

(RE)PRODUCING LESBIAN INFERTILITY

Discrimination in Access to Assisted Reproductive Technology

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This paper discusses a small corpus of Australian anti-discrimination cases from the 1990s dealing with access to assisted reproductive technology by single women and lesbian women. Two central propositions emerge from the paper's analysis of these cases: first, the less a complainant's circumstances appear to conform to the norm of the heterosexual nuclear family form, the less likely it is that exclusion from access to reproductive assistance will be considered to be discriminatory; and secondly, the further one moves towards a medical paradigm framing the issues in terms of a 'medical need' for fertility treatment, the less likely it is that eligibility criteria which exclude 'alternative' family forms will be considered discriminatory. The paper concludes with a discussion of some of the premises behind and implications of the proposed amendments to the *Sex Discrimination Act 1984* (Cth).

For those who believe equality is an elemental rule of law, the discourse of discrimination is a disappointment.¹

Preamble

In discussing the advent of new reproductive technologies, Anita Stuhmcke argues that such technologies offer a profound challenge to 'current social definitions of reproduction, sexuality and family'² by introducing a third party (at the very least a doctor and sometimes also a donor or surrogate mother) into the procreation process, and more significantly, by making male/female sexual intercourse unnecessary for reproduction. In response to this challenge, legal regulation of these technologies has attempted to reaffirm the norms

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¹ R Robson (1992) *Lesbian (Out)law: Survival under the Rule of Law*, Firebrand Books, p 81.

² A Stuhmcke, 'Lesbian Access to In Vitro Fertilisation' (1997) 7 *Australasian Gay and Lesbian Law Journal* 15, p 16.

associated with the traditional pattern of procreation, to 'control medical advances to limit possibilities for social change':³

legal regulation is a mechanism used to mould reproductive technologies into a form which resembles traditional forms of procreation — restrictive access ... is one method utilised to ensure that only the 'appropriate' people access this health service in order to procreate. Those persons which are 'appropriate' are those which conform to the nuclear heterosexual family form (preferably married).⁴

This restricted access, she argues, is a clearly discriminatory (and one might add, singularly successful) attempt to prevent 'improper' pregnancy' through what might be described as a form of 'regulatory contraception'. 'Inappropriate' women — ranging from the (almost) desirable heterosexual woman in a long-term de facto relationship to the (distinctly less) desirable single (and presumptively) heterosexual woman, to the (f)rankly undesir(eable)/(ing) lesbian woman, whether single or partnered — must be kept away from childbirth:

It is clear that the policy of who may access IVF is based upon exclusion. Only a woman who is heterosexual and in a stable de facto relationship or married is assured of access to IVF. As such women are accepted as the social norm, it appears that the aim of the regulation in all jurisdictions is to prevent those women who deviate from the norm from accessing reproductive technology. There is little doubt that this regulation is discriminatory.⁶

There are nonetheless, Stuhmcke suggests, some signs of legal change to be found in a small corpus of recent and rather extraordinary decisions — each 'remarkable incidents ... in the reproduction revolution'.⁷ Collectively, these decisions are understood by Stuhmcke to indicate two significant legal developments. First, at minimum, they indicate that attempts to limit access to assisted reproductive technologies (ART) to heterosexual married couples may well be found to constitute unlawful discrimination against:

- **heterosexual de facto couples** (on the basis of marital status) (*MM, DD, TA & AB v The Royal Women's Hospital, Freemason's Hospital & State of Victoria*);⁸

³ *ibid.* p 32.

⁴ *ibid.* p 17.

⁵ L Secomb, 'IVF: Reproducing the 'Proper [Family] of Man'' (1994) 4 *Australian Feminist Law Journal* 19, p 32.

⁶ Stuhmcke (1997) p 27.

⁷ D Morgan, 'Rights and the Legal Status of Embryos' (1996) 4(7) *Australian Health Law Bulletin* 61, p 61.

⁸ Unreported, Human Rights and Equal Opportunity Commission, 11 March 1997. A digest and extracts of the decision appear at (1997) EOC 92–886. Throughout

- **single women** (presumably whether heterosexual or lesbian) (also on the basis of marital status) (*Pearce v South Australian Health Commission*);⁹ and
- most controversially, **lesbian couples** (on the basis of sexual orientation). (*JM v QFG & GK*)¹⁰

Second, at a more abstract level, Stuhmcke suggests that these decisions may be indicative of a growing willingness to give legal recognition to 'alternative' family forms. Concluding her analysis of this corpus with a certain optimism, Stuhmcke points to a 'slow response to shifting social norms'¹¹ which she describes as:

a shift in Australian law away from the perceived norm of the heterosexual nuclear family as the only environment where children may be raised to a recognition that other family forms are capable of providing the love and support necessary for family and thus are deserving of legal support.¹²

Introduction: Giving Birth to New Family Forms: A Twinkle in the Legal Eye?

For the purposes of this article, I want to take Stuhmcke's analysis as a point of departure. Her analysis is, in some respects, a compelling one. The corpus she discusses undoubtedly does indicate a change in the accessibility of ART, as a consequence of which assisted reproduction can no longer be limited to (heterosexual) married couples. This is clearly the upshot of the decision in *MM, DD, TA & AB v The Royal Women's Hospital, Freemason's Hospital & State of Victoria*, which will be outlined below.

this article, references are to the unreported full text of the decision. See also Stuhmcke (1997) pp 29–30.

⁹ (1996) 66 SASR 486. See also A Stuhmcke, 'Access to Reproductive Technology: *Pearce v SA Health Commission*' (1996) 5(4) *Australian Health Law Bulletin* 39; Stuhmcke (1997) p 29; K Costigan, 'DI Test Case Good News for Lesbians' (1996) 7(11) *Lesbians on the Loose* 7; K Costigan, 'Baby for IVF Reformer' (1997) 8(6) *Lesbians on the Loose* 5.

¹⁰ Unreported, Queensland Anti-Discrimination Tribunal, 31 January 1997. See also Stuhmcke (1997) pp 29–30; J Devereux, '*Re B and J (Artificial Insemination): Family Court of Australia: Fogarty J (1996) 135 FLR 472*' (1998) 5 *Journal of Law and Medicine* 330; L Bunney, 'Discrimination and Assisted Reproductive Technology: *JM v QFG, GK and State of Queensland (Queensland Anti-Discrimination Board)*' (1997) 5(6) *Australian Health Law Bulletin* 57; Human Rights and Equal Opportunity Commission, (1997) 'Media Release: IVF Discrimination Complaint Upheld' www.austlii.edu.au/do/disp.pl/au/other/hreoc/pubaffar/ivf accessed 25 September 1998.

¹¹ Stuhmcke (1997) p 40.

¹² *ibid.* p 29; Stuhmcke (1996) p 40.

It is much less clear, however, that this corpus — even when it appears to make ART available to single women, as in *Pearce v South Australian Health Commission* — provides evidence of a shift away from the normative preference given to the (heterosexual) nuclear family. This seeming paradox, which will be discussed below, is nicely illustrated by reading *Pearce* together with another, earlier, South Australian decision that concerns a single woman refused access to fertility treatment, and which Stuhmcke does not discuss: *Yfantidis v Jones and Flinders Medical Centre*.¹³

The remainder of the article will be concerned with the decision in *JM v QFG & GK* which deals with the position of lesbian women refused access to ART on the basis of sexual orientation. This scenario is the litmus test for Stuhmcke's argument. That de facto couples should have access to ART ultimately affirms the norm of the heterosexual nuclear family and, even in the circumstance of a single woman seeking reproductive assistance, the (inevitable) presumption of heterosexuality suggests the possibility that, even though a 'family' might have been formed by alternative means, a 'normal' (heterosexual, nuclear) family form might emerge in the event that a (heterosexual) partnership is established. By contrast, the possibility that a lesbian couple might avail themselves of ART represents a much more profound challenge to the norm of the heterosexual nuclear family. That such a possibility should be available was, in effect, the view taken by the Queensland Anti-Discrimination Tribunal in *JM v QFG & GK*. This decision will be outlined below. Had the ultimate outcome of this litigation been to facilitate this possibility, it would have been a very significant — indeed, in Stuhmcke's terms, 'groundbreaking'¹⁴ — decision. However, the subsequent determination of this matter on appeal before a single judge of the Supreme Court of Queensland,¹⁵ then before the Court of Appeal,¹⁶ which will be analysed later in this article, produces quite the contrary effect: a profoundly norm-affirming *resistance* to, in Stuhmcke's terms, any 'significant shift towards allowing all women access to reproductive technology'.¹⁷

As a final prefatory remark, and before turning to detailed analyses of these cases, I would like briefly to signal, in advance, two broad propositions which I take to emerge from, and which provide a thematic structure to, these analyses:

- the less a complainant's circumstances appear to conform to the norm of the heterosexual nuclear family form, the less likely it is that exclusion from access to reproductive assistance will be considered to be discriminatory; and

¹³ (1993) 61 SASR 458. See also (1994) EOC 92–555.

¹⁴ Stuhmcke (1997) p 30.

¹⁵ *QFG & GK v JM* (1997) EOC 92–902.

¹⁶ *JM v QFG & GK* [2000] 1 QdR 373.

¹⁷ Stuhmcke (1997) p 30.

- the further one moves away from a discursive and doctrinal framework constructing the issues in terms of a legal 'right' to access assisted reproduction, towards a medical paradigm framing the issues in terms of a 'medical need' for fertility treatment, the less likely it is that exclusionary eligibility criteria will be considered to be discriminatory.

Sowing Seed In/Fertile Ground

Two (Funereal) Weddings and Some Interstate Travel

Having regard to ... a woman's right to control her own body, a woman's marital status should not determine when and if she is able to receive the medical treatment she seeks. Marital status has no relevance to the type of medical treatment which should be available to women and it should not be a bar to obtaining medical services which are readily available ... [U]nmarried women are entitled to a full range of medical services including treatment for infertility.¹⁸

As members of stable, long-term heterosexual de facto couples whose medical need for infertility treatment was never contested, the complainants in *MM, DD, TA & AB v The Royal Women's Hospital, Freemason's Hospital & State of Victoria*¹⁹ occupy a rather privileged position. Theirs is the paradigmatic example of discrimination in access to ART, the benchmark against which other complainants (implicitly or explicitly) will be measured. Their complaint arose when, during 1993, each of the three women sought in vitro fertilisation (IVF) treatment in two Victorian infertility clinics. Access to the clinics' IVF program was denied in each case because the women were not married. Between 1993 and 1995, complaints of discrimination on the basis of marital status pursuant to sections 22 and 26²⁰ of the *Sex Discrimination Act 1984 (Cth)*²¹ were lodged by the women with the Victorian Equal Opportunity

¹⁸ *MM, DD, TA & AB v The Royal Women's Hospital, Freemason's Hospital & State of Victoria* (unreported, Human Rights and Equal Opportunity Commission 11 March 1997) at paragraph 111.

¹⁹ Unreported, Human Rights and Equal Opportunity Commission, 11 March 1997.

²⁰ These provisions make discrimination on the basis of the sex, marital status, pregnancy, or potential pregnancy of a person unlawful in the provision of goods, services and facilities (s 22) and in the administration of Commonwealth laws and programs (s 26).

²¹ Section 6 of that Act defines direct marital status discrimination in these terms: the 'discriminator' discriminates against the 'aggrieved person' if, by reason of the marital status of the aggrieved person (s 6(1)(a)) or of a characteristic that generally appertains to (s 6(1)(b)) or is generally imputed to (s 6(1)(c)) persons of that marital status, the discriminator treats the aggrieved person less favourably than s/he would treat a person of a different marital status in circumstances that are not substantially different. 'Marital status' is defined in s 4 as the status or condition of being single, married, divorced, widowed, married but living

Commission. In 1996, the complaints were referred to the Human Rights and Equal Opportunity Commission (HREOC) for hearing and determination. Each of the women had been living in a long-term stable heterosexual relationship of between seven and seventeen years' duration. Two of the women — DD and MM — had made deliberate and conscious decisions not to get married, believing the institution of marriage to be either anachronistic or destructive of women's identity, independence and equality. Eventually, and solely for the purpose of entering the IVF program, both women married their partners.²² The third complainant and her partner (who had both been married previously and had no desire to marry again) decided to seek treatment in New South Wales, thus occasioning considerable travel and accommodation costs.

In their defence, the respondent hospitals argued that their policy limiting access to IVF treatment to married couples was required by provisions of the Victorian *Infertility (Medical Procedures) Act 1984*.²³ Section 5 of that Act, read in conjunction with section 10(3), specifically provided that the IVF procedures with which these complainants were concerned²⁴ were not to be carried out unless a number of criteria were fulfilled, including that 'the woman in relation to whom the procedure is carried out is a married women' (section 10(3)(a)).²⁵ The potential penalties for failing to carry out procedures in accordance with the Act included a \$10,000 fine or imprisonment of up to four years (section 5(1)) and the variation (section 7(4)) or cancellation (section 7(5)) of the hospital's ministerial approval to carry out such procedures. Whilst sympathetic to the plight of the complainants, the respondent hospitals considered that they could not jeopardise their licences or risk exposing themselves and individual staff members to prosecution. For its part, whilst sympathetic that the hospitals and medical practitioners had had to

separately from one's spouse, or a de facto spouse (i.e. a member of an opposite sex couple living on a *bona fide* domestic basis as husband and wife).

²² MW and her partner had entirely concealed the fact of their marriage. DD and her partner (having undergone four years of treatment preparatory to entering the IVF program before being informed of their ineligibility) considered concealing their marriage but felt ultimately that they could not be burdened with a long-term secret in circumstances where they already felt that the decision to marry had been imposed upon them.

