Patsalou and Patsalou* (1994) 18 Fam LR 426, 428–9; *In the Marriage of JG and BG* (1994) 18 Fam LR 255, 260.
- 36 *Children and Young Persons Act 1989* ss 84, 86, 87.
- 37 The working with children check is a mandatory check of criminal records for people who work or volunteer in child-related work in Victoria: *Working with Children Act 2005*.
- 38 Submission PP1 347 (South Australian Council on Reproductive Technology).

RECOMMENDATIONS

22. The review panel should be able to seek expert advice about the case before it from people:
 - with understanding of the concerns of people with ongoing disability or illness
 - with expertise in the rehabilitation of people who have committed sexual offences and/or offences involving violence.
23. There should be a gender balance in the membership of the review panel.
24. Members of the review panel should receive training about the conduct of hearings and the principles of natural justice and procedural fairness.
25. Decisions of the review panel should be reviewable by the Supreme Court of Victoria in accordance with the *Administrative Law Act 1978*.
26. The requirement that a woman who undergoes a treatment procedure be 'married and living with her husband on a genuine domestic basis', or 'living with a man in a de facto relationship' should be removed.
27. The Act should otherwise be amended to recognise that some people to whom the Act applies will be married or in heterosexual de facto relationships, some will be in same-sex relationships and others will not have partners.

The process and procedure to be applied should otherwise be for the panel to determine.

The members of the panel should be appointed by the Minister and should receive training about the conduct of hearings, the principles of natural justice and procedural fairness. The panel should comprise five members, including:

- a lawyer with experience in the conduct of hearings and knowledge of relevant areas of law, to sit as chair of the panel
- a person with expertise in child development and welfare and the prediction of risk of harm to children
- a person with expertise in the clinical medical practice of ART
- a psychologist or psychiatrist with expertise in families
- a person with knowledge of the ethics of clinical medical practice.

The inclusion of an ethicist is important to ensure the rights of patients are taken into account. A representative of a religious organisation is not required: religious considerations are not relevant to decisions about the health and wellbeing of children. There should be a gender balance in the membership of the review panel.

The panel should consider any relevant research and/or information available, or consult with a person or persons with expertise in a field that relates to the particular concern(s) being assessed. For example, the panel should be able to seek expert advice from people:

- with understanding of the concerns of people with ongoing disability or illness
- with expertise in the rehabilitation of people who have committed sexual offences and/or offences involving violence.

If the panel decides that a person should be barred from treatment, this should be conveyed to all clinics in Victoria. However, people should be able to reapply to the panel for approval of treatment if their circumstances have changed. If the panel decides that a person is not barred from treatment, the clinic should not be compelled to provide treatment.

Decisions of the panel should be reviewable on points of law, but not on their merits, because they are decisions made by a group of specialists. A decision of the panel should be declared to be a decision for the purposes of the *Administrative Law Act 1978*, giving rise to a right to review by the Supreme Court.

MARITAL STATUS

At present, the Infertility Treatment Act requires that a woman be married or in a de facto relationship with a man in order to undergo treatment.³⁹ As we have already discussed, this requirement no longer applies as a result of the decision in *McBain*.

In recent litigation, Victorian courts have been required to interpret the Act in light of the *McBain* requirements. In *AB v Attorney-General (Vic)*,⁴⁰ Justice Hargrave heard an application by a woman for permission to use the sperm of her deceased husband in a treatment procedure. He found that as a result of the *McBain* decision it was no obstacle to treatment that the applicant was unable to comply with the marriage requirement in section 8(1).⁴¹

In *YZ v Infertility Treatment Authority*,⁴² Justice Morris went further and said that as a result of the *McBain* decision, the Act 'must be read on the basis that certain of its provisions are inoperative, or, at least, must be understood as being subject to some modification'.⁴³ As a consequence, Justice Morris said that the word 'family' in the guiding principles of the Act should be construed broadly, and could extend beyond genetic relations.⁴⁴ Specifically, he said the guiding principle 'assisting the infertile to have children' must be read in modified form and suggested the formulation 'infertile couples or persons should be assisted in fulfilling their desire to have children'.⁴⁵

