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Regulating Reproductive Technologies in Canada

Roxanne Mykitiuk
Osgoode Hall Law School of York University, rmykitiuk@osgoode.yorku.ca

Albert Wallrap

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I. INTRODUCTION

This chapter will identify and examine some of the major legal issues raised by the development and proliferation of technologies involved in assisted reproduction. It will review the application of existing legal principles, statutes and common law rules to these issues, and will illustrate the uncertainty present in the current legal regime in Canada. The chapter will then evaluate the need for a unified regulatory framework for reproductive technologies ("RTs"). While the focus of the chapter is an identification and review of the legal issues, it should be understood that these are shaped in a moral, ethical and social context.

As noted by the Law Reform Commission of Canada ("LRC"), "[m]edically assisted procreation is perhaps one of the best examples of the challenges posed by the development of medical science and the tensions to which they give rise for the law." Distinct from many other forms of medical intervention or practice, the use of reproductive technologies by some citizens can fundamentally
affect the lives of all Canadians and their children. Actions taken behind the traditionally closed door of the doctor-patient relationship involve broader consequences for all members of society. Because the application of reproductive technologies is often carried out within the context of the doctor-patient relationship, many conventional health law issues will arise. Among these are questions of informed consent, standards of care, confidentiality and the legal regulation of the practitioners performing various techniques of medically assisted conception. In these cases, traditional sources of health law—including many of the common law standards and principles and statutory provisions discussed in this book—should provide adequate means for regulating practice and resolving disputes in this area. However, because reproductive technologies hold the potential to transform social relationships, their introduction into medical practice involves issues beyond the physician-patient relationship and the existing regulation of medical practice.

RTs enable the deliberate manipulation of the processes and materials of human reproduction outside of sexual intercourse. Usually, the intention and effect is to produce a child. However, current innovations in reproductive biology and medicine also produce or isolate other reproductive materials or entities: vials of semen, unfertilized ova, zygotes, embryos—which have not existed in this way before. How are we to regard and treat these novel entities? Who has control over them? For what can they be used? The use of RTs, moreover, makes possible the creation of novel social arrangements: post-mortem insemination,

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3 The Royal Commission on New Reproductive Technologies [hereinafter “Royal Commission”] reported that in 1991 between approximately one and two per cent of all births in Canada were the result of either artificial insemination or in vitro fertilization; Royal Commission, Proceed With Care: Final Report of the Royal Commission on New Reproductive Technologies (Ottawa: Minister of Supply and Services Canada, 1992) at 435.


5 As noted by the Royal Commission, there is a problem with the terminology in this area. Technically, the term “zygote” refers to the fertilized egg prior to implantation. “Embryo” refers to the developing entity after implantation into a woman’s uterus until about eight weeks after fertilization, when it becomes known as a fetus. However, since the term embryo is often used in public discourse in place of zygote, we continue to use it in reference to the fertilized egg prior to implantation. For further discussion of this issue see: Royal Commission, supra, note 3 at 607. See also Bill C-47 Human Reproductive and Genetic Technologies Act, 2nd Sess., 35th Parl., 1996 s. 2. Bill C-47 draws a distinction between zygotes (or pre-embryos) and embryos, where the former means a human organism in its first 15 days of development, and the latter refers to one beginning from the 16th day to the 56th day. This distinction seems rather arbitrary and based on such factors as the state of medical knowledge and the embryos’ development of specific human-like features, such as the early indicators of a nervous system. The fetus is defined by its development beginning from the 57th day to birth.

6 See Parpalaix v. CECOS T.G.I. Crettell, August 1, 1984, Gazette du Palais, September 15, 1984 (France). See infra, note 193, (dispositional control over the deceased’s sperm deposit); Hecht v. Superior Court of the State of California for the County of Los Angeles (Kone), 20 Cal.Rptr. 2d 275 (1993) (deceased’s sperm as part of his estate distributed in light of his intentions to procreate after death); R. v. Human Fertilisation and Embryology Authority, ex parte Blood, [1997] 2 All E.R. 687 (C.A.) (use of sperm taken from comatose husband without prior written consent as required by legislation).