²³ This Act was later repealed and replaced by the *Infertility Treatment Act 1995* (Vic) (as amended by the *Infertility Treatment (Amendment) Act 1997* (Vic)) with generally similar provisions, the notable exception being that IVF and artificial insemination procedures are now available to couples in de facto relationships (s 8 read in conjunction with s 3) who also satisfy the other eligibility criteria.

²⁴ Section 10 applied to IVF procedures involving the 'implanting in the womb of a woman an embryo derived from an ovum produced by her and fertilized outside her body by semen produced by her husband' (s 10(1)).

²⁵ As a transitional measure, s 2 of the Act had extended the definition of a 'married woman' to include women who, at the commencement of the Act, were living with a man on a *bona fide* domestic basis (s 2(a)(i)) and who had already undergone examination or treatment with a view to carrying out an IVF procedure (s 2(a)(ii)). The complainants did not fall within this definition.

make a difficult decision, the HREOC concluded unequivocally that the exclusionary policy of the clinics was discriminatory:

The complainants are entitled to the views which they hold about marriage. Any decision to marry or not to marry ought to be a decision of the individuals concerned. Neither decision ought to be imposed by outside bodies of persons ... At the same time the complainants accept that the hospitals were faced with a difficult choice in determining whether to accept them for treatment having regard to the penalties under the Victorian Act ... However, the evidence is clear that the hospitals made a choice albeit a difficult one that they would comply with the Victorian Act with the knowledge that their conduct would be in contravention with the *Sex Discrimination Act*. They must accept the consequences of that choice.²⁶

Some South Australian Progenitors

The HREOC's decision that a marital status condition determining eligibility for ART services will constitute unlawful discrimination had clearly been anticipated by two South Australian decisions — *Yfantidis v Jones and Flinders Medical Centre*²⁷ and *Pearce v South Australian Health Commission*.²⁸ Both cases considered the position of single women seeking to obtain treatment for infertility; both complainants were successful in obtaining the orders that they sought. But it cannot be inferred from these decisions that there is a general acceptance (either judicially or medically) that ART should be accessible on a non-discriminatory basis to single women. By stark contrast to the HREOC's affirmation of the irrelevancy of the marital status of heterosexual de facto couples, the spectral figure of the absent (male) partner is insistently and ominously present.

This is particularly apparent in *Yfantidis v Jones and Flinders Medical Centre*. In 1987, Stella Yfantidis was 25. She had a seven-year-old son from a previous relationship, which had ended in 1986. She had had a series of gynaecological problems both before and after her son's birth, including pelvic inflammatory disease, eventually resulting in the removal of her left fallopian tube. At this time she was informed that her right fallopian tube might be blocked and that it might be difficult for her to conceive again, although there was no further investigation of the right fallopian tube at that time or subsequently. In June 1986, she had commenced a sexual relationship with Samir Sheik-Al-Vasatneh. They lived together for nearly two years from the end of 1987 to October 1990. At the beginning of July 1987, Yfantidis attended the Fertility Clinic at the Flinders Medical Centre where she consulted Professor Jones. She was not, at that point, living with Al-Vasatneh,

²⁶ *MM, DD, TA & AB v The Royal Women's Hospital, Freemason's Hospital & State of Victoria* (unreported, Human Rights and Equal Opportunity Commission, 11 March 1997) at paragraphs 108–10.

²⁷ (1993) 61 SASR 458. See also (1994) EOC 92-555.

²⁸ (1996) 66 SASR 486.

but considered the relationship to be a serious one. As it was her understanding that he considered children to be an important aspect of a permanent relationship and that it might be a determining factor in whether or not they would eventually marry, she had decided to determine whether her right fallopian tube was functional. She had not discussed the purpose of her attendance at the Fertility Clinic with Al-Vasatneh.

In terms of its general operation, the Fertility Clinic undertook two functions: first, the assessment and treatment of couples with fertility problems; and second, the assessment of the fertility status of individuals. In respect of the first of these functions, the Flinders Medical Centre had developed a set of eligibility criteria governing the provision of IVF and artificial insemination (AI) procedures. Specifically, the clinic required that:

- the patient be part of a 'stable couple', understood to refer to a married couple or couple living in a de facto relationship of at least two years' standing;
- both partners submit to the examination; and
- both partners participate in the counselling provided by the clinic.

These criteria applied only once the *treatment* stage had been reached. For the purposes of fertility *assessments*, either of individuals or couples, there was no requirement as to marital status, nor was it necessary that the partner, if any, be examined.

When Yfantidis attended the Fertility Clinic in July 1987, she made it clear to Professor Jones that she did not wish for Al-Vasatneh to be examined and that she merely 'wanted to ascertain "the state of her pelvis"'.²⁹ It was agreed that a laparoscopic assessment of her pelvis would be carried out. The laparoscopy revealed that the right fallopian tube was 'twisted and bound down with adhesions'.³⁰ At the subsequent consultation with Professor Jones, he informed Yfantidis that microsurgery would be a viable option for clearing the fallopian tube and freeing it of adhesions, but that it was uncertain whether this would in fact restore proper function. Professor Jones stated that he would perform the surgery, as requested by Yfantidis, but only on condition that she comply with the three requirements listed above. As she did not comply with the marital status requirement and as she had again made it clear to him that she did not wish for Al-Vasatneh to be involved, Professor Jones refused to perform the microsurgery.

In October 1987, Yfantidis complained to the Equal Opportunity Commissioner, alleging that the refusal to perform the microsurgery constituted discrimination in the provision of goods or services on the grounds

²⁹ (1993) 61 SASR 458 at 463 per Debelle J.

³⁰ *ibid.* p 464.

of marital status.³¹ After an unsuccessful conciliation, the complaint was referred to the Equal Opportunity Tribunal for hearing and determination. The Tribunal dismissed the complaint on the basis that although there had been a refusal to provide a service, this refusal was not 'by reason of' (section 29(5)(a)) Yfantidis' marital status, but rather, it was made on the basis of a 'medical judgment'. Specifically:

The Tribunal accepted Professor Jones' view that it would have been medically reprehensible to perform [the] microsurgery without knowing whether Mr Al-Vasatneh was fertile. It would have been pointless to undertake ... a surgically invasive and complicated procedure to attempt to correct a damaged fallopian tube if Mr Al-Vasatneh had been infertile. Instead, it would be better to pursue other treatment such as donor insemination or the use of in vitro fertilisation with donor insemination. It was also Professor Jones' view that it was medically ill advised to proceed with microsurgery to seek to restore fertility to a woman if she were not going to be exposed to the possibility of pregnancy within the next twelve months [as] there can be a gradual deterioration following microsurgery ... In short, microsurgery would be appropriate only if there was both an intention and an ability for the woman to become pregnant within 12 months after the operation.³²

The Tribunal acknowledged that, had Yfantidis allowed her partner to be involved, she would still have been refused the microsurgery, as she did not comply with the marital status requirement. In this circumstance, the decision to refuse the treatment may well have been on the basis of her marital status. But this, the Tribunal concluded, was not the relevant question, for even if she had complied with the marital status requirement, treatment would still have been refused because she was unwilling to allow her partner to be involved. In this sense, she was not treated less favourably than a similarly situated married woman: regardless of her marital status, *any* woman refusing to allow her partner to be involved would have been refused treatment on that basis. Thus her marital status 'never became a relevant factor':

³¹ Section 39 of the South Australian *Equal Opportunity Act* 1984 makes it unlawful to discriminate by refusing to supply goods or perform services. Section 29 defines discrimination, with the relevant part of that section — s 29(5)(a) — providing that:

[A] person discriminates against another on the ground of his marital status if: (a) he treats the other person less favourably by reason of his marital status than in identical or similar circumstances he treats, or would treat, a person of a different marital status.

Marital status is defined in s 5 as the status or condition of being single, married, divorced, widowed, married but living separately from one's spouse, or a de facto spouse (i.e. a member of an opposite sex couple living on a *bona fide* domestic basis as husband and wife).

³² (1993) 61 SASR 458 at 466 per Debelle J.

We accept the evidence of Professor Jones ... that Ms Yfantidis set the agenda from the outset, by her vehement exclusion of her partner. This precluded, on the medical grounds expressed in the evidence which we accept, any opportunity to explore further the question of providing the service.³³

On appeal to a single judge of the Supreme Court, the Tribunal's decision was set aside and in lieu an order was made that Professor Jones and the Flinders Medical Centre had discriminated against Yfantidis on the grounds of her marital status. DeBelle J found that in determining whether the refusal to provide treatment had been 'by reason of' (section 29(5)(a)) Yfantidis' marital status, the Tribunal had failed to take account of the operation of section 6(2) of the *Equal Opportunity Act* 1984. Section 6(2) provides that where a person acts on a number of grounds, one of which is a ground of discrimination referred to in the Act, then that person will be deemed to have acted on that discriminatory ground provided that it is a 'substantial reason' for the his/her act. Professor Jones' evidence clearly disclosed that there were two reasons for his decision — Yfantidis' marital status and her refusal to allow her partner to be examined — and that each of these reasons was equally important. In DeBelle J's view, the purport of section 6(2) was that it was not necessary for Yfantidis' marital status to be the only — or even the predominant — reason for which the treatment was refused. Nor did it matter, once marital status was accepted as 'a substantial reason' for refusing to provide the treatment, that there were also (non-discriminatory) 'medical reasons' which would have independently justified the refusal to perform the microsurgery. DeBelle J concluded:

The question the Tribunal should have asked itself was, 'Was the appellant treated less favourably than a married woman seeking microsurgery to repair her right fallopian tube for the purposes of becoming fertile?' The answer to that question must be, 'Yes' because the condition as to her marital status disqualified the appellant even if she had agreed to Mr Al-Vasatneh being examined. The medical reasons which justified refusing to perform the microsurgery until he was examined do not alter the fact that the refusal was also based on the appellant's marital status.³⁴

The factual circumstances and findings in this case present a medically, legally complex and, in some ways, exceptional situation. The microsurgery was requested in the broad context of the assessment and treatment of infertility. Even assuming her partner had been fertile, Professor Jones had made it clear that it was very doubtful that the microsurgery would ultimately restore the function of Yfantidis' right fallopian tube, in which case further treatment would have been necessary in order to achieve a pregnancy and may well have included IVF or AI procedures. Because section 5(2) of the *Equal*

³³ *ibid.* at 468 per DeBelle J.

³⁴ *ibid.* at 471 per DeBelle J.

Opportunity Act 1984 exempts IVF and AI procedures from the operation of the Act, such further treatment could lawfully have been refused so long as Yfantidis continued not to comply with any one of the three treatment eligibility criteria set by the Fertility Clinic, including the marital status criterion. The peculiarity of this case is that the microsurgery itself fell both just beyond the fertility assessment stage (at which stage the eligibility criteria were not applicable) and just short of the exemption for IVF and AI procedures (at which point the eligibility criteria would not have been unlawfully discriminatory).

This peculiarity leads Debelle J into a speculation headed 'A Doctor's Dilemma',³⁵ an almost melodramatic piece in which one's sympathies are drawn towards the fated hero/victim forced to tread an impossibly thin and perilous line between the twin dangers of Scylla and Charybdis. On the one side, Professor Jones' 'medical judgment' was that it would have been 'reprehensible' (because it would have been pointless) to perform the microsurgery if Yfantidis' partner were infertile. On the other side was a 'kind of legal minefield'³⁶ constituted by the near-impossibility of finding a form of words in which to express this judgment without exposing himself to liability either for discrimination or in negligence. Debelle J had some astute advice to offer on how to navigate a steady course — in effect, 'Don't take short cuts!':

If he had agreed to perform the microsurgery, Professor Jones was required by law to inform [Yfantidis] of the relevant implications of the procedure. If he had failed to do so he might have been liable to an action in negligence: *Rogers v Whitaker* (1992) 67 ALJR 47. Professor Jones would then have informed [Yfantidis] not only of the risks inherent in the procedure but also that the procedure would be pointless if Mr Al-Vasatneh was infertile and that the only means by which she could have a child, while living with him, was to undergo artificial insemination or in vitro fertilisation. He would then have [lawfully] advised [Yfantidis] that he would refuse those services because she was not married or had not been living in a stable de facto relationship for two years. In short, had Professor Jones expressed himself in these terms, he would simply have been advising [Yfantidis] of all the risks involved ... But he took a short cut and, because he did not express himself in an appropriate manner, he is guilty of discriminatory conduct. In all the circumstances, it cannot be said there is any real culpability in the conduct of Professor Jones. The offence has all the hallmarks of a technical offence.³⁷

Wise counsel for a blameless innocent, adrift in stormy seas.

Notwithstanding that it is entirely speculative and added almost, it appears, as a kind of afterthought, this meditation on Professor Jones' 'dilemma' is, rhetorically, absolutely central. In this meditation, Debelle J

³⁵ *ibid.* at 472.

³⁶ *ibid.* at 473 per Debelle J.

³⁷ *ibid.* at 472–73 per Debelle J.

recasts what the decision itself concludes was Professor Jones' discriminatory conduct as a 'technical offence' devoid of any real culpability. But by that very same gesture, he also effectively recasts the actual determination in favour of Yfantidis as a kind of 'technical success', as it were, devoid of any real merit. This gesture is possible because at no point is it suggested that the exemption in relation to IVF and AI procedures is itself in any way questionable. Indeed, very much to the contrary, Debelle J recommends that '[i]f the exemption is to have any useful operation' it should be extended to include 'any treatment which might ultimately result in in vitro fertilisation or artificial insemination'.³⁸ The 'useful operation' to which Debelle J is referring here is a question of ensuring the simplicity and interpretability of the law: the legislation should 'be capable of ready and easy understanding and application'³⁹ which is not aided by artificially distinguishing between IVF and AI procedures themselves and the various forms of fertility treatment preliminary to such procedures. Debelle J's recommendation to extend the operation of the exemption is also 'useful' for another, more basic but unstated purpose. That is, this recommendation affirms a fundamental normative assumption which very clearly runs counter to the ultimate determination: to argue for the extension of this exemption is implicitly to accept (perhaps even to insist) that a marital status requirement such as the one used by Professor Jones *is*, in effect, an appropriate criterion for determining the availability of (an even more broadly defined range of) reproductive assistance. Or, to put the point somewhat more forcefully, to argue as Debelle J does is to accept implicitly that single women simply should not be able to insist upon access to assisted reproduction.