Although the marital status requirement is no longer legally valid, the commission received a significant number of submissions from people opposed to the use of ART by anyone other than married couples. They argued that it is not in the best interests of children to be born to parents who are not in a married heterosexual relationship. For example, these submissions included statements that 'ART procedures and IVF should be limited to married heterosexual couples',⁴⁶ 'the best interests of a child dictate that a mother and father unit, preferably cemented by marriage, is the ideal arrangement',⁴⁷ and '[r]estriction of IVF to married couples is the best way to give children born through IVF procedures the best chance of achieving [adequate and proper parenting]'.⁴⁸

As discussed in Chapter 2, the commission has reviewed the social science research on outcomes for children born to and raised in a diversity of family types. This research does not support the view that the marital status requirement should be retained to safeguard the health and welfare of children.

Marital status and sexuality are not factors that are considered by child welfare authorities or experts to be predictors of harm to children.⁴⁹ Moreover, our research has shown that the marital status requirement, which excludes a significant number of women from treatment, actually operates to increase the potential for children to be exposed to unacceptable health risks and to be deprived of the capacity to obtain information about their genetic parents.

The commission has concluded that the marital status requirement is not only inconsistent with the principle of non-discrimination, but it also bears no relationship to the health and wellbeing of children, which must be the paramount concern of the law governing ART. It is also unsustainable as a result of the decision in *McBain*.

The commission therefore recommends that the Act be amended to make it clear that women requiring assistance to become pregnant should not be excluded on the grounds that they have no partner or have a partner of the same sex. This would bring Victorian law into line with NSW, Queensland, Tasmania, Western Australia and the ACT.

Once the marital status requirement is removed from the Act, consequential amendments will need to be made to the legislation to recognise that a woman undergoing treatment may have a partner of the same sex or may be single.

INFERTILITY

Section 8(1) of the Infertility Treatment Act, which requires a woman to be 'unlikely to become pregnant', has been interpreted inconsistently for married women, women in heterosexual de facto relationships, and women without legally recognised male partners (whether they are single, in same-sex relationships or in a relationship with a man that is not considered a de facto relationship). The stricter interpretation that is applied to women without legally recognised male partners prevents them from receiving treatment in Victoria, unless they are clinically infertile.

Inconsistent application of the law in this area is unacceptable. It has no rational basis, is discriminatory, exposes women and children to health risks and deprives some children of statutory protections afforded to other donor-conceived children. It also places clinics in an invidious position. If the different application of the 'unlikely to become pregnant' requirement was tested in court, it is possible that a clinic which refused to treat a single woman would be found to be in breach of sex discrimination legislation. At the same time, the licensing conditions imposed on clinics require them to discriminate in this way.

This raises the question of whether there should be unrestricted access for anyone wanting treatment, for whatever reason, or whether there should be some limitation on access that applies consistently to all women seeking treatment.

We received a number of submissions stating that access to ART should be subject to some constraints. It was argued that an infertility requirement is an appropriate way of setting a threshold for access to limited health resources and a means of encouraging people to explore other options,⁵⁰ that circumventing infertility was the original purpose of ART and that this should remain the case.⁵¹ Others argued that an infertility requirement might be useful for access to more invasive procedures such as IVF/ICSI, as opposed to donor insemination.⁵² Submissions which supported an infertility requirement often said that it should apply to all women equally. As one submission commented, 'the level of [in] fertility, which is required before ART services are provided, should be uniform for all women, regardless of their marital status or sexual orientation'.⁵³

39 *Infertility Treatment Act 1995* s 8(1).

40 (2005) 12 VR 485.

41 *AB v A-G (Vic)* (2005) 12 VR 485, 498.

42 [2005] VCAT 2655 (Unreported, Morris P, 20 December 2005).

