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Pastoral Care for Children Conceived through IVF

Passing on Catholic teaching effectively means exercising both the doctrinal and pastoral ministries of a Church which professes to be both Mother and Teacher.

Australia's first IVF-conceived baby, Candice Reed, was born on 23 June 1980.[1] Since then, there have been an estimated 90,000 more Australians born following conception through IVF or related technologies.[2] The rate of IVF-conceived births as a percentage of all births has doubled each decade from less than 1% in 1990, to 1.9% in 2000, to 4% in 2009.[3]

Social factors around access to IVF introduce variations in this rate. IVF clinics in Australia are usually located in capital cities or major population centres, and the expense often puts IVF out of reach for those who do not carry private health insurance. The rate of IVF-conceived births is likely to be higher than 4% for higher-income, privately insured people living in capital cities.

So on average across Australia today, in a primary or secondary school class of 25 young people, it is very likely that at least one student - and in capital cities, probably more than one student - has been conceived through IVF. For school teachers, there are pastoral care implications.

It is already clear that, at an age when children often seek answers to questions of personal identity, the realisation that one was conceived through IVF can profoundly challenge a child's sense of self and self-worth - especially when donor gametes and/or surrogacy have been used. Both processes can place restrictions on a child's knowledge of or contact with those who have contributed to their genetic make-up or biological history. Reflecting on her own search for her genetic father, one donor-conceived adult has eloquently captured a contradiction intrinsic to donor-IVF and surrogacy:

> It's hypocritical of parents and medical professionals to assume that biological roots won't matter to the "products" of the cryobanks' service, when the longing for a biological relationship is what brings customers to the banks in the first place.[4]

School teachers who seek to answer students' questions about their conception and birth need to negotiate difficult social and psychological terrain. In this as in every moral issue, passing on Catholic teaching effectively means exercising both the doctrinal and pastoral ministries of a Church which professes to be both Mother and Teacher.[5]

It goes without saying that teachers and others involved in faith formation must fully understand the Church's stance on the use of IVF technology.[6] But they must also be very conscious of the pastoral duty incumbent on all who teach Catholic faith, since it is unacceptable to communicate the Church's objective ethical assessment of IVF technologies if one does not also communicate the Church's deep understanding of and pastoral concern for both the adults who seek to have children through IVF and the children so conceived.

For teachers this means not only communicating the content of Church doctrine accurately and with integrity, but also manifesting a sincere, compassionate, nurturing attitude toward those with whom they are communicating and for whom they are responsible to provide pastoral care. How should a teacher proceed?

In the first place, it is important to affirm the deeply-felt need to 'parent' which drives infertile couples to believe they have no option but IVF. The Church esteems parenthood as a married couple's sharing in the creative and sustaining activity of God, one of the ways in which persons reflect God's image and likeness and cooperate with God's ongoing divine activity in the world.

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Affirming this drive to parenthood also means acknowledging that the experience of infertility is a form of suffering that might prompt couples to consider absolutely any option to relieve it.[7] Prior to any critique of the methods to which they may turn, then, strong affirmation of the goodness of their innate drive to parenthood opens up the possibility of talking to, and about, such couples in pastorally therapeutic ways.

It is also important to affirm, as the Church does, the positive potential of the medical sciences. Even as it addresses the ethics of IVF, the Church offers:

> a word of support and encouragement for the perspective on culture which considers science an invaluable service to the integral good of the life and dignity of every human being. The Church therefore views scientific research with hope and desires that many Christians will dedicate themselves to the progress of biomedicine and will bear witness to their faith in this field.[8]

In highlighting the potential of science, teachers should be careful to draw students' attention to the central ethical distinction between what is technically possible and what is ethically defensible.[9] To put it simply, "that fact that we *can* do something does not automatically mean that we *ought* to do it." Examples abound: that fact that mankind has the capacity to split the atom and create weapons of mass destruction, or to exploit the environment thoughtlessly, does not make it ethically right to do either. Senior students may be led to explore the value base inherent in all of the sciences, to which Einstein alluded:

> Science can only ascertain what *is*, but not what *should be*, and outside of its domain value judgments of all kinds remain necessary.[10]

Along with the ethical questions, students should also be led to consider three central values: the dignity of the human person, the essentially relational nature of humankind, and the importance of being open to the transcendent. These values underlie the Church's final assessment of IVF. The first two are grounded in our creation in the image and likeness of the Triune God, in whom both unity and relationship are constitutive. Our openness to the transcendent is manifested in many ways, from vague enjoyment of the natural world to quite specific Christian spiritualities.

Teachers are professionally trained to identify and to 'tap' their students' capacity to grasp these truths. The students' sense of justice and fairness based on human dignity, their experience of desiring to form relationships of various kinds, and their hope of building a brighter future, are all indicative of these values and good starting points for exploring the deeper ethical questions.

Beyond the Church's ethical issues with the practice of IVF – principally to do with the destruction of human embryos – there lies an even more profound problem: IVF separates the creation of a human person from its proper locus in the personal loving act of two other human persons.[11]

This teaching is based in a rich theological view of personhood. 'Life' is ultimately 'gift', to be received with gratitude and passed on with humility through actions which realise our deepest and most intimate human nature. While we are created *as* individuals, we are created *for* relationship with others.[12] We achieve this most fully when we give ourselves ('gift' again) to another person totally and unreservedly and, on the foundation of that mutual giving and receiving, establish a community of life marked by growing affective unity and an openness to the possibility of creating, sustaining and bringing to maturity another human person, our child. Most importantly, the self-same intimate act which realises the couple's personal unity (in the image and likeness of God) also realises their creative potential (in the image and likeness of God), and so the gift of 'personhood' is passed on to the new person through the unifying and creative mutual self-gift of two persons.

While this argument has a certain elegance, it may fail to convince a couple consumed by their felt need to parent children at any cost. As the history of Catholic moral theology attests, even the clearest reasoning will not always succeed in overcoming profoundly felt human drives and passions. Therefore our moral traditions have long distinguished between the objective moral meaning of human actions, and the degree of personal culpability with may be attributed to the persons who choose those actions. Two of the traditional 'modifiers of responsibility',[13] fear and passion, may apply in the present case: it is entirely possible that a couple's fear of remaining childless and what that might mean for their marriage and sense of purpose in life, or indeed the strength of their passionate drive for parenthood, might overwhelm all other factors in their reception of the Church's teaching on IVF technology.

As always, doctrinal clarity must be matched by deep pastoral compassion and understanding of the pressures to which this couple feel subjected: who but God can judge the couple's ability and desire to '*do and pursue the good'* as they perceive it? Only to the extent that we fulfil *both* our doctrinal duty to teach *and* our pastoral duty to care can we claim to pass on the Church's teaching about IVF in its fullness.