10 Knoppers et al., supra, note 8 at 630.

virgin births, post-menopausal pregnancy, multiple “parents,” anonymous genetic parents, and embryos conceived at one time being born at different times, or to different people. How are we to understand these new social arrangements and how should they be regulated? These and other questions focus on the ways in which RTs are defined and conceptualized in theory, as well as accessed and controlled in practice. The use of RTs holds implications for kinship and thereby alters our understanding of the legal, social, and emotional bonds created by heredity and the consequences presumed to ensue from processes of intercourse, conception and birth.

Typically, health law investigates the principles, statutes, and constitutional and policy framework, which shape the allocation and delivery of health care services and the relationship between the health care provider and patient. The World Health Organization (“WHO”) defines health as a state of physical and mental well-being—a definition broader than that of medicine. Health is more than the absence of disease and includes the harmonious development of the human person. Moreover, since human beings socially interact, whether in the medical sciences or the daily routines of life, health is as much a social construction as a biological condition; its norms are constructed in a social environment and include not only medical-scientific determinants but also social determinants. Law can be one such determinant. Since law helps to determine and regulate the social relations which underpin individual well-being and, by implication, individual health status, law itself becomes one of the factors which affect individual health.

In the area of RTs, where the very novelty of the procedures and their impact suggests the lack of social consensus about the right or proper course of action, the focus turns to the recurring question: what should the law be? The emergence of RTs over the last quarter century has sparked numerous efforts at regulatory reform by panels and commissions established in many jurisdictions throughout the world. These assembled groups considered whether or not to establish a new reproductive order, or to find ways of containing the new possibilities engendered by the RTs within the old reproductive order.

While these forums have led to volumes of recommendations and sometimes, regulations, they have rarely led to legislation. One possible response would be to distinguish between regulating reproductive technologies and establishing legal norms for their consequences. It has been argued that regulation should
focus solely on the particular ends ethically unacceptable in society,\textsuperscript{11} rather than widely constrain and “chill” medical science and technology. Alternatively, a regulatory regime might account for the use of RTs as both a means by assisting biological processes and as ends with social implications. This chapter will explore the legal ramifications of pursuing either approach to the regulation of RTs. Currently, there is a legal vacuum regarding the express regulation of reproductive technologies in Canada. Although statutes and case law in America and other jurisdictions provide some guidance, their application as persuasive forces in the Canadian context remains questionable.

In Canada, the dominant tendency has been to regulate reproductive technologies as medical practice, rather than to address alternatives such as adoption and the social acceptance of infertility. The increasing use of RTs have heightened calls for legal regulation by interested citizens and practitioners who now seek clear guidance from statutory or judge-made law. In recent years there have been several proposals for legal reform put forward by a number of formal commissions, most significantly, the Royal Commission on New Reproductive Technologies (“Royal Commission”). These efforts at the time of writing, however, have yet to result in any comprehensive legislation. The Bill near the end of the enactment process, however, died on the order paper when Parliament was dissolved on April 27, 1997, just prior to a federal election. Although Bill C-47 never came into force, and thus has no legal effect, it illustrates how the federal government has recently approached regulatory concerns for RTs. In this chapter, we occasionally draw upon Bill C-47 to not only describe past regulatory attempts, but also to illustrate possible forms of future legislation that governments may consider in their renewed efforts at regulation.

This chapter canvasses the basic definitions of infertility taking into account both the biological factors and social norms which colour the stipulation of infertility as a medical condition. We then describe the RTs used in the treatment of infertility and raise a number of legal issues arising from the introduction of RTs in medical practice. These issues include: access to RTs, informed consent and the legal rules governing the status, control and disposition of sperm, ova and embryos. This chapter explores the constitutional, common law and statutory implications of such issues. We consider a range of possible legal and regulatory frameworks governing the use of RTs. The chapter ends with a detailed review of specific legal problems generated by the advent of RTs.