43 *YZ v Infertility Treatment Authority* [2005] VCAT 2655 (Unreported, Morris P, 20 December 2005) [26].

44 *YZ v Infertility Treatment Authority* [2005] VCAT 2655 (Unreported, Morris P, 20 December 2005) [40].

45 *YZ v Infertility Treatment Authority* [2005] VCAT 2655 (Unreported, Morris P, 20 December 2005) [43].

46 Submission CP 127 (Salt Shakers).

47 Submission CP 125 (Australian Family Association).

48 Submission CP 81 (Suryan Chandrasegaran).

49 Marital status and sexuality are not included in the list of parental characteristics tracked by the Department of Human Services, nor are they grounds for initiating child protection proceedings: (2002) above n 27.

50 Submission CP 182 (Anonymous).

51 Submission CP 61 (Neil Ryan).

52 Submission CP 143 (The Bouverie Centre, La Trobe University).

53 Submission CP 156 (Law Institute of Victoria).

RECOMMENDATIONS

28. Before a woman undergoes an assisted reproductive treatment procedure a doctor must be satisfied that the woman is:
- in the circumstances in which she finds herself, unlikely to become pregnant other than by a treatment procedure or
 - unlikely to be able to carry a pregnancy or give birth to a child without a treatment procedure or
 - at risk of transmitting a genetic abnormality or a disease to a person born as a result of a pregnancy conceived other than by a treatment procedure (including where the woman's partner is the carrier of the genetic abnormality or disease which is likely to be passed on to a child conceived other than by a treatment procedure).

For the purpose of (a), the doctor may be satisfied that a woman is unlikely to become pregnant other than by a treatment procedure if she does not have a male partner.

For the purpose of (c), the doctor must seek advice from another doctor who has specialist qualifications in human genetics or infectious diseases.

29. Where a woman does not satisfy these requirements she may apply to the review panel, which may authorise the clinic to provide the treatment procedure.
30. In deciding such applications the review panel should have regard to:
- the guiding principles of the Act
 - whether the treatment being sought is for a therapeutic goal, and is consistent with the best interests of the child to be born.
31. In circumstances where donated gametes are not available, treatment with donated embryos should be permitted even where one partner in a couple has viable gametes.
32. An ethics committee should be established to consider the ethical implications of new developments in treatment or new applications of existing techniques.
33. The Infertility Treatment Authority should provide administrative support to the ethics committee and should be responsible for

The main argument for some kind of infertility requirement was that some ART treatments create health risks for the child and the mother. The fact that some donor-conceived children experience psychological problems was also seen as a reason for limiting access. One donor-conceived person who believes that donor conception involves the unacceptable separation of a child from his or her genetic parent said in a submission:

Whilst there may be an equal opportunity discrepancy between the applications of 'unlikely to conceive' and 'clinically infertile', these two realities have many different implications for the child/adult. Donor conception already creates a subset generation of people with different rights to those conceived 'the old fashioned way'. Will not expanding the accessibility to donated gametes have more serious and far-reaching consequences?⁵⁴

On the other hand, some submissions argued that the infertility requirement should be removed. For example, some people argued that an infertility requirement unnecessarily 'medicalises' ART.⁵⁵ It was also argued that an infertility requirement is discriminatory against lesbian women because ART services are currently available to fertile heterosexual women with infertile husbands and there is no suggestion these women should conceive by having sex with another man, rather than accessing treatment in a clinic.⁵⁶

The commission has concluded that it is appropriate to limit access to ART because of its potential effects on the health and wellbeing of women and children. We do not propose that clinical infertility should be required as this would mean that some women who are married or in de facto relationships who are currently eligible for treatment would be excluded. It would also exclude women without male partners. Instead, the commission recommends that a woman be eligible for treatment if she is unlikely to become pregnant, and that her inability to become pregnant (or to carry a pregnancy or give birth to a child, or likelihood of transmitting a genetic abnormality or disease) be assessed on the basis of the circumstances in which she finds herself (whether single, married, in a same-sex relationship, psychologically averse to having sexual intercourse with a man, or otherwise). In this way, the 'inability to become pregnant' criterion would be interpreted broadly enough to permit people to seek treatment even where it is not due to clinical infertility.