This is well captured in a message that all IVF-conceived children need to hear from the Church:

> Although the manner in which human conception is achieved with IVF and ET cannot be approved, every child which comes into the world must in any case be accepted as a living gift of the divine Goodness and must be brought up with love.[14]

This positive statement of the Church's respect for the dignity all human life, regardless of how or why conception is achieved, should be *the first and most consistently reiterated theme* in a teacher's response to any questions regarding IVF.

Students' concerns for their sense of identity are even more critical when conception has occurred using donor gametes, and more complex again in the case of surrogacy arrangements. Hence different jurisdictions have taken great pains to prioritise the donor-conceived

child's right to information regarding the gamete donor[15] and, in the case of surrogacy, to ensure that the child's right to information about and contact with the surrogate mother and any gamete donors is subject to court-approved agreements.[16] But because individual donor arrangements may be subject to different legal agreements between parties, teachers need to be quite careful when discussing any particular student's right to information or contact. Depending on their age, level of affective maturity and family situation, it may be better to refer the student's concerns back to his or her own parents.

Discussing surrogacy with students poses yet another risk of which teachers must be wary. Putting to one side the question of commercial surrogacy (not permitted in Australia), even so-called 'altruistic surrogacy' raises questions about the potential 'commodification' of children – that is, the risk of treating children who are the subjects of surrogacy arrangements as if they were objects, possessions or goods in respect of which contracts or legal arrangements can be entered.

In the eyes of some donor-conceived children, it is fundamentally unjust that IVF and surrogacy laws are framed primarily around the interests and wants of the adult parties who seek these options, with little or no real attention given to the legitimate interests and even the rights of the children created.[17] This 'rights-based' argument adds to the Church's fundamental difficulty with IVF.

Appropriate pastoral care for students conceived through IVF begins with reminding them that it was their parents' great desire to have a child that drove them to consider IVF in the first place. This is at least an affirmation of their respect for the child as a person. This focus on the parents' primary motivation for using IVF or surrogacy can help to defuse at a subjective level some of the tension which can be created by the Church's objective critique of the technology, but teachers must be careful not to dilute that objective critique in the process. Once again, prudent assessment of the student's age, level of affective maturity and family situation may provide teachers with some guidance on how to achieve an appropriate balance.

Every child has a need and a right to be affirmed, valued and respected regardless of the decisions their parents have or have not made in their regard. This surely is the overriding pastoral obligation that comes to light as the Church, Mother and Teacher, strives to fulfil its mission in Catholic education.

ENDNOTES

[1] Lindy Kerin and staff, "First IVF baby turns 30" (23 June 2010), ABC News, www.abc.net.au/news/2010-06-23/first-ivf-baby-turns-30/877426

[2] IVF (in vitro fertilisation) refers to fertilisation of ova by sperm in a petri dish. In recent years, the more popular method of fertilisation has been intra-cytoplasmic sperm injection (ICSI) in which a single sperm is directly injected into an ovum. The GIFT process (gamete intra-fallopian transfer) is now used rarely in Australia: in 2009 GIFT resulted in just one clinical pregnancy and live delivery (of twins). In this paper, all of these will be referred to simply as 'IVF'.

[3] Australian Bureau of Statistics (ABS), *Births Australia 2010,* ABS, http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/3148B41DC3875A59CA25793300168145/$File/33010_2010.pdf; Australian Institute of Health and Welfare (AIHW), "IVF birth numbers higher than ever (13 June 2003), AIHW, www.aihw.gov.au/media-release-detail/?id=6442464476 and *Assisted Reproductive Technology in Australia and New Zealand 2009* (Nov. 2011), AIHW, www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737420484

[4] Katrina Clark, "My father was an anonymous sperm donor" (17 December 2006), Washington Post, www.washingtonpost.com/wp-dyn/content/article/2006/12/15/AR2006121501820.html

[5] See, for example, Paul VI, *Humanae vitae (On the regulation of Birth)* (25 July 1968), # 19. This echoes the title of John XXIII's 1961 social encyclical *Mater et magistra*, which states that "the Catholic Church has been established by Jesus Christ as Mother and Teacher…" The Church as Mother and Teacher is also discussed in the *Catechism of the Catholic Church*, #2030-2046.

[6] The Catholic Church's teaching on IVF is to be found in two documents from the Sacred Congregation for the Doctrine of the Faith (SCDF): *Donum vitae (On respect for human life in its origin and on the dignity of procreation: Replies to certain questions of the day*) (22 February 1987), Holy See, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19870222_respect-for-human-life_en.html ; and *Dignitas personae (On certain bioethical questions)* (8 September 2008), Holy See, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20081208_dignitas-personae_en.html

[7] The SCDF states: "*The suffering of spouses who cannot have children . . . is a suffering that everyone must understand and properly evaluate*. On the part of spouses, the desire for a child is natural: it expresses the vocation to fatherhood and motherhood inscribed in conjugal love." For this, see *Donum vitae*, II:8; cf *Dignitas personae*, #3.

[8] *Dignitas personae*, #3.

[9] *Donum vitae*, Introduction #4.

[10] Albert Einstein, "Address at *Princeton Theological Seminary"* (19 May 1939), Panarchy, panarchy.org/einstein/science.religion.1939.html

[11] The SCDF states: "The humanisation of medicine . . . requires respect for the integral dignity of the human person first of all in the act and at the moment in which the spouses transmit life to the new person." For this, see *Donum vitae*, II.B.7.

[12] Benedict XVI has stated: ". . . understand who the human being is: he is not a "monad", an isolated being who lives only for himself and must have life for himself alone. On the contrary, we live with others, we were created together with others and only in being with others, in giving ourselves to others, do we find life." For this, see Benedict XVI,"Homily at Rome's Prison for Minors 'Casal del Marmo'" (18 March 2007), Holy See, http://www.vatican.va/holy_father/benedict_xvi/homilies/2007/documents/hf_ben-xvi_hom_20070318_istituto-penitenziario_en.html

[13] The traditional five modifiers (ignorance, passion, force, fear and habit) are thoroughly discussed in traditional textbooks of moral theology and moral philosophy. See, for example, Henry Davis SJ, *Moral and Pastoral Theology*, 8th ed. (London: Sheed & Ward, 1959), Vol 1, 16-33 ; and Austin Fagothey SJ, *Right and Reason: Ethics in Theory and Practice*, 4th ed. (St Louis: Mosby, 1967), 22-29.

[14] *Donum vitae*, II.B.5. "ET" here refers to embryo transfer *in utero* of either 'fresh' or frozen embryos.

[15] In Western Australia, for example, donor-conceived children have the right to basic information regarding their donor and, if the donor agrees, to contact with the donor in adult life: see the Reproductive Technology Council information booklet online at www.rtc.org.au/publications/docs/Q&A.pdf

[16] Under Western Australian legislation, a parentage order must establish details of a child's future contact with the birth mother

and any information to be provided to the child. See *Surrogacy Act 2008* (WA), Part 3 Division 3, (WA) Reproductive Technology Council, www.rtc.org.au/docs/090513_A1_Surrogacy_Act_2008_(WA).pdf

[17] Katrina Clark, "*My father was an anonymous sperm donor.*"

All on-line resources accessed 25 September 2012.