The proposition that eligibility criteria that exclude single women from accessing ART on the basis of their marital status will amount to unlawful marital status discrimination was expressly considered and accepted in *Pearce v South Australian Health Commission*.⁴⁰ In that case, the plaintiff, who had separated from her husband in 1994 and who was at the time of bringing the action living alone, wished to participate in an IVF program. She was denied access to the program by the hospital's administrator on the basis of a mandatory licensing condition contained in s 13 of the *Reproductive Technology Act 1992* (SA) which prohibited the provision of artificial fertilisation procedures to single women. The relevant parts of that section are as follows:

13(1) ... [A] person must not carry out an artificial fertilisation procedure except in pursuance of a licence granted by the Commission.

(3) A licence will be subject to ...

³⁸ *ibid.* at 473 per Debelle J.

³⁹ *ibid.*

⁴⁰ (1996) 66 SASR 486.

- (b) a condition preventing the application of artificial fertilisation procedures except for the benefit of married couples in the following circumstances;
 - (i) the husband or wife (or both) appear to be infertile; or
 - (ii) there appears to be a risk that a genetic defect would be transmitted to a child conceived naturally ...
- (4) In subsection (3) — ‘married couple’ includes two people who are not married but are cohabiting as husband and wife and who:
 - (a) have cohabited continuously as husband and wife for the immediately preceding five years; or
 - (b) have, during the immediately preceding six years, cohabited as husband and wife, for periods aggregating at least five years.

The plaintiff therefore sought and obtained a declaration of inconsistency by virtue of section 109 of the Constitution (Cth) between section 13 of the *Reproductive Technology Act* 1992 (SA) and section 22 (read in conjunction with section 6) of the *Sex Discrimination Act* 1984 (Cth).⁴¹ Such an inconsistency was ‘not difficult to discern’:⁴²

When the provisions of the *Sex Discrimination Act* and the *Reproductive Technology Act* are examined side by side it is *immediately apparent* that there is direct inconsistency between the two sets of legislation. ... It is *not surprising* that none of the parties ... sought to resist the conclusion that there was a collision between the two pieces of legislation such as to amount to ‘inconsistency’ within s 109 of the *Australian Constitution*.⁴³

What emerges strikingly from this passage is the Court’s own (and entirely proper) insistence on the self-evidence of its conclusions. That such restrictions on access to ART do present problems of marital status discrimination *is* ‘immediately apparent’ — it *is* obvious.⁴⁴ Contrary to Stuhmcke’s analysis, however, it is not obvious that this decision indicates a ‘shift in terms of the social perceptions of reproductive technology itself’ such that, following this decision, ART will be considered ‘just another means of family formation’.⁴⁵ It is not at all obvious that this decision ‘represents a legal sanctioning of “alternative” family forms’ or that it points to ‘a shift ... away

⁴¹ See notes 20 and 21 above.

⁴² (1996) 66 SASR 486 at 489 per Williams J.

⁴³ *ibid.* at 490 per Williams J (emphasis added).

⁴⁴ Stuhmcke (1995) p 40; S Edwards and D Templeman, ‘Discrimination in Access to Reproductive Technology’ (1994) 2(10) *Australian Health Law Bulletin* 126, p 127; M Kirby, ‘Examination of Reproductive Technology’ (1994) 2(8) *Australian Health Law Bulletin* 93, p 94.

⁴⁵ Stuhmcke (1996) p 40.

from the perceived norm of the heterosexual nuclear family'.⁴⁶ Moreover, and of particular interest for my purposes, it is not even obvious that this decision 'means that reproductive technology in South Australia should now be available to single persons'.⁴⁷

Regrouping

This last proposition may seem a somewhat paradoxical assertion. The Court did conclude that there was an inconsistency between the provisions of the *Reproductive Technology Act 1988 (SA)* purporting to restrict access to ART to married and (heterosexual) de facto couples, and the provisions of the *Sex Discrimination Act 1984 (Cth)* prohibiting marital status discrimination. Such a conclusion was, in the Court's view, 'immediately apparent' and it might seem logically to follow from this that ART should now be available in South Australia, to single persons. Appearances, of course, can be deceiving and they are never immediate: when *Pearce* is read in conjunction with its conspicuously absent precursor, *Yfantidis* — when *Yfantidis* is taken as the (visibly invisible) lens that draws *Pearce* into focus — even the most minimal implications of the decision that Stuhmcke asserts are cast into doubt.

In order to make this argument (one which is complex and in some ways counter-intuitive), I want to begin by examining two related propositions advanced by Stephen Edwards and Deborah Templeman concerning the broader implications of *Yfantidis*. First, they suggest that the reasoning of this decision might logically be extended to include circumstances where access to fertility treatment falling short of IVF and AI procedures is refused on the basis of, for example, sexual orientation, age or disability. Second, they suggest that any attempt to reformulate discriminatory eligibility criteria in terms of a (medical) definition of infertility would be 'unlikely to find favour in the courts'.⁴⁸ When each of these propositions is considered in turn, it will become apparent that neither is sustainable.

Discussing generally the issue of whether 'providers of reproductive technology should be allowed to impose conditions in relation to marital status', Edwards and Templeman note that the National Bioethics Consultative Committee recommended in 1991 that 'discriminatory restrictions on access [to ART] should be reviewed by State anti-discrimination instrumentalities'.⁴⁹ Following on from this recommendation, they suggest:

The *Yfantidis v Jones* decision may indicate that momentum is gathering for the issue to be brought to a head. No doubt homosexual couples and those who might be excluded from access by age, prior

⁴⁶ Stuhmcke (1997) p 29.

⁴⁷ *ibid.* p 28.

⁴⁸ Edwards and Templeman (1994) p 127.

⁴⁹ *ibid.*

children or disability, will be watching developments in relation to marital status discrimination with interest.⁵⁰

These groups may well have been watching with interest, but they will certainly not have been watching with any great optimism. For (as suggested above), despite an outcome ultimately favourable to the plaintiff, to the extent that the issue was 'brought to a head' in *Yfantidis*, this was not by way of a recommendation that restrictions on access to ART should be relaxed so as to make such services more generally available beyond the paradigm of the 'normal', heterosexual married or de facto couple. Indeed, Debelle J's recommendation was precisely to the contrary.

The reason why *Pearce*, by contrast, might appear to provide the basis for some optimism for those looking to its broader implications is that it is not structured by the kind of internal tension between outcome and premise that I take to be central to *Yfantidis*. In *Pearce*, there is no 'Doctor's Dilemma'. The question for consideration is a purely constitutional one: is there an inconsistency between the state and the Commonwealth legislation?⁵¹ There is an unambiguous (one might almost say clinical) simplicity about this question which is certainly appealing. It is all the more so when contrasted with the kinds of questions which *Yfantidis* raises: when is a 'medical judgment' not a medical judgment; when are 'medical reasons' not medical reasons; when is a decision 'based on' medical grounds also based on discriminatory ground; and when is a "medical judgment" ... merely disguised or dressed up discrimination?⁵² That these are complex and elusive questions is readily demonstrated by examining Debelle J's assertion that the refusal to perform the microsurgery was, in fact, a 'medical judgment'. Professor Jones' evidence was that, because of the risk of a gradual deterioration, microsurgery would be appropriate only in circumstances where the woman had an 'intention and an ability to become pregnant within 12 months after the operation'.⁵³ Given that *Yfantidis* could not gain access to IVF or AI procedures, and assuming that she were to remain with the same partner, in the event that her partner were infertile, she would not have had the requisite intention or ability to become pregnant within twelve months. Thus, in Professor Jones' 'medical' judgment, to proceed without knowing whether this eventuality would occur or not would have been (medically) 'reprehensible'. And so, in Debelle J's terms: 'In one sense, the question of discrimination could be said to depend on whether Mr Al-Vasetneh was infertile.'⁵⁴ Well, yes and no. Whilst *Yfantidis*' intention and ability to become pregnant within twelve months may have depended on Al-

⁵⁰ *ibid.*

⁵¹ Of course, as there is no legislation preventing sexual orientation discrimination at Commonwealth level, homosexual couples will find nothing to be optimistic about in this constitutional question.

⁵² *Yfantidis v Jones & Flinders Medical Centre* (1993) 61 SASR 458 at 469 per Debelle J.

⁵³ *ibid.* at 466 per Debelle J.

⁵⁴ *ibid.* at 472 per Debelle J.

Vasetneh's fertility, it was *equally* dependent on her ability to gain access to IVF or AI procedures. If IVF and AI procedures had been available to single women, then — regardless of her partner's fertility status — she would have had the requisite intention or ability to become pregnant within twelve months. This, moreover, is a legal, not a medical, phenomenon. In this sense, it stretches the terminology to suggest that the refusal to perform microsurgery was (independently) justified on the basis of 'medical reasons'.

That it can be difficult to tell the difference between medical and legal phenomena is precisely the problem raised by the second broader implication of *Yfantidis* that Edwards and Templeman identify — namely, that it is unlikely that there will be judicial acceptance of any attempt by fertility clinics and practitioners to translate discriminatory eligibility criteria (such as a marital status condition) into the definition of 'infertility' itself. They put the point in these terms:

The authors were told that at least one fertility clinic has attempted to circumvent the problem [of fertility clinics not having been granted specific exemptions to the operation of anti-discrimination legislation] by defining the problem of infertility as the inability of a man and a woman in a stable relationship to conceive within a certain time. It remains to be seen whether such an approach would support a successful defence of [sic] a complaint. It would seem merely an attempt to include restrictions in the permitted recipients of services in the definition of the services themselves. Such an exercise in semantics is unlikely to find favour in the courts.⁵⁵

The last sentence of this passage strikes me as a very odd conclusion to draw from *Yfantidis*. Debelles J's deference to the 'medical reasons' which independently justified Professor Jones' decision not to perform the microsurgery — and I have already indicated my scepticism that these are properly described as 'medical reasons' — seems itself to provide an example of precisely such an 'exercise in semantics'. One can readily imagine, given Debelles J's insistence that this was a mere 'technical offence' arising primarily from a carelessness of expression, that an explanation of his refusal to perform the microsurgery couched in terms of this definition of infertility would have been a solution to Professor Jones' dilemma as appealing as Debelles's own advice that the refusal should have been couched in terms of a *Rogers v Whitaker*-type warning.⁵⁶ If this seems to be drawing a long bow, Professor

⁵⁵ Edwards and Templeman (1994) p 127.

⁵⁶ Indeed, it might even be preferable, for it is not entirely clear that Debelles J's advice does, in fact, resolve Professor Jones' dilemma. The principle enunciated by the majority in *Rogers v Whitaker* (1992) 67 ALJR 47 is that patients must be informed of all the 'material risks' involved in a proposed treatment, not that they must accept a doctor's determination of the desirability of proceeding, given those risks. In terms of *Rogers v Whitaker*, it would have been perfectly appropriate for Yfantidis, once properly informed of the risks and consequences involved in the microsurgery along the lines (and indeed in the very terms) that Debelles J

Jones' letter to Yfantidis' GP recounting the consultation at which the microsurgery was refused reveals reasoning quite precisely in these terms:

When I saw her back at my Fertility clinic ... [I] reiterated that she would need to be either married or in a stable de facto relationship (in this situation I would suggest at least two years) before we would contemplate undertaking high technology infertility management of this nature. I also had to reiterate to her that we would need to discuss this with her partner and that he would have to be fully investigated through our clinic. I also suggested that they would need to see our Fertility clinic Counsellor before proceeding.

Ms Yfantidis was upset at what she saw to be an intrusion on her personal right and I tried to explain to her that we try to take all factors into consideration including the stability of her relationship which of course has significant potential bearing on the environment into which any child resulting from the management would be born. In addition to this the *Family Relationships Act* is quite clear on the fact that the *management of infertility concerns a couple not an individual* and that there can be *no legal pressure on medical practitioners to treat a single woman for infertility* should he believe that this is not in her best interests or in the interests of the potential child.⁵⁷

In Professor Jones' view, then, single women cannot consider that they are entitled, as a matter of 'personal right', to fertility treatment: they are not entitled to exert (legal) pressure on medical practitioners in order to obtain such treatment. Rather, the availability of fertility treatment for a single woman will depend on a medical practitioner's assessment of what is in the 'best interests' of the woman herself and of any potential child. This involves a consideration of 'all factors', including the environment into which any child resulting from such treatment might be born. Holding out the promise of reasoned and rational decision-making based on relevant information, this suggestion that 'all factors' will be taken into consideration is a powerfully — but also falsely — seductive one: reading this passage as a whole, it is patently clear that Professor Jones is *never* going to determine that it is in the best interests of a single woman and any potential child to proceed with 'high technology infertility management of this nature' in circumstances in which the woman is not 'either married or in a stable de facto relationship' of a certain duration. Although it remains unstated and unexamined, this is the very pre-determination, the pre-judgement, on which the marital status eligibility criterion is based in the first place. Similarly, the proposition that 'management of infertility involves a couple and not an individual' means that it would simply not be necessary even to consider *any* 'factors' in relation to a single

suggests, still to insist that she wished to proceed, which would have left Professor Jones facing precisely the same dilemma.

⁵⁷ *Yfantidis v Jones & Flinders Medical Centre* (1993) 61 SASR 458 at 465–66 per Debelle J (emphasis added).

woman seeking fertility treatment: a single woman would fall, pre-emptively, outside the scope of infertility management.