If treatment is being sought for the purpose of avoiding the transmission of a genetic abnormality or disease, a doctor should be satisfied that the woman is at risk of transmitting such an abnormality. Genetic counselling should be offered to women seeking treatment for these reasons. Genetic counselling is provided by health professionals who can offer information and guidance about health issues that have a genetic basis.

There will be some situations in which treatment may be desirable for a woman who does not satisfy the requirement of being unlikely to become pregnant, or likely to transmit a genetic abnormality or disease. One example is the situation where a woman who has a living child, who is suffering from a genetic condition or other disorder, wishes to conceive a child who is a genetic match for this child. The child who is conceived through assisted reproduction may be able to donate bone marrow or some other tissue which could be used in the medical treatment of the sibling. The conception of a child to act as a 'saviour sibling' is controversial and the particular circumstances of the case would need to be carefully considered to ensure protection of the health and welfare of that child. As technology develops there may be other situations where treatment may be desirable, but where women do not meet the statutory criteria.

We recommend that the ITA review panel proposed above should be able to approve treatment for reasons other than an inability to become pregnant or the avoidance of a genetic abnormality or disease. The review panel will have the capacity to address the medical, social and ethical issues which are relevant to the particular case. The provision will also ensure the legislation is sufficiently flexible to respond to new problems. Only treatment for a therapeutic goal which is consistent with the best interests of the child should be permitted by the review panel. This would preclude the possibility of allowing a person or couple to select an embryo for a particular genetic trait, as opposed to selecting to exclude a particular trait, for non-therapeutic purposes. The review panel is the appropriate body to consider cases such as these, which raise ethical questions about new applications of ART and preimplantation genetic diagnosis (PGD) because it is centralised and independent, both of clinics and of government.

DONATED EMBRYOS

During our consultation process the ITA raised an issue about eligibility for donated embryos.⁵⁷ Currently a couple may only receive a donated embryo if neither member of the couple has viable gametes.⁵⁸ For example, if a man is fertile but his partner is unable to produce any eggs, the couple must use donated eggs to form an embryo to be transferred to the woman for gestation. This can be problematic because donated eggs are relatively scarce, in part because the process for successfully freezing and thawing eggs is still being developed. By contrast, donated embryos are more commonly available because they can be more successfully used after freezing. Further, many people in treatment programs have more embryos in storage than they need and choose to donate them once they cease treatment. The commission therefore recommends that treatment with donated embryos should be permitted even where one partner in a couple has viable gametes, in circumstances where donated gametes are not available.

ETHICAL IMPLICATIONS

Several submissions raised ethical concerns about the potential for ART to be used for purposes other than to achieve a pregnancy. These concerns were predominantly related to the practice of PGD. PGD is used by parents who wish to avoid passing a serious genetic disease to their children. Embryos are examined to determine if they are affected by a particular disease or disorder and only unaffected embryos will be transferred to the mother. There is a tension between the capacity of PGD to assist in the avoidance of specific genetic disorders and its potential to address a broader range of parental objectives. One submission argued that PGD amounts to eugenics and has negative implications for those people in the community who live with a disability.⁵⁹

A number of ethical considerations arise in the broader application of a service such as PGD. As technology develops there are likely to be more treatments and services available to people which also raise ethical considerations. The commission believes it is important for these developments to be subject to public scrutiny and discussion.

The ITA has already established an ethics panel but the existence, function and composition of this panel is not specified in the legislation. The commission recommends that an ITA ethics committee be established to consider and

advise on ethical concerns raised about new developments in and use of treatment. Such a process would be distinct from the processes we have recommended for consideration of issues that arise on a case-by-case basis (by clinical ethics committees and the review panel).