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Sex Cells

Sex Cells, written by Rene Almeling, describes the commercial market that has emerged in the United States for human eggs and sperm. Almeling examines how agendas that are economically, biologically and culturally driven have lead to distinctly different practices within egg agencies and sperm banks. Further, she observes how these practices subsequently shape an individual's perception of the commodification of human gametes.

Rene Almeling is an Assistant Professor of Sociology at Yale University with an interest in gender, markets, medicine, and genetics.[1] She has written extensively on gender and reproduction. Between 2002 and 2006, Almeling interviewed forty-five staff members, nineteen egg donors and twenty sperm donors from six gamete donation programs in the United States of America for her book, *Sex Cells*. Recipients of the eggs or sperm were not interviewed.[2] *Sex Cells* has approximately 230 pages, and is divided into three sections; an introduction describing economic markets and several sociological opinions on commodification, in particular bodily commodification. This is followed by two parts. The first part unfolds the organisation of the market, through examination of how the product (eggs or sperm), is characterised and the portrayal of the product to the consumer in the market place. Part Two examines the sociological and physical experience of the market through the donors' viewpoint. This encompasses sourcing the product, and being paid for the product. The final section of Part Two examines the connections that a donor may feel towards the end result (child) of the product they provided for the market. At the end of the book there is an extensive note section which provides some comprehensive notes on interviews and further explanations on the decisions made that shaped the book. This article discusses each section of Almeling's book:

Introduction

Almeling notes that the human gamete market consists of two products from two biologically distinct sources – eggs or ova from women and sperm from men. Viewing this market from a biological aspect where both products are genetic material, eggs and sperm could have equal value in the market. Structurally the markets for eggs and sperm could operate on the same principle - recruit donors to donate genetic material for purchase by prospective customers to conceive children. However, as women have a limited supply of eggs, they could be valued as a scarce resource. As sperm can be replenished easily, it may not be valued as much by the market. Conversely, a societal framework may value sperm more highly based on the income inequality of the genders. But, woven into this commercial market explored by Almeling is a cultural expectation – women are supposed to be the selfless care givers and men are supposed to be the rational hardworking patriarchs.

Commodification (the assigning of a monetary value to a bodily good or service) has been contested since the world's oldest profession – prostitution. Almeling discusses the divided attitudes towards commodification. Scholarship on one side believes the trading of money for a human being, or some part of a human being could be a normal expansion of the commercial markets. However, assuming bodily commodification is harmful for society and the individual, social relations could be threatened by this market expansion. Conversely, other scholars consider the market a variable social process, inconsistent in its operation, and consider economic processes are shaped by the social factors surrounding the market and those who participate in the market.[3]

Through the analyses of the interviews with staff and donors at egg agencies and sperm banks, Almeling considers in *Sex Cells* the interplay of these different forces in the American market place for human gametes.[4]

Organizing the Market

The first section of *Sex Cells* discusses the organisation of the commercial market from the initial tentative use of anonymously donated sperm, to the slick marketing techniques used for the characterisation of the "goods" (gametes) within the market today. The effect of the HIV epidemic on established practises, and the impact of artificial reproduction techniques are also considered.

The dawning of the twentieth century saw physicians surreptitiously using donated sperm for fertility treatment.[5] Eventually when sperm donation was classified as a medical procedure, physicians sought donations of fresh sperm from anonymous medical students and young doctors, matching physical, racial, and where they could "mental" and religious features to the husband of the couple.[6]

By the mid 1980's, the HIV epidemic changed the ground rules for sperm donation. As freezing and quarantining sperm for at least six months prior to use became the standard practise amongst clinics, physicians relinquished control of sperm donation to commercial banking. Minimum sperm counts, sexual disease clearances, and a strong family health history became part of the algorithm for donating.[7]

Although an established model for gamete donation existed, egg donation programs did not utilise the model established by sperm banks. Fresh egg donations were preferred. Less risky egg retrieval procedures introduced in the late 1980's saw women other than those undergoing fertility treatment start to donate their eggs. In early programs the donor would often be known to the recipient. The openness of egg donation programs led to questions regarding sperm bank practices.[8]

In the United States sex specific agencies for gamete donation developed within different branches of medical research. Policies vary between the different agencies/ banks on the different coasts of the United States, with some providing basic information regarding a recipient's pregnancy to the release of identifying information when offspring reach eighteen years of age.[9]

Selling Genes, Selling Gender

Egg agencies and sperm banks were found to employ similar marketing language – helping people.[10] Both egg agencies and sperm banks screen for genetic and infectious diseases. This highlights an analogous concern regarding the exchange of bodily fluids within the market place. However, Almeling reveals that societal cultural views of sex and gender shape the "economic logic" and the "altruistic rhetoric" utilised by the agencies. Women were expected to demonstrate the traditional role of "selfless caregiver," and were questioned on their feelings regarding the thought of someone who is genetically related to them being created and out in the world.[11] Men were never requested to consider this aspect of donation, based on the assumption that women are more attached to their eggs than men are to their sperm.[12]

Sperm banks locate themselves near universities assuring them of a ready supply of intelligent males who were flexible with their time constraints, and were cash strapped. If donors are prepared to release identifying information when their offspring reached eighteen some of their shortcomings are overlooked, i.e. lack of height or chubbiness. The most ideal egg donors are young mums and high academic achieving single women. Both sperm and egg programs utilised education to ascertain "genetic based intelligence."[13]

As three generations of family health outcomes are required from the donor, it was unusual for a program to accept adoptees, who cannot provide a history due to the circumstances of their birth.[14] This is significant. These agencies are helping to create families with children who also might not necessarily know the details of their family history for three generations. Also worth observing is that Almeling noted that sperm banks reject more than 90% of potential donors and egg agencies more than 80%.[15]

The major marketing mechanism described was the donors' profile which introduces donors to recipients. Women are encouraged to craft a feminine profile including their motivation for donating, while motivation is not considered an important aspect of sperm donor profiles. The real incentive that draws donors – the financial incentive – is moulded into "gender-appropriate" terminology on donor profiles.[16] Consequently through market practices the recipient is procuring a "gendered commodified personification of the donor."[17]

When a donor is chosen by a recipient it is called a match. For egg agencies this is the trigger to begin the medical and psychological selection processes to confirm suitability prior to the signing of the legal contract. (Unsuitable donors have continued in programs if a recipient has become attached to them). Sperm banks differ as they release profiles after medical screening and sperm count completion. Prospective sperm bank customers are therefore requested to nominate several potential donors allowing for the possibility that someone else has purchased a particular vial.[18]