A. INFERTILITY

Reproductive technologies are considered as a treatment for the condition of infertility experienced by women and men. Infertility may be viewed as a medical problem with biological and physiological aspects, or as a social condition of childlessness. However, one’s view of whether childlessness should be as good and acceptable a choice as having children can shape the distinction between medical problem and social condition. The Royal Commission states that “[d]efining infertility as a socially generated problem implies that we should look to social solutions.”\textsuperscript{12} Moreover, for both medical and social conditions (or problems), the communication of what it means to be infertile involves particular language and definitions chosen by medical practitioners, legislators, and other interested parties. Recourse to reproductive technologies as a response to infertility, however, has traditionally been based on the diagnosis of infertility as a medical problem or disease to be treated according to medical procedures. In the medical model, physicians and other health care practitioners identify and evaluate the condition of infertility, and then make choices about the appropriate use of RTs and their regulation. Many critics and commentators question the claims of the medical community to define or diagnose infertility as a medical problem and then to prescribe RTs as the best possible treatment to achieve reproduction. Closer examination of the causes and incidences that identify the condition of infertility raise questions about the appropriateness of the medical model as a framework within which to define the treatment of infertility. We will now consider alternative definitions and illustrate the ways in which the condition and definition of infertility shape the legal regulation of RTs.\textsuperscript{13}

According to most medical definitions, infertility is the inability to produce a child despite regular unprotected intercourse over a certain period of time during a woman’s fertile period. According to Bernard Dickens, in an oft-quoted passage:

Infertility includes infecundity, meaning inability to conceive or impregnate, and pregnancy wastage, meaning failure to carry a pregnancy to term through spontaneous abortion and stillbirth. Infertility includes primary infertility, where a couple has never achieved conception, and secondary fertility, where at least one conception has occurred but the couple is currently unable to achieve pregnancy.\textsuperscript{14}

In Canada, infertility is typically defined as failure to conceive within one year of regular unprotected sexual intercourse.\textsuperscript{15} The WHO, however, stipulates a time period of two years.\textsuperscript{16} At least some medical practitioners treat infertility

\textsuperscript{12} Royal Commission, supra, note 3 at 173. The common assumption is that the need and desire to have children is a normal part of our lives.
\textsuperscript{13} See Royal Commission, ibid., at 172-75. See also S. Franklin, “Deconstructing ‘Desperateness’: The Social Construction of Infertility in Popular Representations on New Reproductive Technologies,” in M. McNeil, I. Varcoe & S. Yearley, The New Reproductive Technologies (New York: St. Martins Press, 1990) at 200. See also T. Balakrishnan & R. Fernando, “Infertility Among Canadians: An Analysis of Data from the Canadian Fertility Survey (1984) and General Social Survey (1990),” in Royal Commission, The Prevalence of Infertility in Canada, vol. 6 (Ottawa: Ministry of Supply and Services, Canada, 1995). Infertility has also been categorized as perceived or inferred infertility, where the former refers to the woman’s “subjective” perception of infertility, and the latter to an “objective” inference of infertility according to basic criteria; ibid., “Aggregate infertility” is said to be a combination of perceived and inferred infertility; ibid.
\textsuperscript{15} Royal Commission, supra, note 3 at 183.
negatively as a “malfuctionning” of the human system over a period of time, and thus as a “disease.” In Canada, three formal commissions have enunciated three different definitions of “infertility” which span the spectrum of the medical and the social. The Ontario Law Reform Commission (“OLRC”) defined infertility in terms of couples who “have attempted, but failed, to produce a child and do not respond to conventional therapy.”18 The OLRC’s definition is limited to medical criteria, and does not include “personal choices that bear no relation to the issue of medical need.”19 Similarly, the LRC defined infertility as “the involuntary, significant reduction of reproductive capacity,” as based on the “inability to become pregnant after one year of unprotected intercourse.”20 On the other hand, the Royal Commission simply defined the “prevalence of infertility,” as “the physiological and sociological aspects of infertility.”21 The three definitions of infertility above illustrate the conflation of social and medical factors. The recommendations by each formal commission, and thus possible regulatory regimes, seem to vary according to these definitions and the social context of their production.