The question of precisely what 'infertility management' means does not seem to have been central to the decision in *Yfantidis*: it is not canvassed by DeBelle J at all, and the only significance attached to the letter I have quoted, above, is that the first paragraph is taken to show the multiple grounds, including marital status, on which the decision to refuse the microsurgery was based. Nor is the question directly addressed in *Pearce*. It is, however, immanent and crucial in determining the proper manner in which the *Reproductive Technology Act 1992* (SA) is to be read down once there has been a determination that there is an inconsistency between that legislation and the Commonwealth *Sex Discrimination Act 1984*. Williams J puts the point in these terms:

I consider that by reason of the reference to "married couples" in s. 13(3) of the *Reproductive Technology Act* it is useful in the public interest to make a declaration of inconsistency between s. 13 of that Act and the provisions of the *Sex Discrimination Act*. The will of the South Australian Parliament as expressed in the *Reproductive Technology Act* is that the relevant procedures only be available under licence in the event of *infertility* [section 13(3)(b)(i)] or in cases where there appears to be a *risk that a genetic defect would be transmitted to a child* naturally conceived [section 13(3)(b)(ii)]; whether these principles will be retained upon the reading down of the legislation ... is a matter for another day.⁵⁸

The meaning of 'infertility', then, is crucial in assessing the significance of *Pearce* for single women (or men, for that matter) seeking access to reproductive assistance. And this returns me to the proposition that I advanced earlier: namely, contrary to Stuhmcke's analysis, it is not at all clear, despite the self-evidence and obviousness of the finding that there was an inconsistency, that this decision actually means that assisted reproduction will now be available to single women. Indeed, if upon reading down the legislation, 'infertility' (along with the risk of transmission of a 'genetic defect') were to continue to define the proper scope of the application of artificial fertilisation procedures, and if 'infertility' were to be understood along the lines outlined by Professor Jones in *Yfantidis*, it is quite clear that single women would not be eligible for 'infertility management', notwithstanding the decision in *Pearce*.

Before proceeding to the final section of this article, I would like briefly to recapitulate what the analysis up to this point has aimed to show. First, it is clear that any attempt to exclude (heterosexual) de facto couples from accessing ART by means of an eligibility criterion requiring them to be married will constitute unlawful marital status discrimination. Second, it is by no means clear that single women are in an analogous position. Both *Yfantidis*

⁵⁸ *Pearce v South Australian Health Commission* (1996) 66 SASR 486 at 491 (emphasis added).

and *Pearce* resulted in successful outcomes for the particular litigants: respectively, a determination that a refusal to provide treatment had been discriminatory, and a declaration of inconsistency between the Commonwealth *Sex Discrimination Act* 1984 and a marital status eligibility criterion set down in state legislation regulating access to ART. Despite this fact, it is not clear that either decision carries with it a (judicial) willingness to accept, and give legal sanction to, alternative means of family formation and alternative family forms. *Yfantidis* very clearly leaves open the possibility of legislative intervention extending the exemption from the operation of anti-discrimination legislation under which IVF and AI procedures fell (in that jurisdiction) to an even more broadly defined range of fertility treatments; the consequence would be that eligibility criteria governing this broader range of fertility treatments relating to marital status (or sexual orientation, age, disability, prior children and so on) could not be found to be unlawfully discriminatory in terms of the relevant state anti-discrimination legislation. Within the different doctrinal context of constitutional law, *Pearce* equally leaves open this possibility: 'infertility' may well continue to be a legislatively mandated criteria for accessing ART and, depending on how that term is defined, 'infertility' may well come to stand in for discriminatory eligibility criteria through precisely the 'exercise in semantics' that Edwards and Templeman envisage.

Other Mothers: Lesbian Access to ART

Distinctions between women on the basis of sexuality have little or no relevance in relation to recognising the right to personal autonomy over reproductive matters.⁵⁹

Pearce may have considered these questions to be 'a matter for another day'. That day certainly arrived with the litigation in *JM v QFG & GK*.⁶⁰ JM was a 23-year-old woman who had been living in a stable and exclusive lesbian relationship for over four years. Her partner had an eleven-year-old daughter, conceived by private donor insemination. With her partner, JM decided to have a child, also by artificial insemination. After having had some difficulty in accessing fertility clinics in Queensland, JM contacted the Queensland Fertility Group (QFG) clinic. Her initial telephone contact with QFG, in which she stated that although she was not married she was in a long-term relationship, without specifying that it was a lesbian relationship, was favourable. She subsequently made an appointment to see one of QFG's doctors, Dr GK. Dr GK agreed to treat her by means of artificial donor insemination (ADI). At the conclusion of the interview, JM was given a form requiring that both 'husband' and 'wife' consent to the ADI treatment. JM considered forging the

⁵⁹ J Chester (1997) '*JM v QFG Queensland Anti-discrimination Tribunal*, RG Atkinson, President No H38 of 1996 31 January 1997' 5 *Journal of Law and Medicine* 21, p 23.

⁶⁰ Unreported, Queensland Anti-Discrimination Tribunal, 31 January 1997.

signature but later communicated to Dr GK that she was unwilling to fill out the form dishonestly and asked to be treated on the basis of her 'real circumstances' — that she was involved in an exclusive, stable lesbian relationship — whereupon he refused to treat her. JM then lodged a complaint with the Queensland Anti-Discrimination Commission which, following unsuccessful conciliation, was referred to the Queensland Anti-Discrimination Tribunal (QADT).

By contrast with the three decisions I have considered up to this point, this litigation takes place in a legal environment in which there is no legislation regulating access to ART procedures. In the three jurisdictions in which there is a legislative framework — South Australia, Victoria, and Western Australia — a number of eligibility criteria are prescribed.⁶¹ These are as follows:

⁶¹ *Reproductive Technology Act 1988 (SA)*; *Human Reproductive Technology Act 1991 (WA)*; *Infertility (Medical Procedures) Act 1984 (Vic)*, repealed and replaced by the *Infertility Treatment Act 1995 (Vic)*. It is clearly beyond the scope of this article to give a comprehensive treatment of each of these legislative frameworks, particularly as they are directed at a range of ART issues very much broader than the question of access to assisted reproduction — for example, the ethical constraints that should apply to research using human reproductive material, surrogacy arrangements, regulating the donation, storage and disposal of human reproductive material, systems for recording information relating to the outcomes of AI and artificial fertilisation procedures, establishing statutory bodies with various functions relating to ART, licensing medical practitioners and institutions to carry out AI and artificial fertilisation procedures and/or to undertake research involving human reproductive material and so on. For present purposes, therefore, I have confined my consideration to the question of the eligibility criteria which these legislative frameworks establish. This is nonetheless somewhat arbitrary and might tend to conceal the interaction between the issue of access to ART and other parts of the legislative framework. For example, where legislation requires that donors of human reproductive material give instructions as to the use, storage and disposal of that material, this might have the practical effect of creating restrictions on access to assisted reproductive procedures requiring (anonymously) donated reproductive material. Lauren Finestone (of Sydney's Inner City Legal Service) notes two instances of enquiries from women attempting to access public fertility and reproductive services in New South Wales who had either been refused access to fertility programs at public hospitals or had had the supply of donor semen withdrawn. In each instance, the stated reason for the decision was that 'the donors had clearly stated that their sperm was not to be used by single women or lesbians': L Finestone, 'Access to Donor Sperm Services' (1999) 10(2) *Lesbians on the Loose* 14. It is not entirely clear in those jurisdictions in which, unlike New South Wales, there is legislation regulating access to ART, how donor consent requirements would interact with eligibility criteria in circumstances such as these. Taking as an example the position under the new Victorian *Infertility Treatment Act 1995* (which makes IVF and ADI available to married and de facto couples (ss 3 and 8)), what effect would be given to an anonymous donor's specification that his/her reproductive material be used by married couples only and not by de facto couples? Or indeed, to consider a rather more complex possibility, could anonymous donors specify that their reproductive material be used only by lesbians and single women given that such individuals are not eligible for treatment involving IVF or ADI in the first place?

- *Reproductive Technology Act 1988 (SA)*:
 - the husband or wife (or both) appear to be infertile (s 13(3)(b)(i)); or
 - there appears to be a risk of transmitting a genetic defect to a child conceived naturally (s 13(3)(b)(ii)).
- *Infertility Treatment Act 1995 (Vic)*⁶²
 - a doctor is satisfied on reasonable grounds from an examination or from treatment he or she has carried out that the woman is unlikely to become pregnant from an oocyte produced by her and sperm produced by her husband/de facto other than by a treatment procedure (s 8(3)(a)); or
 - a doctor, who has specialist qualifications in human genetics, is satisfied from an examination he or she has carried out, that if the woman became pregnant from an oocyte produced by her and sperm produced by her husband/de facto, a genetic disease might be transmitted to a person born as a result of the pregnancy (s 8(3)(b)); and
 - both partners have consented, in writing (s 9(1)(a)) and in such form as the Infertility Treatment Authority may require (s 36), to the carrying out of the procedure (s 8(2)), and such consent has been lodged in accordance with the requirements of the legislation (s 9(2)); and
 - prior to a woman's consenting to undergo a treatment procedure: the doctor in charge of the woman's case has given the couple a list of approved counsellors (s 10(1)(a)) and enough information about the procedure and the alternatives to the procedure to enable to couple to make an informed decision about whether or not to undergo the procedure (s 10(1)(b)); and the couple has received counselling from an approved counsellor (s 11(1)); and

⁶² Whilst not constituting clear eligibility criteria — in the sense of statutory requirements which must be fulfilled before AI or artificial fertilisation procedures are carried out — the guiding principles set out in s 5 give an indication of the range of policy considerations which are intended to provide a framework for the operation of the legislative scheme. Listed in descending order of importance (s 5(2)), these considerations are that:

- (i) the welfare and interests of any person born as a result of a treatment procedure are of paramount importance (s 5(1)(a));
- (ii) human life should be preserved and protected (s 5(1)(b));
- (iii) the interests of the family should be considered (s 5(1)(c)); and
- (iv) infertile couples should be assisted in fulfilling their desire to have children (s 5(1)(d)).

- prior to a woman's undergoing a treatment procedure: the couple have supplied any information that is required to be recorded in accordance with the legislation (s 10(2)); and the doctor in charge of her case has taken all reasonable steps to ensure that an approved counsellor will be available to give further counselling to the couple after the procedure has been carried out (s 11(2)).⁶³
- *Human Reproductive Technology Act 1991 (WA)*:
 - the male and female partners, as a couple, are infertile (s 23(a)(i)) where the reason for the infertility is not age (s 23(d)); or
 - their child would otherwise be likely to be affected by a genetic abnormality or disease (s 23(a)(ii)); and
 - each of the parties has given effective consent (s 23(b)); and
 - consideration has been given to the welfare and interests of the participants (s 23(e)(i)) and any child likely to be born as a result of the procedure (s 23(e)(ii)) and such consideration has not disclosed any reason why the procedure should not be carried out (s 23(e)).

The absence, in the Queensland context, of a set of statutorily prescribed eligibility criteria gives rise to two pertinent distinctions between *JM v QFG & GK* and the other cases I have discussed. First, as there are no clear proscriptions on access to ART, medical service providers in this jurisdiction are not confronted by mandatory licensing conditions which appear to require that the provision of ART procedures be limited to married couples (as in *MM, DD, TA & AB v The Royal Women's Hospital, Freemason's Hospital & State of Victoria*)⁶⁴ or to married and/or de facto couples (as in *Pearce v South*

⁶³ The requirements of this Act are substantially the same as those of its predecessor, the repealed *Infertility (Medical Procedures) Act 1984 (Vic)* which was in force at the time of the events giving rise to the dispute in *MM, DD, TA & AB v The Royal Women's Hospital, Freemason's Hospital & State of Victoria*, which required that:

- not less than 12 months before the carrying out of the procedure, the woman and her husband had undergone such examination or treatment by a medical practitioner as might reasonably be expected to establish whether or not a procedure other than a fertilization procedure might cause the woman to become pregnant (s 10(3)(c)); and
- that as a result, the medical practitioner was satisfied that it was reasonably established that the woman was unlikely to become pregnant other than by means of artificial fertilization (s 10(3)(d)); and
- the couple had received (s 10(3)(e)(i)) and would be able to continue to receive (s 10(3)(e)(ii)) appropriate counselling; and
- that there had been written consent by both partners (s 10(3)(b)).

⁶⁴ Unreported, Human Rights and Equal Opportunity Commission, 11 March 1997.

Australian Health Commission).⁶⁵ Not surprisingly then, given the reasoning in those two decisions, Dr GK's first argument before the QADT — namely, that there was an 'unwritten agreement'⁶⁶ between QFG and the Queensland government that only married women and women in (heterosexual) de facto relationships were eligible for access to IVF and ADI services — was rejected by the QADT. This conclusion was reached notwithstanding that it was argued by Dr GK that it was his understanding that funding (and possibly also licensing) might be withdrawn if this agreement were ignored.⁶⁷ The QADT determined that there were 'apparently no guidelines which say that ADI is only available in Queensland to married couples in stable heterosexual relationships'.⁶⁸

There was evidence presented by the Director-General of Health indicating that the Queensland government's approach to donor insemination and IVF was generally on the lines outlined in the Demack Report which recommended that ADI should generally only be administered to married women or women in (heterosexual) de facto relationships where the husband/male partner also consents to the procedure.⁶⁹ The basis of the preference for this informal approach seems to have been that, as it would be difficult to introduce legislation based on the Demack Report, provided that clinics and practitioners operated generally in accordance with this approach, no comprehensive legislation would be enacted. The only specific regulatory control exercised by the Queensland Health Department over the activities of fertility clinics was, the QADT continued, by virtue of Part 3 Division 4 of the *Health Act 1937* (Qld), which creates a statutory power in the Chief Health Officer of the Department of Health to grant mandatory licences to private hospitals, including private day surgery facilities, which licences could be granted subject to certain conditions. QFG had had some correspondence with the Chief Health Officer in relation to the establishment of its day theatre facilities at St Andrew's Place. A licence to establish the facility was granted on 18 October 1993 subject to a number of conditions, as follows:

- that a formal contractual arrangement with St Andrew's Hospital be established, bringing the day surgery facility within the operation of the hospital's institutional ethics committee;

⁶⁵ (1996) 66 SASR 486.