Sperm donors are rarely provided with recipient information, unlike egg donors who are often provided with personal anecdotes to personalise the transaction. Egg agencies prefer "repeat donors,' who are reliable with proof of a previous child - the ability to produce an egg that results in a pregnancy. Sperm banks just require donors to have a high sperm count.[19]

Experiencing the Market

Producing Eggs and Sperm

This section of the book examines donors' perception of the market through their experiences of donation and remuneration.[20]

A woman who undergoes egg donation experiences similar procedures to a woman who undergoes infertility treatment. However, one is paid a large sum of money to undergo the procedure and the other pays large sums of money. Egg donors were found to describe the procedures less melodramatically and the impact on their lives as less onerous than infertile women. For sperm collection, men are expected to perform an act that has been shrouded in clandestine ignominy. Men commented that the procedure is not as pleasurable as expected. When describing their donation men invoked business rhetoric, such as "taking care of business," potential donors as "prospects," and recounting that the first visit to the bank was similar to attending a new job. All of this exemplifies a sperm bank framework which is ultimately going to influence the donor's experience of bodily commodification.[21]

Being a Paid Donor

As acknowledged previously, one of the major reasons men and women donate their gametes is the remuneration as donors are often in low paying jobs or students. Also, women often played down their interest in compensation, whereas men were more honest in their approach to receiving remuneration. About a fifth of the donors who were interviewed did state that helping others conceive a child was their main priority in donating. These people were at a different stage in their lives and had often seen a personal struggle with infertility. Some sperm donors thought they had genes that were worth passing on, offering longevity, intelligence, athleticism.[22]

Compensation varied markedly between the genders.

Compensation for sperm donors was approximately $50.00-$75.00. For women, a risk factor is calculated into the compensation. The American Society for Reproductive Medicine ethics statement determined that about $5000 was acceptable; over that figure justification needed to be provided and over $10,000 was not acceptable. After the control of the gamete market was relinquished by physicians (a regulated professional body with a code of ethics), to businesses the market in America is no longer easily regulated.[23]

Often staff of egg agencies determined how much a woman would be paid for her eggs. Although acting in the best interests of the donor they also ascertained what a recipient could afford.[24] Due to the scarcity of donors, African or Asian women are able to command much greater compensation. Egg agencies in essence broker a deal between a donor and a recipient, who then execute the steps of their transaction elsewhere - in fertility clinics. However, sperm banks are more than a brokerage house; they provide a place for sampling, testing, storage and shipping. Women are paid for each egg retrieval, irrespective of how many eggs are obtained. Yet a man must produce a sample that meets the sperm bank benchmark to be paid. Men were often paid fortnightly (pay check), whereas women were compensated once retrieval surgery was completed.[25] The market forces of the economy of sex cells are further tangled by sperm donors being rare and egg donors being plentiful. Almeling suggests that egg donation may be more culturally acceptable.[26]

Egg donors would often work with a particular recipient, thus the economic valuation of eggs becomes an intimate exercise, with the transaction framed as a gift. Conversely, sperm donors provide sex cells for several future parents.[27] Both donor responsibilities are similar to those of a job, however, egg donors are encouraged to think of their job as a meaningful one. Gifts are often presented to egg donors as a reciprocal arrangement for the gift they are providing. Traditional portrayals of the removed male and altruistic female also shaped the feelings which the donor was expected to exhibit. However, the biological offspring of sperm donors are more likely to attempt to make contact with their biological parent through a sperm bank's identification release program. The biological offspring of egg donors seldom attempted contact with their biological mother.[28]

At one non-profit sperm bank the framing of donations was a little different and the men spoke of their donation as a service, providing a middle ground between a job and gift. Only one man knew something specific about his recipients unlike the women who donated eggs, where up to 80% of donors had some knowledge of their recipients. Again, it was found cultural and social forces were at play: men tend to help others through paid work and women through rewarded giving.[29]

Thus, this framing of gift and job created different donation and remuneration experiences for donors. Men utilising the business rhetoric described "recipients" as customers, sperm banks as "middlemen," and samples "not being on the market yet." Women sometimes discussed the recipients "investment" of time and money to have a child through IVF and egg donation. However, it was the male donors who described feelings of "objectification and alienation" and that their bodies were "assets or resources."[30] One donor was asked to "resolve his problem" after providing a low quality specimen. As another said, there was pressure to perform at the job. Even those who did not need the money and thought donating was an "act of charity," felt like second class citizens as sperm banks often ask donors to enter through a side or back door. The feeling of sperm donors being a resource was further heightened by a sense that sperm banks are really in business for women, so they can have a child. The non-payment for low quality samples enhanced the sentiment of being a performing resource. This experience of commodification by sperm donors encouraged a sense of alienation. Almeling does not describe the women in the study utilising such language. One woman spoke of being of more "value" and registered with altruistic donation programs such as the bone marrow register, hence providing no sense of feeling dehumanised as suggested by some scholars in discussions of commodification of the body.[31]

Defining Connections

In the final chapter of *Sex Cells*, the connections between the donor and the child born are examined through the donation experience and cultural and societal influences.

The birth of a child involves an egg, sperm, and a woman who carries the child to birth. Almeling noted the focus of most social science research is towards to the parents who will raise the child, who may or may not have contributed to the birth of the child. The fusion of cultural and biological suppositions, expect women to feel a greater association with their eggs than men with their sperm. Evolutionary psychology contends that women have fewer eggs than men have sperm, and the process to produce eggs and have a child requires greater effort on the part of the woman, thus she will have a greater amount invested in an offspring than a man. Further, Almeling notes, social scientists have challenged maternal instinct stating that the view is overly reliant on biological determinism. Through referencing in the surrounding social context, biological ties can become dependent on what the person is providing, gestation or genetics. Surrogate mothers downplay any connection to the children they bear, highlighting the female recipient's role especially if she has provided the egg. Alternatively, a woman who gestates a child conceived with a donor egg will highlight her role as the gestating mother rather than the donor's genetic connection to the child. [32]

'I'm a Father!' or 'Just an Egg'

As described previously, the algorithms within sperm banks and egg agencies orientate donor views. Generally sperm donors define themselves as the father of children who are born as a result of their donation. Younger donors appeared to be more dismissive of their role and the life experiences of older donors was reflected in their understanding of their role, often distinguishing their own

children from their "other" children.[33] On the other hand, egg donors did not consider themselves the mother of the children born through their egg donation. Consistently, women interviewed stated that their donation consisted of "just an egg," and they are giving a "gift."[34]