Infertility has also been variously identified as a social condition. The traditional view emphasizes the dominant model of the nuclear family, consisting of heterosexual parents and their biologically-related children. Under this model, infertility derogates from the “ideal family” as the norm of a married heterosexual couple with children. This model generates strong social pressure to satisfy the norm for couples to procreate. The basic assumption is that the need and desire to have children is a normal part of our lives.22 Moreover, the stigma of childlessness can be overwhelming, especially for women who have historically

17 Ibid., at 172.
18 Royal Commission, supra, at note 2 at 14.
19 Ibid., at 10.
20 Royal Commission, supra, at note 3 at 186.
21 Ibid., at 173. The Royal Commission assumes that physiological dimensions can be, at times, entirely separated from sociological dimensions.

been defined and identified through their roles as mothers.23 The “treatment” of women for the condition or “disease” of infertility must therefore be viewed in this gender-specific context. In response to involuntary childlessness, RTs promise enablement or, at least, give hope for procreation. However, RTs may also generate new stresses and problems where “infertile” women may feel pressured to use RTs, and to continue to do so, cycle after cycle even when treatment repeatedly fails. This pressure can have significant economic, physiological and psychological costs. Conversely, women who choose to reproduce (in “surrogacy” contracts) may be stigmatized as “deviant” — or criminal under some proposed legislative models — in spite of the considerable social pressure to produce children. The commercialization of procreation is viewed as problematic in light of societal norms; the basic assumption is that human reproduction is usually outside the market realm.

Persons who do not have partners of the opposite sex are not generally recognized as being “infertile” when procreation outside of marriage is not socially desirable. In addition, single women who procreate without the involvement of a male partner, lesbian couples, or women who wish to have a child without becoming pregnant may be considered as socially infertile, and may seek access to various forms of assisted reproduction. Some individuals and couples who carry genetic conditions may wish to avoid natural procreation and passing these conditions onto their child. Those persons not considered medically “infertile” in light of definitions in formal guidelines or informal practices may therefore use reproductive technologies.

Infertility is said to be caused by, or at least associated with, several factors of medical (or biological), environmental and social dimensions. The more common physiological causes have been recognized as sexually transmitted diseases, smoking, and age.24 Where people wait longer before attempting to reproduce, they face lower chances of success due to biological aging and the increased exposure to risk factors over time.25 Infertile individuals may, also, wait longer than those who are fertile, before seeing a physician. Other possible causes of biological infertility include environmental toxins and workplace hazards, diet, alcohol, caffeine, illicit drugs, medical disease, medical procedures with unintended effects, sterilization, and contraception.26 Having identified some possible causes, one also faces the possibility of confusing them with the effects of infertility. For example, it could also be argued that old age is not only a cause of infertility but also an effect of one’s natural progression to a state of

26 Ibid., at 190-91, 255, 261-62; Ontario Law Reform Commission, vol. 1, supra, note 18 at 12-13. It is well known that the old age factor affects the fertility of females much more so than males.
not being capable to reproduce. Thus, RTs leading to post-menopausal pregnancy may be said to address both the causes and effects of infertility.

Infertility is often regarded as affecting couples, thus reinforcing the idea that treatments be only available to socially recognized unions. This obscures the fact that single individuals may be concerned about their reproductive health status and may seek treatment even before wishing to reproduce. Moreover, individuals may not be aware of their medical or biological infertility. Where infertility is reported as a percentage of the adult population of childbearing age, teens and post-menopausal women (who have now gained access to RTs in some countries) who are infertile will be excluded. These and numerous other considerations illustrate how social values and policy preferences have circumvented the biological definitions of infertility and may not be included in reported figures based on actual treatment. The medically infertile couple, for example, has maintained dominance as a privileged form of social relationship.

The use of “couples” as a standard for recognizing infertility does not account for men’s “child-bearing” age. Most reproductive technologies have focused on women as the problematic part of the couple. They can be the subjects of treatment even when the male partner is medically (or biologically) infertile. Sometimes, fertile women undergo invasive procedures, such as in vitro fertilization, for the treatment of their infertile husbands. This tendency occurs in the face of empirical evidence indicating that the incidence of infertility among men ranges from approximately half to equal that of women. However, men’s infertility is much less researched and understood than women’s. This is an example of the social and gendered aspect of infertility. Although infertility is generally thought to be on the rise, this may, in part, stem from the large number of women who delay having children to establish their careers. It is therefore appropriate to consider the condition of infertility as an inextricable complex of social and medical (or biological) dimensions.