⁶⁶ *JM v QFG & GK* (unreported, Queensland Anti-Discrimination Tribunal, 31 January 1997) at p. 5.

⁶⁷ Chester (1997) p 21; Bunney (1997) p 59.

⁶⁸ *JM v QFG & GK* (unreported, Qld Anti-Discrimination Tribunal, 31 January 1997) at p 8.

⁶⁹ *ibid.* See also Chester (1997) p 21; Bunney (1997) p 59; AG Demack (1984) *The Queensland Report of the Special Committee Appointed by the Queensland Government to Inquire into Laws Relating to Artificial Insemination, in Vitro Insemination and Other Related Matters*, Queensland Government.

- that QFG maintain its accreditation with the Reproductive Technologies Accreditation Committee (RTAC) and the National Health and Medical Research Council (NHMRC);⁷⁰ and
- QFG seek ACHS accreditation.

In the QADT's view, no one of these conditions indirectly required either that single women and lesbian couples be considered ineligible for ADI or that infertility be defined in the terms adopted by Dr GK.

Second, because JM's complaint was formulated in terms of lawful sexual activity discrimination rather than marital status discrimination, the question of the meaning of 'infertility'⁷¹ assumes an importance which it did not have in the marital status cases. This question arises by virtue of Dr GK's second argument before the QADT — namely, that JM had failed to satisfy a further eligibility criterion in that she did not present with 'medically defined infertility'. In the cases discussed above, none of the criteria other than marital

⁷⁰ The NHMRC's *Ethical Guidelines on Assisted Reproductive Technology* require that 'whether or not required by State law, reproductive medicine units offering ART must obtain accreditation' (NHMRC (1996), AGPS, p 3) by the RTAC. This accreditation must include consideration of:

- compliance with the NHMRC guidelines;
- compliance with the RTAC's Code of Practice;
- certification and maintenance of appropriate professional standards in clinical and laboratory work; and
- maintenance of quality assurance programs for clinical and laboratory work.

The relevant NHMRC guidelines specify nothing in relation to access to ART. This is by contrast to the previous guidelines — Supplementary Note 4 to the *NHMRC Statement on Human Experimentation*, entitled *In vitro fertilisation and embryo transfer* — which stated that IVF and ovum donation should only be available to people within an 'accepted family relationship' (Stuhmcke (1997) p 25). When the *National Health and Medical Research Council Act* (Cth) was passed in 1992, all the NHMRC guidelines, with the specific exception of Supplementary Note 4, were saved and the NHMRC was 'required to issue revised guidelines in this area' (NHMRC (1996) p iv). This revision was commenced in October 1993 by the Australian Health Ethics Committee (AHEC) which eventually produced the *Draft Guidelines on Assisted Reproductive Technology*, to which the QADT referred (see below), in June 1996. One might speculate then (although this is certainly a complex and uncertain area of law) that it is the AHEC guidelines (with their expansive approach to the proper availability of ADI) that will eventually replace the old Supplementary Note 4 and fill the gap that is left in the new NHMRC guidelines. In this event it would, in fact, be a mandatory licensing condition (indirectly imposed by means of the requirement to maintain NHMRC and RTAC accreditation) that QFG adopt this more expansive approach to access to ART.

⁷¹ Conspicuously, the term itself is not defined any of these three pieces of legislation.

status (including those requiring that the couple be 'infertile') were directly raised: marital status functioned as the clear threshold criterion of eligibility on the basis of which access was refused and on the basis of which a finding that such refusal constituted unlawful discrimination could readily be made. In the case before the QADT, however, the question of precisely how to define (medical) 'infertility' became the crucial issue.

Therefore, before going on to discuss the determinations on appeal from the QADT's decision, I want to consider the different approaches taken by Dr GK and the QADT in defining infertility. This consideration is based on two analytical premises. First, infertility is not an exclusively *biological* 'fact', a simple aberration of 'nature', 'without a specific cultural backdrop', but rather is equally a *socially* constructed phenomenon existing within a complex matrix of historical and socio-cultural specificities.⁷² Second, and more importantly, ART has itself produced the circumstances in which considerations other than the 'biological facts' of infertility have been made apparent. Just as there is 'no pure biology in a socialised world',⁷³ nor is there any pure technology. As Morgan succinctly puts it:

Artificial reproduction means that it is no longer necessary to determine reproduction according to who can have sex with whom, and the result is the construction of a matrix of hierarchies for determining who can have artificial reproduction with whom ... A form of technological incest — of 'unnatural relations' — is thereby created to minimise the repugnance which might otherwise attach to some ... uses of that technology, and to legitimate those 'approved' forms of use.⁷⁴

Dr GK's argument before the QADT was that it was the policy of QFG only to treat medical conditions resulting in 'infertility,' defined as 'a medical problem affecting one or even both partners such that through normal [heterosexual] intercourse, they are unable to achieve a pregnancy'.⁷⁵ The 'problem' with a lesbian couple, he argued, is that there may be no medical problem affecting either of them.⁷⁶ The refusal to offer ADI services was based, therefore, on the 'biological/medical fact' that JM was not infertile — that is, there was no medical cause for her 'infertility' — rather than on the basis of her lawful sexual activity. Now, if the clinical simplicity and certainty of Dr GK's proposition that his decision was based on JM's lack of 'infertility' rather than on her lawful sexual activity seems intuitively appealing, that is because it is. But, as will become clear in analysing one of the more extended

⁷² D Morgan (1995) 'Technology and the Political Economy of Reproduction' in M Freeman (ed), *Medicine, Ethics and the Law*, Stevens & Sons, p 40; Chester (1997) p 23.

⁷³ Morgan (1995) p 40.

⁷⁴ *ibid.* p 25.

⁷⁵ *JM v QFG & GK* (unreported, Queensland Anti-Discrimination Tribunal, 31 January 1997) at 6.

⁷⁶ *ibid.*

versions of Dr GK's understanding of the nature of infertility treatment, this appearance of definitional precision is deceptive:

the implication always is that you are treating something which has gone wrong or isn't working. If someone has blocked tubes we can try and fix them; if someone doesn't ovulate we can fix that; if someone has a very low ... sperm count we can fix that. Now in this case with lesbians we're not — our group doesn't have any views or antagonism towards lesbian relationships and perhaps that should be stated in case we're made to look like a sort of bunch of rednecks. We're not. But lesbians cannot have children because they have a biological problem. No two females and no two males can have children. Now people may have access and say 'We would like to get hold of some sperm because we want a child' and that may or may not be a good thing. We're not there to comment on that ...

I have given our medical definition which is the way doctors would understand infertility ... I think it's an excellent definition of infertility. If you wish to add on to that [that] people who biologically cannot have children should have access to some of the services like — donor sperm ... then that's another thing altogether. But we won't change our definition of infertility to suit the politics or the political correctness of the 1990s. Medical infertility is — has a definition and it's grown up and the way we view it is the way we view it and we can't change that. That's just the way you're programmed, it's how you're educated. That's what medicine is all about.⁷⁷

The sleight of hand here lies in the fact that there are clearly circumstances in which infertility treatment would be available but which are not readily comprehended in Dr GK's view of the nature of infertility and the role of infertility treatment, based as it is on an assumption of infertility as a purely biological/medical condition. For example, although insisting that it is implicit in the notion of infertility that there is 'something which has gone wrong or isn't working', something 'we can fix', Dr GK's own evidence clearly showed that in the many cases where there is no known medical reason for the infertility, the couple will still be defined as infertile.⁷⁸ Similarly, what

⁷⁷ One cannot but speculate: does this mean that the appearance of intellectual intransigence is to be preferred to being made to look like a bunch of rednecks? These statements formed part of Dr GK's evidence before the QADT and were cited by Ambrose J in *QFG & GK v JM* (1997) EOC 92-902 at 74,433-74, 434.

⁷⁸ *JM v QFG & GK* (unreported, Queensland Anti-Discrimination Tribunal, 31 January 1997) at 7. 'Unexplained infertility' is described by Dr GK (in evidence presented before the QADT and cited by Ambrose J in *QFG & GK v JM* (1997) EOC 92-902 at 77, 434) as follows:

It's unexplained infertility which is infertility which [sic] apparently everything is there. The tubes are there, the sperm is there and the eggs are there but someone isn't getting pregnant. Can we help them get pregnant? Then that's what we treat yes, that is unexplained infertility ... It is saying

would be the position of a woman involved in an exclusive lesbian relationship who did have an identifiable fertility problem which would lead to the conclusion that, even 'through normal [heterosexual] intercourse', she would be unable to achieve a pregnancy? And conversely, what precisely is the basis of a distinction between a heterosexual woman seeking ADI services because of her male partner's infertility and a lesbian woman in JM's position? In either case, the 'medical (in)fertility' status of the recipient, considered as an individual, is identical. The telling difference, however, is that infertility is (socially) constructed so as to legitimate and protect the integrity of the exclusive couple relationship in the former case (the heterosexual *couple* is infertile) but not in the latter (the lesbian *woman* is not).

The QADT approach to the question of the definition of infertility proceeds from the starting point that infertility cannot be defined solely as a medical condition; rather, it is a complex phenomenon involving both 'physical and socio-cultural dimensions'.⁷⁹ Moreover, the QADT's approach rather shifts the focus of the debate concerning access to ART by incorporating (alongside the issues of infertility) a broader set of considerations, including the welfare of any potential child, the parenting capacities of the prospective parents,⁸⁰ and the risks involved in seeking other means to achieve pregnancy. The QADT proceeded by considering a number of policy documents/guidelines on the appropriate use of ART,⁸¹ giving particular emphasis to the Australian Health Ethics Committee Draft Guidelines on Assisted Reproductive Technology.⁸² The relevant provisions — which I quote at length to show their difference from the narrowness of Dr GK's definition — are as follows:

that in the testing that we do now we cannot find a reason for that couple not getting pregnant but they have some fertility and we will treat them.

⁷⁹ *JM v QFG & GK* (unreported, Queensland Anti-Discrimination Tribunal, 31 January 1997) at 13.

⁸⁰ In noticeable contrast, Dr GK had agreed in evidence that, even if doctors at QFG thought people were completely unsuitable to be parents, and even if this were confirmed by psychological testing, they would probably still receive treatment so long as they were married or in a stable (heterosexual) *de facto* relationship: *JM v QFG & GK*, *ibid.* at 7. See also Bunney (1997) p 64.

⁸¹ Namely:

- the Reproductive Technologies Accreditation Committee Code of Practice;
- the National Health and Medical Research Council Supplementary Note 4 (which as it dealt only with IVF was not thought to have any applicability to ADI); and
- the National Bioethics Consultative Committee's report on access to reproductive technology.

⁸² *JM v QFG & GK* (unreported, Queensland Anti-Discrimination Tribunal, 31 January 1997) at 12.

2.1 The techniques of ART may be used when proper attention has been given to the ability of prospective parents to provide a stable and supportive environment for any child born and when:

- (a) the couple is infertile and other methods of treatment of infertility have failed or are not appropriate in the particular case or offer little prospect of pregnancy; or
- (b) there is serious risk of transmitting to the child a grave hereditary disease or disability.

ART should be used only when there is a reasonable chance of pregnancy and there is no significant risk of adversely affecting the health of the mother or the child.

2.2 However, donor insemination may be used when the woman is not infertile or there is a serious risk of transmission of a grave hereditary disease or disability and:

- (a) when conditions exist for ensuring the well being of any child born of ART; and
- (b) only when the woman or the child born of ART may otherwise be exposed to significant risk through her pursuit of pregnancy.⁸³

The QADT considered that there was no reason why JM and her partner would not come within the definition in cl 2.1(a), but that if they did not, given the risk of HIV infection inherent in using private/informal donor insemination, they would certainly come within the parameters set by cl 2.2.⁸⁴

The QADT concluded, therefore, that Dr GK had adopted an unnecessarily narrow and discriminatory definition of infertility that was neither medically justified nor prescribed by any guideline to which Dr GK was bound.⁸⁵ Moreover, even had there been such a guideline, it would itself have been in breach of the *Anti-Discrimination Act 1991 (Qld) (ADA)*. Thus Dr GK's refusal to provide ADI services to JM constituted unlawful discrimination in the provision of services (s 4) both as direct discrimination (s 10(1))⁸⁶ and indirect discrimination (s 11(1))⁸⁷ on the basis of lawful sexual

⁸³ *ibid.*

⁸⁴ *ibid.* at 13.

⁸⁵ *ibid.*

⁸⁶ Section 10(1) defines direct discrimination as follows:

Direct discrimination on the basis of an attribute happens if a person treats ... a person with an attribute less favourably than a person without the attribute is or would be treated in circumstances that are the same or not materially different.

activity (s 7(1)(l)).⁸⁸ There was direct discrimination in that Dr GK refused services to JM on the basis of her lawful sexual activity of being engaged in an exclusive sexual relationship. There was indirect discrimination in that:

- the form requiring the consent of JM's male partner imposed a term with which JM was unable to comply (s 11(1)(a)); and
- with which a higher proportion of people seeking ADI and not involved in a stable lesbian relationship would be able to comply (s 11(1)(b)); and
- which was not reasonable since there were accepted definitions of infertility which did not require discrimination against a person such as JM involved in an exclusive and stable lesbian relationship (s 11(1)(c)).