The break down of motherhood into conception, pregnancy, birth and caregiving combined with the emphasis placed on the recipients by egg agencies, provided women with a different framework to men. The emphasis on the recipient saw almost 70% of women noting their gamete would be placed in another's body, whereas only 5% of men bothered with this detail. However, women simply saw themselves as providing an egg, easily making a division between biological and social parenting. When challenged, women described the recipient as being the one who is present at conception, who carries the child and provides the home for the child. The egg donor is divorced from all these actions. However, for men there is an uninterrupted link between sperm and child. These attitudes are embedded in the culture of the egg agencies and sperm banks.[35]

The tradition of recognising the male contribution as being one of providing the seed and women of nurturing the seed stems from the ancient Greeks. Almeling uses the anthropologist Carol Delaney's argument that maternity and paternity are expressed within the cultural context in which they exist. Identity release programs enhance the male paternity cultural role by suggesting his role is important in the donor child's life, but egg agencies encouraged a desensitising to the genetic relationship of the mother to her egg and a reinforcement of the nurturing role of mothers. Thus, a paradox exists - men do care and consider the provision of sperm links them to fatherhood. However, as the features of motherhood are able to be separated, women donating an egg, can separate themselves from the different phases of conception to birth and nurturing a child. Men cannot divide up fatherhood into stages, thus they are still a father of some description. This sensitising of the genders affects the interpretation of social and biological parenthood.[36]

Conclusion

Most women cycle with their recipient for egg transfer, unlike sperm which can be frozen, thus there is no cause for the development of an intimate relationship. The risk involved with masturbation is less than that with egg collection, therefore women are paid more irrespective of how many eggs are retrieved, yet a man is only paid for his performance linked to a standardised protocol, even though sperm donors are rare. To do this differently, Almeling suggests that eggs retrieved could go to a number of recipients and sperm could become exclusive to one recipient, with the donor developing a relationship with the recipient. Women could be paid for the number of eggs retrieved and be treated as employees just like men are at sperm banks.

Almeling challenges the accepted model that the biological differences between men and women determine the differences in the markets for eggs and sperm. What she offers is an insight into the sociological and cultural influences that manipulate the market for sex cells to meet the cultural norms of "maternal femininity and paternal masculinity."[37] While these are traditional manifestations, unexpected differences are experienced. It is surprising that it is the men who feel more dehumanised than the women through the manipulation. The organisation of the market for gametes as being either a "job" or a "gift" ultimately affects the donor rationalisation that comes with being renumerated for the donation. Providing the gift of an egg is not seen as selling your baby to another. Donor identification release programs more common in sperm banks in the United States help with acknowledging that the sperm donors' contribution is of some significance - as your offspring may want to contact you. However, both sperm donors and egg donors are discouraged from seeing themselves as being responsible for their offspring.

Sex Cells illustrates that as with any marketplace the market is manipulated to provide a product to a consumer who desires the product. The manipulation of this market also affects the donor and recipients' experience of bodily commodification.

The following was offered by a psychologist working in one of the agencies interviewed for *Sex Cells*: "Medically, the invention of IVF really broke it down to [fallopian] tubes, eggs, uterus, sperm. To this day, that's how we solve the problem. Do you need sperm or eggs, or do you need both? Or do you need a uterus? What do you got, what do you need, and what can you give up psychologically? Then sort of broker what you need."[38] Is this how we want future generations created?

Note: All gamete donations in Australia must be altruistic. Reimbursement of reasonable costs is allowed. Clinics are not permitted to use gametes where the donor has not consented to release identifying information. These regulations are part of the *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* issued by the National Health and Medical Research Council of Australia.[39]

The Catholic Church teaches that the conception of a child should be "brought about as the fruit of the conjugal act specific to the love between spouses." It accepts any medical intervention which assists the couple's sexual intercourse to result in pregnancy. However, it rejects any techniques (such as IVF) which seek to bring about conception in other ways. It specifically rejects all forms of "heterologous artificial fertilisation" which seek "to obtain a human conception artificially by the use of gametes coming from at least one donor other than the spouses who are joined in marriage."[40]

ENDNOTES

[1] Yale University, Sociology, "Rene Almeling," Yale University, http://www.yale.edu/sociology/faculty/pages/almeling/

[2] Rene Almeling, *Sex Cells* (Berkley, California: University of California Press, 2011), 14.

[3] Ibid., 5-13.

[4] Ibid., 11.

[5] Ibid., 26-7. There had been early court ruling where children born from sperm donation were considered illegitimate.

[6] Ibid., 26-28. [7] Ibid., 28-33. [8] Ibid., 35-43.
[9] Ibid., 83. [10] Ibid., 53. [11] Ibid., 59.
[12] Ibid., 59. [13] Ibid., 57. [14] Ibid., 58.
[15] Ibid., 59, 199. Sperm donors are mainly rejected due to a low sperm count. Egg donors rejection varied from health reasons to lost to follow-up.
[16] Ibid., 60-64. [17] Ibid., 65. [18] Ibid., 65.
[19] Ibid., 66-8. [20] Ibid., 87. [21] Ibid., 87-109.
[22] Ibid., 110-119. [23] Ibid., 45, 72. [24] Ibid., 70-1.
[25] Ibid., 69. [26] Ibid., 82. [27] Ibid., 72-4.
[28] Ibid., 78-9. [29] Ibid., 125-133. [30] Ibid., 134-137.
[31] Ibid., 134-140. [32] Ibid., 142-5. [33] Ibid., 145-9.
[34] Ibid., 150-3. [35] Ibid., 158-160. [36] Ibid., 161-164.
[37] Ibid., 178. [38] Ibid., 53.
[39] Australian Government, *National Health and Medical Research Council, Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research, 2004 (as revised in 2007 to take into account the changes in legislation) June 2007* (Canberra: Australian Government, 2007), 25, 27, 76, 77.
[40] Congregation for the Doctrine of the Faith, *Instruction on Certain Bioethical Questions (Dignitas Personae)*, #12, Holy See, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20081208_dignitas-personae_en.html

All on-line resources accessed 1 October 2012.

Kerri Anne Brussen ✠

Spiritual Care of the Dying Person

The Catholic bishops of England and Wales have issued a guide to the spiritual care of the dying person. It reminds us that spiritual care is an essential part of holistic palliative care, and that every health professional has a role to play in the provision of spiritual care.

On 25 June 2010, the Department for Christian Responsibility and Citizenship from the Catholic Bishops' Conference of England and Wales issued *A Practical Guide to the Spiritual Care of the Dying Person*. A forty-four page booklet, it is available either as a printed publication or a free download from the web.[1] A draft version of the statement had previously been released for public comment on 3 February 2010.[2] The writers of the statement were palliative care physician Dr Catherine Gleeson, bioethicist Dr David Albert Jones (now the Director of the Anscombe Bioethics Centre in Oxford), chaplain Fr Paul Mason, and the theological consultant to the Bishops' Conference of England and Wales Revd Dr James Hanvey SJ. As an invitation to people to obtain and read this booklet, this article presents some of its most important insights:

Our Spiritual Dimension

We human beings have a deep intuition that there should be purpose and meaning in our lives. Over a lifetime, therefore, we search for purposes and commitments which will give us meaning. Many of us find what we are searching for in our relationships, in our work, and in many other experiences. We find it in what we have learnt, how we have changed and who we have become, and in the sense that we have made a difference through our lives. Many of us find it through spirituality and spiritual practices, perhaps (or perhaps not) as part of a religion which reveals our connection to a Higher Being.