The infertile are said to have several options: treatment by RTs; adoption; or “live with it.” A more comprehensive and comprehensible approach would account for these options in social context, particularly the prevailing perceptions and attitudes towards “family” relations. The alternatives of adoption and the “live with it” option have not yet alleviated public concerns. Public adoption involves an average six-year wait due to a shortage of babies to be adopted. The process is long and complex, and remains difficult for single women and men. Alternatively, the widespread acceptance of the “live with it” option would require a notable shift in social norms in Canadian society. Such shifts in Canadian values seem difficult to recognize and therefore to account for within government policy and a regulatory regime. The lack of adoption opportunities and the basic social unacceptability of infertility have generated an increasing demand for RTs and their regulation. The various conditions, problem definitions, and options for the treatment of infertility have generated much confusion among practitioners and interested parties.

In response to the prevalence of infertility, the Royal Commission recommends that priority be given to prevention of infertility rather than focusing solely on its treatment. The federal government’s White Paper proposes to address the condition of infertility by stressing “infertility prevention, social solutions and, lastly, infertility interventions that are appropriate, safe, and effective.” Such proposals, if implemented, would require the re-allocation of resources among lines of prevention and treatment within the health care system. We will now consider the challenges of RTs and their regulation as a primary treatment for infertility, providing new opportunities for reproduction by infertile individuals and couples.

B. REPRODUCTIVE TECHNOLOGIES

Several reproductive technologies exist for treatment of infertility, namely, donor or non-donor artificial insemination, in vitro fertilization and related technologies, and embryo manipulation and research. Artificial insemination is the oldest and most basic reproductive technique, and may occur by husband/partner (“AHI”) or by donor (“AID”). It involves the artificial (or therapeutic) placement of sperm into the vagina, cervix, uterus, or fallopian tube at the appropriate time. The placement coincides with ovulation so as to increase the chances of conception. As a relatively inexpensive and non-invasive procedure, artificial insemination has been a popular first choice for the treatment of biological and social infertility. However, another reproductive technique is
required where infertility is due to the absence or blockage of a woman’s fallopian tubes (i.e., when the egg cannot pass through the fallopian tubes to be fertilized and implanted in the uterus).

In vitro fertilization has rapidly developed since its introduction in the late 1970s, and has brought with it many new possibilities for assisted reproduction. In vitro fertilization basically involves the retrieval of a woman’s eggs from her ovaries and the fertilization of those eggs (in a glass petri dish, or in vitro) outside her body and their re-implantation either into her womb or that of another woman. The in vitro process usually involves the creation of many embryos and the selection of a few for implantation; the remaining embryos may be destroyed, frozen for later use, donated to other women or couples, or used for research. In vitro fertilization is much more onerous than artificial insemination. The monitoring of ovulation, the inducement of superovulation, and the retrieval of a woman’s eggs are invasive with attendant medical risks and side effects. In vitro fertilization is typically used when infertility is due to the absence or blockage of a woman’s fallopian tubes, or male factor infertility.

Assisted reproduction may also involve related technologies such as gamete intra-fallopian transfer (GIFT) and intracytoplasmic sperm injection. In treatment of male factor infertility, in vitro fertilization may be combined with the micromanipulation techniques of sperm injection and egg manipulation (i.e., zona cutting or drilling for easier sperm penetration). Intracytoplasmic sperm injection is a relatively new procedure, which involves the careful selection and injection of a single sperm into an egg. GIFT is a procedure which places sperm and eggs directly into the fallopian tube. It is combined with superovulation, a preliminary process, which produces additional eggs for placement back into the fallopian tube to increase the possibility of conception. The fertilization itself is said to occur naturally. The GIFT process, however, does not assist women with fallopian tube blockage.

Embryos may also be genetically screened or even manipulated prior to implantation. For example, it may someday be possible to manipulate an embryo to produce one containing the same genetic information as a living or deceased human being; to alter its genetic structure so that such alteration may be transmitted to a subsequent generation; or to create animal-human hybrids. Such attempted manipulations might also be implanted into a woman and even brought to term. Moreover, in vitro fertilization and genetic screening may someday allow for the screening and manipulation of embryos for particular genetic traits. Current in vitro procedures already involve a selection process where the most viable of many embryos are chosen for implantation. The remaining embryos may be frozen, stored, and manipulated for use at a later date. As well, these remaining embryos may be used for research purposes, where researchers manipulate, through experimentation, various environmental factors or the genetic makeup of embryos.