(Re)Producing Lesbian Infertility

Writing a few months before the appeal to the Supreme Court from the QADT's decision, Leanne Bunney noted, with some prescience, that:

The decision in *JM* should have been unproblematic. If a lesbian couple in a stable relationship decide to have children, then their ability to do so should in no way be different to those persons in stable heterosexual relationships. The focus should be on the capacity of the individuals to be parents, not on their sexual preference. In this respect, the Tribunal's findings should not be faulted.⁸⁹

⁸⁷ Section 11(1) defines indirect discrimination as follows:

Indirect discrimination on the basis of an attribute happens if a person imposes ... a term —

- (a) with which a person with an attribute ... is not able to comply; and
- (b) with which a higher proportion of people without the attribute ... are able to comply; and
- (c) that is not reasonable.

⁸⁸ Section 7(1) lists the range of attributes on the basis of which discrimination is prohibited: sex, marital status, pregnancy, parental status, breastfeeding, age, race, impairment, religion, political belief or activity, trade union activity, lawful sexual activity and association with or in relation to, a person identified on the basis of any of the above attributes. By virtue of s 8, in the context of both direct and indirect discrimination, discrimination on the basis of an attribute includes discrimination on the basis of characteristics generally belonging to (s 8(a)) or imputed to (s 8(b)) persons with an attribute as well as discrimination on the basis of an attribute that a person is presumed, by the discriminator, to have (s 8(c)), or that a person had, even if the person did not have the attribute at the time of the discrimination (s 8(d)).

⁸⁹ Bunney (1997) p 60.

The decision clearly was not 'unproblematic', however. QADT President Roslyn Atkinson was deluged with abusive phone calls at the time — indeed, more complaints/criticisms were received in respect of the decision than any other of the QADT's decisions.⁹⁰ The level of public homophobia from key political figures — I recall, in particular, the comments by Tim Fischer (then Deputy Prime Minister), Michael Wooldridge (then Federal Health Minister) and Mike Horan (then Queensland Health Minister) — was astounding.⁹¹

In the last part of this article I want to consider the appeals from this decision — before Ambrose J in the Supreme Court of Queensland in *QFG & GK v JM*⁹² and in the Queensland Court of Appeal before Davies, Pincus and Thomas JJA in *JM v QFG & GK*.⁹³ Both decisions set aside the finding of direct discrimination and remitted the finding of indirect discrimination to the QADT for reconsideration as to whether it was reasonable to require that in order to be eligible for ART services a person had to be 'medically infertile', as that was defined by Dr GK. Both decisions found that there was no direct discrimination because the reason for refusing treatment was that JM was not 'medically infertile:' that is, she did not have a medical condition such that through normal heterosexual intercourse, without contraception and with the same partner for a period of 12 months, she was unable to achieve a pregnancy. Along with women engaged in 'stable and exclusive lesbian relationships,' numerous categories of individuals fell outside this definition: 'women desiring to give a virgin birth';⁹⁴ women, regardless of their sexual orientation, who, for whatever reason, remain celibate;⁹⁵ heterosexually active

⁹⁰ See Stuhmcke (1997) p 30. Atkinson J's appointment to the Qld Supreme Court in 1998 reignited criticism, with Opposition Justice spokesperson Lawrence Springborg suggesting that the overturning of a number of Atkinson's decisions as QADT President by the Supreme Court, including the *JM v QFG & GK* decision, indicated that she lacked the expertise for such a position: K Costigan, 'Chilly Reception for Judge in DI case' (1998) 9(10) *Lesbians on the Loose* 5, p 5.

⁹¹ The following is an indicative list of print reportage: 'Lesbian Awarded \$7500 and Donor Sperm Rights', *Courier Mail*, 1 February 1997; 'We'll Stop Lesbians', *Sunday Mail*, 2 February 1997; 'Angry Fischer Hits Lesbian Baby Ruling', *Sunday Mail*, 2 February 1997; 'Lesbian Win Angers Fischer', *Daily Telegraph*, 3 February 1997; 'Sperm Access Guidelines are Needed', *Courier Mail*, 3 February 1997; 'Tribunal Abused on Lesbian Ruling', *Courier Mail*, 3 February 1997; 'State to Ban Lesbians from Fertility Programs', *The Australian*, 3 February 1997; 'Axe Hangs over Lesbian Fertility Funding', *The Australian*, 4 February 1997; 'Lesbian Ruling Opens Ethical Can of Worms', *Sunday Mail*, 9 February 1997; 'MP to Cut Off Clinics from Lesbians', *The Australian*, 14 February 1997. See also Chester (1997) p 22. Both Stuhmcke and Costigan note Mike Horan's comparison between lesbians and Nazis breeding a super race: Stuhmcke (1997) p 30; K Costigan, 'Lesbian Proves 'Less than Equal' Not Good Enough' (1997) 8(3) *Lesbians on the Loose*.

⁹² (1997) EOC 92–902.

⁹³ [2000] 1 QdR 373.

⁹⁴ *QFG & GK v JM* (1997) EOC 92-902 at 77, 425; 77426; 77, 430 per Ambrose J.

⁹⁵ *ibid.* at 77, 428; 77, 430; *JM v QFG & GK* [2000] 1 QdR 373 at 384 per Davies JA.

women not engaged in a stable relationship with one man for a period of 12 months;⁹⁶ and heterosexual couples who did not engage in unprotected sex for a period of 12 months because they 'did not wish to reproduce a child having a particular characteristic of the male partner'⁹⁷ and so on. In none of these instances would a refusal of treatment be 'on the basis of' a lawful sexual activity: it would be on the basis of a failure to comply with Dr GK's definition of medical infertility.

This still left open, arguably, the question of indirect discrimination. Section 11 of the *ADA* defines indirect discrimination in the following terms:

- 11.(1) Indirect discrimination on the basis of an attribute happens if a person imposes ... a term —
 - (a) with which a person with an attribute does not or is not able to comply; and
 - (b) with which a higher proportion of people without the attribute comply or are able to comply; and
 - (c) that is not reasonable.
- (2) Whether a term is reasonable depends on all the relevant circumstances of the case, including, for example —
 - (a) the consequences of failure to comply with the term; and
 - (b) the cost of alternative terms; and
 - (c) the financial circumstances of the person who imposes ... the term.

Discussion of the question of indirect discrimination⁹⁸ revolved primarily around the issue of whether or not Dr GK's requirement that a woman demonstrate what he understood to be 'medical infertility' before he would agree to treat her by means of AD was 'reasonable' within the terms contemplated by section 11(2). The QADT was strongly criticised (and quite rightly, I would argue) for not having undertaken any proper consideration of the factors enunciated in section 11(2). The structure of the legislation is such that 'reasonableness', in this situation, cannot be reduced (as the QADT seems to have done) to a consideration of the proper meaning of 'infertility'. In other words, it cannot be determinative of this issue that the definition adopted by Dr GK was neither medically necessary nor prescribed by any binding guideline, or that other, non-discriminatory definitions were available.⁹⁹ Rather, the Court of Appeal found that what was required was a 'weighing of the nature and

⁹⁶ *JM v QFG & GK* [2000] 1 QdR 373 at 384 per Davies JA.

⁹⁷ *ibid.*

⁹⁸ In the Supreme Court (1997) EOC 92-902 per Ambrose J at 77, 429; 77, 430; 77, 432-77, 433; 77, 434-77, 437 and in the Court of Appeal [2000] 1 QdR 373 per Davies JA at 386-87; per Pincus JA at 392-94; per Thomas JA at 396-97.

⁹⁹ In the Supreme Court (1997) EOC 92-902 per Ambrose J at 77, 429; 77, 435 and in the Court of Appeal [2000] 1 QdR 373 per Davies JA at 387; per Pincus JA at 392.

extent of the discriminatory effect, on the one hand, against the reasons advanced in favour of the term on the other'¹⁰⁰ and a consideration of all the relevant circumstances, including the factors listed in section 11(2). Specifically per Davies JA:

It was therefore necessary to consider ... [Dr GK's] decision to treat only what he defined, in accordance with an accepted definition, [as] the medical condition of infertility. It was also necessary to consider the requirement of the Queensland Department of Health, who had power with respect to the licensing of clinics ... that the guidelines set out in the Demack Report be followed. Those guidelines ... restricted the service to married couples or heterosexual couples in a stable de facto relationship in which the male partner consented to the treatment.¹⁰¹

And per Thomas JA:

I would add that the circumstance that a doctor considers that a potential patient does not demonstrate any need for the services that are requested would prima facie seem to be a very reasonable basis for refusing or delaying the provision of such services. Other relevant factors would include the absence of authoritative guidance from public authorities, and the circumstance that on a subject where community views may range very widely, the concept of tolerance which the *Anti-Discrimination Act* would seem designed to promote, would demand that a wide ambit be permitted in the concept of determining the reasonableness of individual responses to such situations.¹⁰²

The finding of indirect discrimination was therefore set aside and the matter was remitted¹⁰³ to the QADT to be determined in accordance with these considerations.¹⁰⁴

¹⁰⁰ *JM v QFG & GK* [2000] 1 QdR 373 per Davies JA at 387.

¹⁰¹ *ibid.*

¹⁰² *ibid.* at 396–97 per Thomas JA.

¹⁰³ Both Thomas JA (at 397) and Pincus JA (at 393–94) agreed that they would have preferred not to remit the matter at all, but that such an order was not available.

¹⁰⁴ These are by no means unproblematic directions. In the first place, as indicated above, the QADT did, in fact consider, and in quite some detail, the effect of the guidelines outlined the Demack Report and the powers of the Queensland Health Department in respect to the licensing of private hospitals. The Tribunal's conclusion, in effect, was that QFG's day surgery licence was not conditional upon compliance with the guidelines set out in the Demack Report. The conclusion that Dr GK was operating under a misapprehension as to the consequences of non-compliance with the guidelines would have to be a very potent factor in 'weighing the nature and extent of the discriminatory effect' against 'the reasons advanced in favour of the term:' *ibid.* per Davies JA at 387.

Second, the appeal to 'medical necessity' Ambrose J cites as a factor (and indeed, a very significant factor) in determining 'reasonableness' is by no means

without difficulty: see *ibid.* per Thomas JA at 396–97; see also *QFG & GK v JM* (1997) EOC 92–902 per Ambrose J at 77, 426; 77, 436. ‘Medical necessity’ is, by definition, a function of the meaning given to ‘infertility’. That is, if infertility is not defined as a medical condition affecting one or both partners such that they are unable to achieve a pregnancy after twelve months of unprotected intercourse, then the question of whether a woman in JM’s position demonstrates any ‘medical need’ for infertility treatment will emerge rather differently. In this sense, ‘medical necessity’ is a kind of cipher for ‘infertility’ and, as such, it is no more transparent and no less contested.

Third, to insist that ‘all relevant circumstances’ need to be considered seems to open, rather than to foreclose, further discussion of the issues. For example, might it not follow from the lack of ‘authoritative guidance from public authorities’ that an inclusive approach is to be preferred: to do otherwise would be to create exclusions where none have been agreed by open, transparent and morally pluralistic collective decision-making processes. To take another example, just what is it that the concept of tolerance requires in a morally pluralistic community which values individual autonomy in defining and pursuing one’s own conception of the good life, including making one’s own proactive choices?

These are conceptually and analytically complex questions, discussion of which does not render the reasonableness of Dr GK’s position somehow self-evident. To suppose otherwise is to fail to grasp this complexity. Darryn Jensen’s discussion of this case is an illustration in point. Jensen laments at some length that the effect of the QADT’s approach would be to treat individual private-sector service providers ‘not as free agents, who may draw upon their moral, ethical and religious beliefs in making decisions about whom they will contract with and what they will contract to do, but as slaves who, having chosen a particular profession, are not free to decide how to practise it’: D Jensen, ‘Legislating Morality: The Case of Anti-discrimination Legislation’ (1996) 21 *Australian Journal of Legal Philosophy* 23, p 26. This strikes me as a very curious argument for a number of reasons. First, medical practitioners are, of course, not (nor should they be) ‘free agents’ able independently to decide how to practise medicine — indeed, the whole point of Dr GK’s evidence was that he was not free to disregard what he considered to be the proper medical definition of infertility and that he was, as a matter of proper professional conduct, required to limit infertility treatment by means of ADI to those circumstances in which it was, according to this definition, clinically indicated. Secondly, to the extent that Jensen’s argument is based on drawing a distinction between services ‘provided under the protection of a legislative monopoly’ (p 31) (which should be provided on a non-discriminatory basis) and services provided by individual private-sector service providers (which should be governed by the principles of freedom of contract), he has clearly oversimplified the issues: medical practitioners do, in effect, practise under the protection of a legislative monopoly. And furthermore, private-sector service providers receive the vast majority of their funding from public funds (by way of the Medicare system and by way of funds distributed by the NHMRC). Indeed, one of Dr GK’s arguments was that he was concerned about a withdrawal of (public) funding if he did not comply with the guidelines in the Demack Report. Third, Jensen repeatedly asserts that the real difficulty raised by this decision (and, indeed, by anti-discrimination legislation generally) is that it undermines ‘individual autonomy on matters of morality and ethics’ (p 27); that it risks subjecting persons to the ‘dictates of moral choices made by others’ (p 32); that it ‘allows government to use legislative process to impose a hierarchy of values in

The premise of the analysis (in the previous section) of the QADT's decision was that the 'biological facts' of 'infertility' stand in a mutually dependent/mutually reinforcing relationship with the prevailing culturally and historically specific social norms of 'proper' familial, reproductive and sexual relations. Regardless of my hesitations in relation to how the QADT approached the question of reasonableness, the significant achievement of that decision was to render the interdependence of the social and the biological aspects of infertility perceptible and thereby to resist the definitional sleight of hand presented by Dr GK's evidence. In the final section, following, I want to trace a similar move — a doctrinal sleight of hand, as it were — by which the converse outcome is achieved. In particular, I want to focus on the manner in which the term 'lawful sexual activity' is interpreted in relation to an 'exclusive and stable lesbian relationship'.