As the Guide notes, "illness is a time when… questions of a spiritual nature rise to the surface." This happens "especially… when someone is approaching the end of their life."[3] At this time, we want to make sense of the journey which has been our life. There may be unfinished business, such as completing certain tasks, making a will, planning our funeral, having significant talks with our loved ones, and perhaps trying to set things right where there has been a longstanding quarrel or where we have done the wrong thing. Also, "at such times, many people who might not describe themselves as 'religious' might wish to return to a faith they were brought up with, finding in it hope and comfort."[4]

Our spiritual dimension is an inescapable part of who we are. If care is to be truly holistic, it cannot attend only to the physical, emotional and social dimensions of who we are. Truly holistic care also attends to our spiritual dimension.

Spiritual Distress

The Guide notes many phenomena which may indicate spiritual distress. Sometimes, the spiritual dimension is quite explicit. For example, a patient may complain that they have done nothing to deserve this sort of suffering, or they may feel angry because God has not answered their prayers and healed them, or they may feel very afraid about meeting God when they die. At other times, however, the spiritual dimension of their difficulty can be quite hidden. It may be spiritual distress if a patient experiences persistent pain which does not respond to medication, or ill-defined yet persistent anxiety, or unresolved grief or anger, or a host of other symptoms. Families and friends can experience spiritual distress too.

Above all, the Guide encourages health professionals to consider the spiritual dimension and spiritual distress as they seek to understand and respond to symptoms exhibited by patients and their families and friends.

Spiritual Care

If we do not consider the spiritual dimension, we fail our patients, and we may even do them harm.[5] This is a particular danger nowadays, when many health professionals are not entirely comfortable either with the spiritual dimension of life or with providing spiritual care.

While chaplains have a special role, the Guide reminds us that every health professional should be concerned about and involved in spiritual care. It offers many suggestions about doing this. It is appropriate to inquire about

spiritual concerns – asking, for example, "How are you in yourself?" or "Are there particular things that are on your mind at the moment?"[6] While we should not thrust our beliefs onto a patient, in some cases it can bring a patient great comfort if we are able to pray with them.[7]

On this matter, it is significant to note a recent systematic review of peer-reviewed articles about spiritual care. It concluded that the results of providing spiritual care "are substantially positive and beneficial, thus confirming the place of spirituality in the holistic construct of palliative care."[8]

Ethical Issues

All the above was discussed in the first chapter of the Guide. The second chapter explores ethical issues. It insists that we should respect life, and therefore that we should not seek (either by what we do or by what we do not do) either to hasten or bring about death. However, the Guide adds that we must also accept death, and therefore we should not try to flee from the inevitable by seeking out every possible treatment. Health professionals show their respect for patients and their families by involving them in discussions and decisions about these matters.[9]

While we must not under-treat pain, the Guide warns that overtreatment "can render people unconscious or semi-conscious when this is not necessary…. This could deprive people of the opportunity to make a good death, setting things right as much as they can, making peace, saying their goodbyes."[10] Wherever possible, patients should be involved in decisions about their level of pain relief and sedation. "Some individuals prefer to be more alert, accepting that they may have some degree of pain or other symptoms."[11]

The Mystery of Death

The final chapter of the Guide invites us to ponder the mystery of death. Some health professionals do become desensitised and somewhat blasé about death, so this is an important reminder. The Guide invites us to consider the significance of what is happening "for the person, for the carers, for us all." Such reflection "opens us to something of the depth of being human." "In the process of dying everyone – the person dying and his or her carers – will in some way be touched by the most profound questions of life. What does it mean? Is death the way in which our lives end in nothingness or is death a movement into something which is unknown?"[12] Christian belief is that "after death the righteous will live for ever with the risen Christ."[13] However, even Christian believers must ponder their faith anew as they encounter the reality and the mystery of death.

Another review has said that this Guide is relevant to health professionals who care for dying patients, for these patients' families and friends, and for these dying patients themselves.[14] I agree. I hope therefore that this brief discussion will encourage many health professionals, along with many patients and their families and friends, to obtain, read and reflect upon this important statement.

ENDNOTES

[1] *A Practical Guide to the Spiritual Care of the Dying Person*, Catholic Church in England and Wales, http://www.cbcew.org.uk/document.doc?id=65 or http://www.catholic-ew.org.uk/Home/News-Releases/Benchmark/Spiritual-Care-of-the-Dying-Person-2010/(language)/eng-GB. The publication details of the printed booklet are London: Catholic Truth Society, 2010. This booklet is available in Australia for $7.95 from St Pauls Publications, PO Box 906, Strathfield NSW 2135. For the press release which announced the issue of this document, see http://www.catholic-ew.org.uk/Home/News-Releases/2010/Catholic-Bishops-Conference-launches-A-Practical-Guide-to-the-Spiritual-Care-of-the-Dying-Person/(language)/eng-GB

[2] For the draft statement and the press release which announced the public consultation, see Catholic Church in England and Wales, http://www.catholic-ew.org.uk/CBCEW-Media-Library/Archive-Media-Assets/Files/Catholics-in-Healthcare/Consultation-Draft-guide-to-the-spiritual-care-of-the-dying-person-pdf and http://www.catholic-ew.org.uk/Home/News-Releases/2010/Consultation-Guide-on-the-spiritual-care-of-the-dying-person/(language)/eng-GB. Comments were sought "particularly from healthcare professionals and chaplains" so the guide would be "as clear, practical and helpful as possible."

[3] *Practical Guide*, 5. [4] Ibid., 9.

[5] Ibid., 6. [6] Ibid., 15. [7] Ibid., 20.

[8] Mark Cobb, Christopher Dowrick, and Mari Lloyd-Williams, "What Can We Learn About the Spiritual Needs of Palliative Care Patients from the Research Literature," *Journal of Pain and Symptom Management* 43, no. 6 (June 2012): 1105-1119 at 1115.

[9] *Practical Guide*, 23. [10] Ibid., 31.

[11] Ibid., 18. [12] Ibid., 33-35.

[13] *Catechism of the Catholic Church*, #989.

[14] Bart Beckers SJ, Review of *A Practical Guide to the Spiritual Care of the Dying Person*, Thinking Faith (The Online Journal of the British Jesuits), http://www.thinkingfaith.org/articles/BOOK_20100723_1.htm

All on-line resources accessed 1 October 2012.