The ITA ethics committee should be a body whose members are appointed by the Minister. The ITA should provide administrative support and should have responsibility for convening the committee. It should also act on the advice of the committee when making decisions about applications and conditions for licence. This means that where the ITA becomes aware of a new development in treatment, or a new application of an existing technique (for example, a new form of PGD), the matter must be considered by the ethics committee before it permits clinics to make those treatments available pursuant to the ITA's conditions for licence. The committee would be guided in its consideration by the principles of the Act.

The membership of the committee should comprise:

- a representative from the Fertility Society of Australia (to engender consistency with national/RTAC approaches)
- a senior clinician not involved in ART, with experience in research
- an ethicist
- a person with expertise in public health policy and research, including the broad social determinants of health
- a person with expertise in child development and families.

The commission believes this combination of members will have the expertise to raise and address the many issues that may arise for consideration by the committee. We therefore do not believe that the ethics committee should necessarily include a representative of a religious organisation (although it is likely that some members of the committee will hold religious and other personal beliefs). It is not possible to adequately represent the range of perspectives advocated by the diversity of religions in Australian society.

The committee should be able to consult with experts in particular areas, for example a person with knowledge of and expertise in disability policy, as the need arises.

54 Submission CP 60 (Confidential).
Permission to quote given on 5 July 2004.

55 Submission CP 88 (Deborah Dempsey).

56 Submission CP 82 (Anonymous).

57 Correspondence from the Infertility Treatment Authority, by email, 15 February 2007.

58 *Infertility Treatment Act 1995* s 20.

59 Submission CP 166 (Christine Campbell).

RECOMMENDATIONS

34. Where the Infertility Treatment Authority becomes aware of a new development in treatment, or a new application of an existing technique, the matter must first be considered by the ethics committee before it permits clinics to make those treatments available pursuant to the Infertility Treatment Authority conditions for licence.
35. Where an approved doctor, scientist or counsellor considers that a new development in treatment or a new use of treatment raises ethical concerns, the matter must be referred to the Infertility Treatment Authority ethics committee for advice.
36. In reaching a decision about whether clinics should be able to make the new development in treatment available, the ethics committee:
 - must have regard to the guiding principles of the Act
 - may choose to undertake public consultation.
37. The Infertility Treatment Authority should act on the advice of the ethics committee when making decisions about applications and conditions for licence.
38. The ethics committee should comprise five members appointed by the Minister, including:
 - a representative from the Fertility Society of Australia
 - a senior clinician not involved in assisted reproductive technology, with experience in research
 - an ethicist
 - a person with expertise in public health policy and research, including the broad social determinants of health
 - a person with expertise in child development and families.
39. The committee should be able to consult with experts in particular areas, for example a person with knowledge of and expertise in disability policy, as the need arises.
40. The Infertility Treatment Act should be renamed the Assisted Reproductive Technology Act.
41. The Infertility Treatment Authority should be renamed the Assisted Reproductive Technology Authority.

CONSENT, COUNSELLING AND INFORMATION

There was general consensus in submissions, consultations and research conducted by the commission on the importance of the consent, counselling and information provisions of the Act. These provisions all contribute to the process of ensuring that people make informed decisions that are appropriate for them and for any child that may be born as the result of treatment. The commission believes that the principles we have identified to guide and inform all aspects of ART should be incorporated into the pre-treatment processes. It is also necessary for prospective patients to be given information about the processes and mechanisms established to protect the interests of children, their right to have decisions reviewed, and their right to be heard by the ITA review panel.

LEGISLATION AND REGULATORY BODY

The commission believes that in recognition of the fact that many people who seek and undergo ART are not infertile, references to infertility should be removed from the name of the legislation and the licensing authority. The commission recommends that the Act be renamed the Assisted Reproductive Technology Act, and that the ITA be renamed the Assisted Reproductive Technology Authority.