Queen Victoria's Descendants: Reconfiguring Lesbian Sex as (Lawful) Heterosexual Inactivity

It is clear from even the most cursory consideration of these judgments that the question of the meaning to be given to the term 'lawful sexual activity' in the factual circumstances presented by this case was a vexing one. Ambrose J formulates the problem in these rather extraordinary terms:

One of the problems I have in dealing with the facts and arguments in this case is that [Dr GK] declined to provide services to [JM] not because of her lesbian activity but because of her heterosexual inactivity.

...

respect of those moral questions with regard to which there is no agreement' (p 30); that it allows the state to force upon the community 'a particular conception of what is good ... at the expense of other conceptions of what is good' (p 31); and that it 'forces cooperation to the end of securing a particular pattern of distribution of benefits' (p 34) and must therefore 'involve the legislature in stating a preference between two differing views as to what is a desirable pattern of distribution' (p 34). This insistence on the centrality of safeguarding a doctor's ability to make autonomous moral, ethical and religious choices, sits rather uncomfortably with Dr GK's own evidence. Dr GK was emphatic in his evidence before the QADT that he was not operating under any particular moral view on the question of whether lesbians should 'be allowed to get pregnant at all' and that his policy was not based on any 'antagonism towards lesbian relationships' (cited by Ambrose J at in *QFG & GK v JM* (1997) EOC 92–902 at 77, 434 and 77, 433 respectively). Indeed, Ambrose J noted that '[o]n the facts of this case there is *no suggestion* that [Dr GK] acted under *any philosophical or religious constraint*' (emphasis added; at 77, 436) in refusing to treat JM. And, paradoxically, although it was Dr GK's view that he was acting in accordance with the ethical requirements of his profession, professional ethics are themselves not a matter of autonomous moral choice: see, by contrast, Jensen (1996) at 26.

The Tribunal's approach appears to have been to treat an exclusive and stable lesbian relationship ... as the 'lawful sexual activity' upon which the complaint was based.

On the evidence however it seems that had [JM] also engaged in lawful heterosexual activities at the same time she was engaging in lawful homosexual activities [Dr GK] would have had no policy or practice which would have resulted in his refusal to give her the medical artificial insemination service she sought.¹⁰⁵

In the Court of Appeal, Thomas JA agreed, with only 'some slight hesitation', that for the purposes of section 7 of the *ADA*, 'lawful sexual activity' does not include (lawful) sexual inactivity: thus 'the practice of chastity would not ordinarily be regarded as a form of sexual activity'.¹⁰⁶ Ultimately reaching the same conclusion, Pincus JA gives the question a rather more detailed consideration, noting that: first, in its ordinary meaning 'activity' describes 'a doing of something, not the condition of refraining from doing it',¹⁰⁷ second, it must have been obvious to those drafting the legislation that not engaging in a lawful sexual activity could constitute a ground of discrimination and yet no appropriate form of words encompassing such a circumstance was used;¹⁰⁸ and third, the QADT has a power to make orders of a 'very drastic kind',¹⁰⁹ including orders to pay unlimited sums of money, subject only to a limited right of appeal.¹¹⁰ These considerations, taken together, lead to the conclusion that:

the proper course is to give the word 'activity' its ordinary meaning — of doing something rather than nothing¹¹¹ — instead of an extended one; I would exclude from the expression 'lawful sexual activity' ... the condition of not engaging in a particular sort of sexual activity.¹¹²

¹⁰⁵ *QFG & GK v JM* (1997) EOC 92–902 at 77, 424.

¹⁰⁶ *JM v QFG & GK* [2000] 1 QdR 373 at 396.

¹⁰⁷ *ibid.* at 392.

¹⁰⁸ *ibid.*

¹⁰⁹ *ibid.*

¹¹⁰ *ibid.*

¹¹¹ Perhaps proving, as a matter of statutory interpretation, that Queen Victoria was right all along when she could not imagine that two women could possibly 'do' anything?

¹¹² *JM v QFG & GK* [2000] 1 QdR 373 at 392. This strikes me as an extraordinary piece of reasoning. Pincus JA is quite right in pointing out that a consideration of the meaning of 'activity' in this context has broader implications for the interpretation of other protected attributes listed in s 7 of the *ADA*, giving the particular example of 'trade union activity'. It follows logically from his argument that, for example, to dismiss an employee because they did not engage in trade union activity would not amount to employment discrimination, an outcome that seems both absurd and clearly unintended. It also seems to me to be equally arguable (contrary to Pincus JA's view) that, as a matter of statutory interpretation,

It may well be, as each of these judges assumes, that had JM engaged in (lawful) heterosexual activities at the same time as she was engaging in (lawful) homosexual activities — or should that be (lawful) heterosexual *in*activities? — then Dr GK would not have refused to treat her by means of ADI. This is hardly the point, for had JM been engaging in lawful heterosexual activities she would not have been in an exclusive and stable lesbian relationship. And indeed, given the radical invisibility of her relationship, for Ambrose J, she might just as well not have been:

Accepting that [JM's] 'stable lesbian relationship' constituted under s. 7(1)(l) of the Act the attribute of 'lawful sexual activity' it does not follow as a matter of law that the possession of such an attribute showed that [JM] was at least physically or psychologically 'not able to comply' with the requirement.

There is no evidence whatever to suggest that the respondent was physically or psychologically incapable of engaging in heterosexual intercourse. The evidence indicates that because of her lesbian sexual orientation she had chosen an exclusive sexual activity which excluded the possibility of achieving pregnancy in the normal way. There is no evidence that as a matter of choice she was not capable of engaging in heterosexual activity either instead of or in addition to the homosexual activity which she had chosen with her partner ...¹¹³

The Court of Appeal was even more emphatic, and it was clearly not accepted, even for the sake of argument,¹¹⁴ that a 'stable lesbian relationship' could constitute a 'lawful sexual activity'. Thomas JA was insistent that one must not 'overwork' the term "lawful sexual activity" by adding personal relationship factors such as 'exclusive relationship' to the concept.¹¹⁵ To characterise the relevant attribute of lawful (lesbian) sexual activity as 'an exclusive and stable lesbian relationship' is to 'overload the term' by introducing factors of 'individual arrangement and relationship' 'over and above the attribute' of lawful sexual activity.¹¹⁶ Davies JA was equally clear: 'being engaged in a relationship is not an activity; it is a state. The activity is the sexual activity which may or may not be carried out in that relationship.'¹¹⁷

The form of this argument bears a remarkable similarity to Dr GK's definition of medical infertility. Paradoxically, of course, if ever a term was 'overworked' and 'overloaded' by the introduction of 'factors of individual

an 'extended' meaning of lawful sexual activity should be preferred: in the context of a remedial statute, the fact that it must have been envisaged by the drafters that not engaging in an activity was a possible ground of discrimination, as I think Pincus JA rightly assumes (at 392), suggests that the term should be interpreted so as to give effect to what the Legislature must have contemplated.

¹¹³ *QFG & GK v JM* (1997) EOC 92–902 at 77,427–77,428.

¹¹⁴ Cf *ibid.* at 77,427 per Ambrose J.

¹¹⁵ *JM v QFG & GK* [2000] 1 QdR 373 at 396.

¹¹⁶ *ibid.* at 394.

¹¹⁷ *ibid.* at 384.

arrangement and relationship', then surely it is this term. As was argued in the previous section, this definition of infertility functions to mediate a set of 'biological facts' and a normative assumption as to the value of heterosexual relationships in order to protect the integrity of those relationships: ADI would be available, on this definition, to a 'fertile' woman seeking ADI because of her male partner's 'infertility' (because, as a couple, they are 'infertile') but not to a woman in JM's position (because as an individual she is not 'infertile'), although there is no 'biological' difference between the women in these two circumstances. Similarly here, the (re)definition of 'lawful sexual inactivity' in this argument ultimately functions to protect the integrity of exclusive heterosexual relationships by reducing 'an exclusive and stable lesbian relationship' into (lawful) 'homosexual activity'. Thus, whereas exclusive heterosexual relationships are normally understood to be exclusive sexual/affective associations, JM's relationship is understood by both decisions to have neither of these characteristics: it is neither (hetero)sexually active nor is it an exclusive affective association.¹¹⁸ One cannot imagine it being suggested that it would be reasonable to require a 'fertile' heterosexual woman whose male partner was 'infertile' to go beyond the parameters of her relationship and engage in heterosexual activity with a third (fertile, male) party in order to achieve a pregnancy in 'the ordinary biological way'. Yet this is clearly the imperative that both decisions impose on JM.

Epilogue

What the preceding analysis makes apparent is that the discourses of law and medicine, in parallel ways, reaffirm the normative value of heterosexual (preferably marriage) partnership as the only acceptable social form for the raising of children. Thus, whilst women in (heterosexual) de facto relationships have been able to obtain access to ART, this has been achieved through a double movement of assimilation (to the medico-legal narrative of 'proper' familial, reproductive and sexual relations) and exclusion (of the 'improper' pregnancy). In other words, whilst (heterosexual) de facto couples will now be seen, for the purposes of access to ART, as 'equivalent to' (heterosexual) married couples, the same cannot definitively be said of single women (whatever their sexual orientation), and this is clearly not the position of lesbian women (whatever their relationship status). Rather, these two groups of women may find that their access to ART is regulated by a (now) legally sanctioned definition of 'medical infertility' which they will never meet without first reinventing themselves in the image of the heterosexual nuclear family.

It is more than a little curious, then, that the Federal Court decision in *McBain v State of Victoria*,¹¹⁹ handed down shortly before publication of this article, should have generated such an extraordinary response from the

¹¹⁸ A Stuhmcke, 'Court Strips Lesbian of Sexual Identity' (1998) 9(9) *Lesbians on the Loose* 13, p 13.

¹¹⁹ Unreported, Federal Court of Australia, 28 July 2000. References are to the text of the decision published at [2000] FCA 1009.

Commonwealth government. The applicant, John McBain, was a gynaecologist specialising in reproductive technology and the use of IVF techniques. In August 1999 he was consulted by a single woman — Lisa Meldrum — who wished to obtain treatment combining IVF of her own ovum and the use of donor sperm. McBain stated to Meldrum that administration of the proposed treatment was precluded by provisions of the *Infertility Treatment Act* 1995 (Vic). Specifically, section 8(1) of that Act requires that a woman who undergoes a ‘treatment procedure’ — defined in section 3 as including ‘artificial insemination of a woman with sperm from a man who is not the husband of the woman’ and ‘the medical procedure of transferring to the body of a woman a zygote formed outside the body of any woman’ — must be either ‘married and living with her husband on a genuine domestic basis’ (section 8(1)(a)) or ‘living with a man in a de facto relationship’ (section 8(1)(b) and section 3(1)). McBain therefore sought a declaration that section 8 of the *Infertility Treatment Act* 1995 (Vic) was inconsistent with section 22 of the *Sex Discrimination Act* 1984 (Cth).¹²⁰

There were four respondents: the State of Victoria, the Victorian Minister for Health, the Infertility Treatment Authority (who by letter submitted to any orders the Court might make) and Lisa Meldrum (who adopted the submissions made by the applicant). The first two respondents — the State of Victoria and the Minister for Health — adopted a “neutral” position on the alleged inconsistency’ between the Victorian Act and the Commonwealth Act in that they ‘neither asserted there is no inconsistency nor conceded any inconsistency’.¹²¹ Given this neutral position, the court heard as *amici curiae* the Australian Catholic Bishops Conference and the Episcopal Conference of the Roman Catholic Church (referred to collectively as the Catholic Church) who contended that there was no inconsistency.

The Catholic Church put forward a number of arguments — arguments one might characterise as obscure, verging on baroque — in support of this contention. First, it was submitted that as ‘the central case of becoming pregnant is intercourse between a man and a woman’ and as it is not appropriate to ‘describe the act of the man as providing a “service” to the woman’,¹²² the provision of fertility treatment is not properly described as a ‘service’ within the meaning contemplated by section 22 (read in conjunction with section 4) of the *Sex Discrimination Act* 1984 (Cth). The court concluded that what needed to be characterised as a ‘service’ for the purposes of the Act was not the ‘central case’ of achieving pregnancy through intercourse but the medical processes involved in fertility treatment. In the ‘ordinary use of language’, these processes clearly fell within the definition of ‘services’ in section 4 of the Act, which definition included ‘services of the kind provided by the members of any trade or profession’. Second, the Catholic Church pointed to the existence of a number of international instruments that ‘recognise the right of a child to be born into a family, to be raised by its

¹²⁰ See notes 20 and 21 above.

¹²¹ [2000] FCA 1009 at paragraph 3.