Kevin McGovern ✠

Enjoying A Night Out? – The Longer Term Consequences

This article begins with a fictionalised account of a teenage party to celebrate a sporting club's end of season achievements. It then looks at some of the potential outcomes of the behaviours displayed and the longer term consequences.

It was a night of celebration for a group of young men just on the brink of adulthood. They were coming together to celebrate the end of their sporting season. The parents of the young men were also invited to attend

the celebration. As many boys had been part of the club for a number of years, most of the families knew each other. Being boys, it would not a party without girls. Although girls were not involved in their sporting club, a number were invited. A majority of the girls were unknown to the host family.

So what happened that night? Even though some of the attendees were over eighteen, others were not. As expected, the parents who were attending the party would be responsible for their son if he was under eighteen and drinking.[1] *Other boys who did not have parental supervision also brought alcohol with them. However, the host family did not seek permission to serve alcohol, from the parents of the children attending as they were not providing alcohol to any of the young men or women. Many of the young men indulged in alcohol, some drinking too much, others were more restrained either by the presence of their parents or by their own personal standards. What about the young ladies who attended? Only a small number of the parents of the girls contacted the host family to ask about the party, to establish what supervision would be available, and to ascertain the situation with alcohol - whether alcohol was going to be provided or not. Some of the girls decided not to drink, or drank only in moderation. However, for some girls, it was obvious that they had been drinking alcohol before their arrival at the party. They also came with a supply of alcohol.*

A number of the girls latched onto boys, sometimes a boy they had never met before. Thus, a boy occasionally found himself with a girl draped around him. Some of the boys responded to this attention enthusiastically. Occasionally, couples were seen encouraging each other into a dark or private corner. This was not only a risky situation for the girl; it was also a risky situation for the boy. In the heat of the moment, these girls may agree to behaviours that they may subsequently regret, or they may be unable to fend off unwanted and unwelcome advances. On the other hand, who was going to believe whom, when and if the girl decided to call this liaison assault? This complaint could be well founded, or it could be because the boy refused to comply with whatever the girl requested, or it could be because the girl was too drunk to realise what she had agreed to - in a darkened isolated environment where there were no witnesses.

The boys enjoyed their night. As noted, there were some who had too much to drink. For most, there was parental supervision or the supervision of a friend's parent who was taking them home. The police arrived at one point to ask for the music to be turned down. Not an unusual occurrence for a suburban party. Gradually the party thinned and the girls made their way home, often disappearing when their parent rang them from their car to let them know they had arrived at the party to take them home or the taxi they had called had arrived. Some of the girls required escorting to waiting vehicles due to their inebriated state. Very few parents made their way to the front door to collect their daughter, to have a quick chat with the host family and to thank them for hosting the party. Overall it was an enjoyable night for those who attended, parents included.

This account of a party appears innocent enough. It was without any major dramas of people experiencing life-changing accidents or being "king hit." However, it does highlight several issues and risks which have been raised by the media and the medical profession regarding risky behaviour in this age group.

An initial question that needs to be contemplated is: were the young women who attended the party safe? The answer at this function is yes – probably. There were plenty of parents attending, parents who as parents would have been concerned about the safety of all as a duty of care. Even so, the element of risk cannot be denied.

An additional concern is that some of the girls arrived with alcohol or had obviously been drinking alcohol prior to arriving at the party. A number of the girls were aged less than eighteen years, so a further question is who provided these girls with the alcohol they brought with them to the party? Was it their parents or perhaps an older sibling or friend who was over eighteen? Did the friend or sibling have parental permission to provide the girl with alcohol?

Alcohol

The *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* suggest that the safest option for 15-17 year olds is to delay the initiation of drinking for as long as possible.[2] Further, we know that brain maturation is not complete until around the age of 25 years. Because alcohol is known to affect brain development in young people, it is recommended that drinking - especially heavy drinking - should be avoided in the late teens and early adulthood. It has been noted that binge and excessive drinking could adversely affect brain function in later years.[3] What impels young people and their parents to shrug off this information? What impels young people to think that the only way to enjoy yourself is to make sure that you have in your hand, alcohol? Fr Chris Middleton approached this subject in an article recently in *The Catholic Weekly – "Teens and drink: lessons for us all."*[4] Middleton challenges the role that parents and their example may play in the drinking culture of teenagers. He suggests that parents also need to be available to offer transport, provide safe venues for parties and to ring hosts to check on arrangements, irrespective of what their child may think. In this fictitious story, many of the parents of the young men attended the party and were therefore in a position to be more involved in their son's activities that night. However, this was not the case for many of the young women.

Further concerns have been raised regarding the risks involved with alcoholic energy drinks. In June 2011, a 16 year old Victorian girl died after consuming a number of these drinks. Jerril Recheter from Vic Health questions why alcohol companies continue to manufacture and advertise such drinks specifically for the market of young drinkers.[5] These drinks have been dubbed a "blackout in a can" as they have the potential to erase the night's

events. The drinks are also known to create a "wide awake drunk feeling" which leaves the person who has consumed the drink feeling as if they are in control. A number of American states have already banned alcoholic energy drinks.[6] Experimenting with alcohol is not unique to this generation of teenagers but the marketplace now consists of more options than a generation ago, some which are lethal in the wrong hands.[7]

Assault

A further issue created by the behaviour of some of the young men and women that evening is the risk of sexual assault. We readily think of the risk of girls being sexually assaulted, and there are far too many examples of girls and women who have suffered from male violence. In the scenario described above, the risk that one of the girls could have been sexually assaulted cannot be ignored or downplayed. In this scenario, however, the behaviour of the girls could also have put the boys at risk. As noted, some of the girls had been drinking alcohol. For some, this was not social drinking but drinking to such an excess that they were not in control of their actions. This was obvious by their behaviour of seeking out boys to support them. Risky sexual behaviour in drunken teenagers is well documented.[8] While studies focus on sexual coercion by males to females, the behaviour in this account of some of the young women could see the sexual coercion tables turned. On occasions it could have been one of the girls attempting to take a boy into a dark secluded place. While not a similar situation but with a devastating outcome, the short movie *Every Family's Nightmare: Lies, Deception and the High Cost of Justice* is a reminder of a one person's word against another.[9] This is a film that details a year in the life of a family whose fifteen-year-old son was wrongly accused of rape and jailed for a year in Western Australia. To assist in their son's defence, the young man's family assembled an international team of experts. After a year the girl who accused him of rape confessed that she was lying. This battle cost the young man's family everything, and the young man lost a year of his life in jail. Disturbingly, experts state that a similar situation could occur - in any Australian state.[10]

The focus of this film was to highlight how the justice system failed the young man. However, the young men at the party described above could have found themselves in a similar situation to the young man in this film. Both genders should therefore avoid placing themselves in risky situations; especially because, with the influence of excessive alcohol, judgement is impaired, as is recall of events.

It is mainly young males who experience alcohol related harms. Alcohol is involved in 13 per cent of all deaths in Australians aged 14-17 years. Each week at least sixty Australian teenagers are hospitalised and one teenager dies due to an alcohol related cause.[11] Recent media reports describe "party nights" – that is, Friday and Saturday nights - where ambulance crews in the inner city of Melbourne spend their shift attending to alcohol related injuries. Head injuries are common and it is only luck that separates those who are mildly concussed from those who die. Serious longer term consequences involve personality changes, mood swings and paralysis.[12]

Sexually Transmitted Diseases

The *Fourth National Survey of Australian Secondary Students, HIV/AIDs and Sexual Health* published in 2008, found that just under one third of their sample had experienced unwelcome sex, with 17% stating they were too drunk.[13] Almost 25% of the sexually active students said that the last time they had sex they were either drunk or high on drugs, with a significantly higher proportion of males, 34%, compared to 20% of females. Binge drinking was also explored in this survey. 71% of young men and 84% of young women in Year 12 reported an episode of binge drinking during the two weeks prior to the survey. The conclusions from this report suggest that the role of alcohol in unwelcome sex had increased since the previous report in 2002, as had the number of students reporting binge drinking on three or more occasions.

Young people are one of the priority groups that will be targeted in the *Second National Sexually Transmissible Infections Strategy 2010-2013*. Fifty per cent of young people have experienced their first sexual encounter by aged 16.[14] The strategy notes that risk-taking could expose young people to a greater risk of contracting a sexually transmitted disease. The strategy was initially developed as a rising rate of sexually transmitted infections (STIs) had been detected, in particular the rates of chlamydia infection. Also acknowledged is the "causal relationship between STIs and reproductive and sexual health consequences, such as pelvic inflammatory disease and infertility."[15] In 2001, chlamydia diagnosis for the age group 15-29 years accounted for 825 infections for the whole population. Since 2001, the rate of chlamydia infections has more than tripled for both males and females aged over 15 with the largest increase in the 15-19 year age group. For females aged between 15 and 19 years the chlamydia infection rate increased from 569 per 100,000 in 2001, to 2,228 per 100,000 in 2011, and for males, the rate increased from 150 per 100,000 in 2001, to 714 per 100,000 in 2011. Males aged between 20-24 years had the highest male rate of diagnosis for chlamydia, (1,423/100,000).[16] The notification data of sexually transmitted diseases tells us that STIs are more prevalent than they were a decade ago, but this data does not provide any information on the psychological, reproductive or sexual consequences that our young people may experience as a result of an STI.[17] Chlamydia infection rates have been utilised to illustrate the increase in STIs in teenagers and young adults. Other STIs, such as genital herpes and warts, syphilis, gonorrhoea, hepatitis B and C as well as HIV infection, can also cause long term consequences to an infected person.

Conclusion

The transition into adulthood has always been fraught with risks and risk-taking behaviour. As parents of this generation of teenagers and young adults, we need to lead by example. Think about how we celebrate, and show our children how to drink responsibly. Think about the safety

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of our children. Do not be afraid to be the parent who rings to ask about the supervision at a party, the provision of alcohol. Be the parent who picks up their child, rather than allowing them to catch a taxi, offering to take their friends home as well. Tell them of the exquisiteness of love and intimacy in a loving permanent relationship, so as to encourage them to delay sexual intimacy and not be part of the STIs statistics which may leave them with a life-long legacy.

While we cannot protect our children from all risks, we can provide a safer path for them, to grow in adulthood.

Endnotes

[1] Victorian Commission for Gambling and Liquor Regulation "Supplying alcohol to minors in a private home (Liquor Licensing Fact Sheet)," State Government of Victoria, http://www.vcglr.vic.gov.au/resources/6ddd7d5b-3e0d-4b7b-bc16-ad6c019b33ac/vcglrsupplyingalcoholtominorsinprivatehome1pplowres.pdf

[2] National Health and Medical Research Council, *Australian Guidelines to Reduce the Health Risks from Drinking Alcohol* (Canberra: Commonwealth of Australia, 2009), 57.

[3] Ibid., 86.

[4] Chris Middleton, "Teens and drink: lessons for us all," *The Catholic Weekly,* 17 June 2012.

[5] Jerril Recheter, "Caffeine and alcohol a toxic mix says VicHealth CEO," Vic Health, http://www.vichealth.vic.gov.au/en/Media-Centre/Opinion-pieces/Current/Caffeine-and-alcohol-a-toxic-mix-says-VicHealth-CEO.aspx

[6] Michael Winter, *Michigan bans alcoholic energy drinks,* USA Today, Nov 5, 2010, http://content.usatoday.com/communities/ondeadline/post/2010/11/michigan-bans-boozy-caffeinated-energy-drinks/1; CBS Chicago, *State Senate Votes To Ban Alcohol Energy Drink,* CBS Chicago, Dec 2, 2010, http://chicago.cbslocal.com/2010/12/02/state-senate-votes-to-ban-alcohol-energy-drinks/

[7] Recheter.

[8] NHMRC, 60.

[9] Screen Australia, *Every Family's Nightmare: Lies, Deception and the High Cost of Justice*, Screen Australia, http://www.screenaustralia.gov.au/showcases/nightmare/

[10] *Every Family's Nightmare*, 2-3.

[11] Australian Medical Association, *Alcohol Use and Harms in Australia (2009) - Information Paper*, Australian Medical Association, http://ama.com.au/node/4762

[12] Emily Portelli, "Doctors sinking in a violent tide fuelled by alcohol," *Herald Sun*, September 17, 2012.

[13] Anthony Smith et al, *Secondary Students and Sexual Health 2008: Results of the 4th National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health*, 31, La Trobe University, http://www.latrobe.edu.au/arcshs/downloads/arcshs-research-publications/secondary-students-and-sexual-health-2008.pdf

[14] Australian Government, Department of Health and Ageing, *Second National Sexually Transmissible Infections Strategy 2010-2013, 13,* Commonwealth of Australia, http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-national-strategies-2010-sti/$File/sti.pdf. This also means that 50% of young people have not experienced their first sexual encounter by age 16. This reminds us of the importance of encouraging young people to abstain from sex – or at least to delay their first sexual contact for as long as possible. For more on this, see: Nicholas Tonti-Filippini and Helen McConnell, "Understand, appreciate, protect: effective education in sexuality," in *Common Ground? Seeking an Australian Consensus on Abortion and Sex Education*, ed. John Fleming and Nicholas Tonti-Filippini (Strathfield: St Pauls Publications, 2007), 153-181.

[15] Ibid., 3.

[16] *Sexually transmitted infections (4102.0 - Australian Social Trends, Jun 2012),* Endnote 15, Australian Bureau of Statistics, http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features10Jun+2012#

[17] *Second National Sexually Transmissible Infections Strategy*, 5.

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