¹²² *ibid.* at paragraph 10.

mother and father, and to know its parents'.¹²³ Because there is a rebuttable presumption that the parliament intends to legislate in accordance with its international obligations,¹²⁴ the term 'services' should be interpreted in a manner that is consistent with the rights of the child articulated in those international instruments. The court concluded, however, that these same instruments also protect the individual's right to self-determination (including a right freely to determine one's social and cultural development) and the individual's right to freedom from discrimination in the exercise of the rights articulated in those instruments.¹²⁵ In the court's view, this 'tell[s] against the existence of an untrammelled right of the kind for which the Catholic Church contends'.¹²⁶ Moreover, the *Sex Discrimination Act 1984* (Cth) gives effect to a particular international instrument — the *Convention on the Elimination of All Forms of Discrimination Against Women* — and should not be interpreted in a way that would 'give primacy to implications drawn from other treaties over the words of the very treaty to which the Commonwealth Act gives effect'.¹²⁷ The interpretive issues are clear:

The words of the relevant part of the definition of 'services' are clear and unqualified. They are eminently apt to pick up a service by a medical practitioner, and there is no occasion to introduce into them a qualification derived from an assumption made in treaties dealing with other topics, namely that a child will be born into a family as a result of natural processes involving a married couple. The fact that those treaties proceed on that assumption does not mean that they are to be taken to assert or imply a prohibition against the birth of a child as a result of some other, medically assisted, mechanism.¹²⁸

Third, the Catholic Church argued that the specific 'treatment procedures' McBain sought to provide to Meldrum — namely, 'artificial insemination of a woman with sperm from a man who is not the husband of the woman' and 'the medical procedure of transferring to the body of a woman a zygote formed outside the body of any woman'¹²⁹ — were services that could only be provided to women and as such fell within section 32 of the *Sex Discrimination Act 1984* (Cth). This section has the effect that the prohibition against discrimination on the basis of sex embodied in that Act does not apply

¹²³ *ibid.* at paragraph 11. Reference was made to the *Declaration of the Rights of the Child* (Principles 6 and 7) and the *International Convention on Civil and Political Rights* (Articles 10 and 23).

¹²⁴ *Minister for Immigration v Teoh* (1995) 183 CLR 273 at 287.

¹²⁵ See for example, the *International Covenant on Economic, Social and Cultural Rights* (Articles 1 and 2(2)); the *International Convention on Civil and Political Rights* (Articles 1 and 2(2)); and the *Declaration of the Rights of the Child* (Preamble).

¹²⁶ [2000] FCA 1009 at paragraph 12.

¹²⁷ *ibid.*

¹²⁸ *ibid.* at paragraph 13.

¹²⁹ *Infertility Treatment Act 1995* (Vic), s 3.

'to or in relation to the provision of services the nature of which is such that they can only be provided to members of one sex'. The court held that to argue that the specific infertility treatments with which this case was concerned fell within the scope of section 32 was to misconstrue the nature of fertility treatments generally. The *Infertility Treatment Act 1995* (Vic) created a single legislative scheme governing the various infertility treatments to which it applied. This scheme did not create differential eligibility criteria for those treatments according to whether they were targeted at overcoming female factor infertility or male factor infertility. Thus:

Parliament has, in effect, characterised the treatments as being of the same general nature, namely treatments aimed at overcoming obstacles to pregnancy. Accordingly the nature of these treatments is that they are capable of being provided to both sexes ... The fact that for biological reasons the embryo is placed into the body of the woman is but the ultimate aspect of the procedure. The vice of the argument is that in order to bring the case within s 32 it is necessary to select from the scope of the service only that part that is provided on or with the assistance of a woman.¹³⁰

Fourth and finally, the Catholic Church argued that if the 'marital status requirement' stipulated in section 8(1) the *Infertility Treatment Act 1995* (Vic) were found to be discriminatory, then section 7B of the *Sex Discrimination Act 1984* (Cth) provided a defence in that the requirement was 'reasonable in the circumstances.'¹³¹ In support of this argument, the Catholic Church pointed to 'the obvious public interest in a child knowing its parents and having a parent of either sex'; the rights of the child embodied in various international instruments; and the underlying public policy considerations evidenced in other legislative provisions (such as section 60B of the *Family Law Act 1975* (Cth)) which provide that 'children have the right to know and be cared for by both parents'.¹³² This line of argument was rejected because the 'marital status requirement' discriminated, on its face, between single women and married women/women in de facto relationships: this amounted to direct discrimination (as contemplated by section 6(1) of the *Sex Discrimination Act 1984* (Cth))

¹³⁰ [2000] FCA 1009 at paragraph 15.

¹³¹ Section 7B provides that:

A person does not discriminate against another person by imposing, or proposing to impose a condition, requirement or practice that has, or is likely to have, the disadvantaging effect mentioned in subsection 5(2), 6(2) or 7(2) if the condition, requirement or practice is reasonable in the circumstances.

In deciding whether a requirement is reasonable in the circumstances, the factors to be taken into account include the nature and extent of the disadvantage resulting from the requirement (s 7B(2)(a)); the feasibility of overcoming the disadvantage (s 7B(2)(b)); and the proportionality of the disadvantage relative to the result sought to be achieved by the person imposing the requirement (s 7B(2)(c)).

¹³² [2000] FCA 1009 at paragraph 17.

whereas section 7B provided a defence only to a complaint of indirect discrimination (section 6(2)).

On the constitutional question of inconsistency, the court's conclusion was unequivocal:

Section 8 of the State Act provides that a woman's marital status, namely her status as a married woman or one living in a de facto relationship, is an essential requirement for the availability of a treatment procedure. Section 22 of the Commonwealth Act makes it unlawful for a person to refuse to provide services to another on the ground of the latter's marital status. That is what s 8 requires a provider of infertility treatment to do. It requires the applicant to treat Ms Meldrum less favourably than a married woman or one in a de facto relationship ... The sections are directly inconsistent, and the former is inoperative to that extent.¹³³

Indeed, it is difficult to see how the court could possibly have reached a different conclusion. If, by contrast, I have lingered in detailing the submissions made by the Catholic Church, it is not because such arguments require careful consideration, but rather because they are so clearly and strikingly implausible, so thoroughly a desperate attempt to grasp at straws. The constitutional card has been played and definitively lost: provisions in state legislation regulating access to ART that purport to limit eligibility to women who are married or living in de facto relationships will be inconsistent with the Commonwealth *Sex Discrimination Act* 1984.

The Commonwealth government's extraordinary response to the *McBain* decision¹³⁴ — to amend the *Sex Discrimination Act* 1984 (Cth) in order to

¹³³ *ibid.* at paragraph 19.

¹³⁴ It is pertinent in this context to remember that *McBain* is only the most recent in a line of similar decisions: *Pearce v South Australian Health Commission* (1996) 66 SASR 486; *MM, DD, TA & AB v The Royal Women's Hospital, Freemason's Hospital & State of Victoria* (1997) EOC 92-902 and, recently, *W v D and Royal Women's Hospital* (unreported, Human Rights and Equal Opportunity Commission, 24 December 1999). This latter decision was handed down shortly before the decision in *McBain v State of Victoria* [2000] FCA 1009 and undoubtedly forms part of the context in which the strategic decision of the State of Victoria and the Victorian Minister of Health to remain 'neutral' on the question of inconsistency in *McBain* was made and out of which the Commonwealth government's proposed amendments to the *Sex Discrimination Act* 1984 (Cth) emerge. In July or August 1994, when she was 37 years old, W made a decision to become a single mother. She rang the general switchboard number of the Royal Women's Hospital to inquire about donor insemination services and was informed that the donor insemination program did not accept single women as this was prohibited by Victorian law. W then sought treatment in a clinic in Sydney between November 1994 and January 1997. She also entered into an arrangement with a male friend in August 1995 and attempted self-insemination on a number of occasions. In February 1996, W consulted D for the purpose of further investigating the reasons she was having trouble conceiving. In the course of this consultation, D confirmed that W was ineligible for the donor

preclude claims of the kind pursued in *McBain* — is a clear acknowledgment of this fact. The Sex Discrimination Amendment Bill (No 1) 2000 proposes to insert the following provisions:

s. 22(1A) Nothing in this section makes it unlawful to refuse a person access to, or to restrict a person's access to, assisted reproductive technology services if that refusal or restriction is on the ground of the person's marital status and is imposed, required or permitted by or under a law of a State or Territory (whether made before or after the commencement of this subsection).

(1B) If:

(a) an anti-discrimination law of a State or Territory expressly states that a range of assisted reproductive technology services (which may be some or all of those services) is not covered by that law; and

insemination program at the Royal Women's Hospital because she was single. W consulted D again in August 1996 to clarify her eligibility for the Melbourne donor insemination program. Contrary to his earlier advice, at this consultation D expressed the view that the *Infertility Treatment Act 1995* (Vic) appeared to prohibit treatment of single women using IVF procedures but not donor insemination services. D stated that, nonetheless, he still could not treat W because the 'ethics committee' would not allow him to treat her. The Commission concluded that the Royal Women's Hospital had refused to provide W with the services she sought on the basis of a policy that 'denied single women access to the relevant services and that the Hospital therefore treated the complainant differently from and less favourably than applicants for donor insemination treatment who were married' (at 12). In relation to D, the Commission concluded that D had not in fact refused to provide a service to W for the purposes of s 22 of the *Sex Discrimination Act 1984* (Cth) because 'as a practical matter he could not provide the service because the Hospital was not itself prepared to grant access to the necessary facilities, particularly scarce donor sperm' (at 13). As it was, in practical terms, impossible for D to provide the requested services, he cannot have refused to provide them.

The Commission considered the question of whether either respondent could rely on the *Infertility Treatment Act 1995* (Vic) as a defence by way of foreclosing the operation of the *Sex Discrimination Act 1984* (Cth). Although underlining that it was not within its power to make any ruling as to the constitutionality of the Victorian Act, the Commission did state that it was 'highly likely' that had the Royal Women's Hospital sought comprehensive legal advice it would have been advised:

either as a matter simply of the construction of the Commonwealth Act, but also probably having regard to the likely inconsistency of the two Acts and the consequent invalidity of the State Act by virtue of s 109 of the Commonwealth Constitution, that it would be acting in breach of the [*Sex Discrimination Act*] if it were to refuse donor insemination treatment to unmarried women (at 14).

- (b) no other law of the State or Territory prohibits a person's access to a service within that range being restricted on the ground of that person's marital status;
- that anti-discrimination law is taken, for the purposes of subsection (1A), to permit the refusal or restriction of the service to the person on that ground.
- (1C) Except as provided in subsection (1B), a law of a State or Territory is not to be taken to permit a refusal or restriction of access to an assisted reproductive technology service merely because it does not cover that service.

The purpose of this amendment, as disclosed by the explanatory memorandum and the Attorney-General's Second Reading Speech, is to enable state and territory legislation to restrict access to ART services on the basis of marital status by ensuring that such legislation would not be rendered inoperative by reason of inconsistency with section 22 of the *Sex Discrimination Act* 1984 (Cth). In relation to the Victorian *Infertility Treatment Act* 1995 and the South Australian *Reproductive Technology Act* 1988, the effect of the amendment would be to revive those provisions that have previously been ruled inoperative for this reason.

On closer analysis, the amendment also has significant broader implications, some of which may be unintended and undesired.¹³⁵ Of particular relevance in the context of the present discussion is the observation that, despite that fact that the impetus for the proposed amendment, crystallised by the decision in *McBain v State of Victoria*,¹³⁶ was a desire to exclude lesbian women and single women from gaining access to ART services, the amendment is potentially much broader in its application. For example, although this is not its intention, the proposed amendment would clearly allow state legislation to exclude de facto couples just as the Victorian *Infertility Treatment Act* 1995 had done until it was amended in 1997. In this respect, even on the most generous reading, the proposed amendment is ham-fisted. For this reason alone, it seems unlikely that the amendment will be passed. Rather, it would appear at this stage that the operative discursive paradigm that will come to govern access to ART will be that of 'medical need' for treatment

¹³⁵ It is relevant to note in this regard that, given the variety of approaches that the states and territories have taken to the regulation of ART, the effect of the proposed amendment would be that that the *Sex Discrimination Act* 1984 (Cth) would operate differently in different states, a circumstance which would amount to giving primacy to state legislation regulating access to ART over Commonwealth legislation implementing Australia's international obligations under the *Convention on the Elimination of All Forms of Discrimination Against Women*. It is strikingly inconsistent with the federal context in which the *Sex Discrimination Act* 1984 (Cth) operates that it should not have uniform application throughout Australia: see *W v D and Royal Women's Hospital* (unreported, Human Rights and Equal Opportunity Commission, 24 December 1999) at 15.

¹³⁶ [2000] FCA 1009.

of 'infertility',¹³⁷ a paradigm which will function in a much more targeted way to preclude lesbian women and single women (but not de facto heterosexual couples) from becoming parents by means of ART.

It is no small irony, then, that fully five years before this amendment was proposed (with its underlying assumption that only heterosexual couples can adequately provide the 'care' and 'attention' and 'protection'¹³⁸ that children need and to which they are entitled) the New South Wales Supreme Court in *W v G*¹³⁹ ordered a woman to pay maintenance for children born to her lesbian partner after private donor insemination. It may well be then, paradoxically, that the signs of legal change that, in Stuhmcke's terms, might indicate a growing willingness__ to accommodate and support alternative family forms are to be found at their conclusion rather than at their conception.

¹³⁷ Indeed, former liberal prime minister Malcolm Fraser has spoken against the amendment because it is, in his view, unnecessary: states need only to limit access to ART to women who demonstrate a medical need for infertility treatment, which by (his) definition will exclude lesbians and single women. The same view was expressed by federal Health Minister Michael Wooldridge, despite the fact that he had earlier indicated some support for amending the *Sex Discrimination Act* 1984 (Cth) following the decisions in *Pearce v South Australian Health Commission* (1996) SASR 486 and *MM, DD, TA & AB v The Royal Women's Hospital, Freemason's Hospital & State of Victoria* (unreported, Human Rights and Equal Opportunity Commission 11 March 1997): see 'Lesbian IVF for Discussion', *BrotherSister*, 3 April 1997, p 7.

¹³⁸ Attorney-General's Second Reading Speech, <http://search.aph.gov.au> accessed on 8 November 2000.

¹³⁹ (1996) 20 FamLR 49. See also Morgan (1996) p 61; *Re B and J (Artificial Insemination)* 135 FamLR 472; Devereux (1998).