So far, we have described the RTs commonly used in Canada. These have been developed in line with medically accepted definitions of infertility and are evolving continually. As illustrated above, however, any effective regulatory framework will have to contend with the controversy surrounding the establishment of a generally agreed upon definition of infertility, and by implication, who may be eligible for what forms of medical treatment. In the absence of such social consensus, any suggested regulatory framework would need to allow flexibility to account for differing outlooks on the definition, prevention and treatment of infertility.

C. Regulating Reproductive Technologies in Canada

The regulation of reproductive technologies in Canada currently involves consideration of various statutes, case law and the Constitution Act, 1982. In this section we will consider existing legislation and related case law concerning the transfer and storage of human tissues, as well as the constitutional constraints imposed by the division of powers and the Canadian Charter of Rights and Freedoms ("Charter") together with the related body of common law. In addition, we will review the proposed legislation put before the order paper of the 35th Parliament, Bill C-47, Human Reproductive and Genetic Technologies Act which would have prohibited specific RTs and certain related forms of medical practice.

The legal regulation of RTs may be broadly classified under the categories of public or private law. The former involves statutory regulation by governments and the latter involves judicial resolution of disputes among private parties at common law. Private ordering may be challenged under human rights legislation, whereas public regulation may, in addition, face review under the Constitution Act. There are those who argue that public regulation would produce a “chilling” effect on medical research and development of RTs. Others, however, reply that private ordering...
merely shelters actual or potential unethical medical research and practice from public scrutiny.

In Canada, there has been no comprehensive legislative response to the legal issues raised by reproductive technologies.46 Moreover, there has been only limited litigation and therefore there is little case law and common law guidance in this area. In the absence of express law, RTs may be implicated in a number of ways, for example, under the heads of human tissue legislation, property law, contracts, torts, criminal law, the regulation of professions, and constitutional law. In the absence of existing legislation and case law directly applicable to RTs, these areas of law become important for regulation.

II. LEGISLATION AND CASE LAW

A. EXISTING LEGISLATION

Although the federal and provincial governments have not yet committed themselves to a comprehensive response to the Royal Commission’s recommendations, some relevant legislation has been introduced. Under regulations of the Food and Drugs Act,47 which became enforceable June 1, 1996, the federal government controls the processing, testing and distribution of semen for donor insemination.48 These regulations now require that semen be quarantined for at least six months to test for HIV and various diseases and genetic conditions.49 The Excise Tax Act50 also regulates the importation of human sperm.51 In additional processing criteria are met, including written notice to the Director. In addition, the regulations also follow the Guidelines for Therapeutic Donor Insemination 1992/3, “as amended from time-to-time,” and published by the Canadian Fertility and Andrology Society. Sections 5 to 8 allow for the importation of tested semen, if additional processing criteria are met, including written notice to the Director. In addition, the regulations require specific procedures be undertaken pertaining to screening, laboratory controls, labelling, records and tracing of semen; ss. 9-18.

47 Food and Drugs Act, R.S.C. 1985, c. F-27.
48 Processing and Distribution of Semen for Assisted Conception Regulations, SOR/96-254 under the Food and Drugs Act, ibid. The regulations also follow the Guidelines for Therapeutic Donor Insemination 1992/3, “as amended from time-to-time,” and published by the Canadian Fertility and Andrology Society. Sections 5 to 8 allow for the importation of tested semen, if additional processing criteria are met, including written notice to the Director. In addition, the regulations require specific procedures be undertaken pertaining to screening, laboratory controls, labelling, records and tracing of semen; ss. 9-18.
49 Ibid., s. 4. (1)(b).
51 Various acts to amend the Excise Tax Act, ibid., have described human sperm using the language of property: Goods and Services Tax Act, S.C. 1990, c. 45, s. 180(1) and Excise Tax Act, S.C. 1993, c. 27, s. 180(2) address the importation of human sperm. R.S.C. 1985, c. 115, Sch. VI, “Zero-Rated Supplies” Part I, s. 5 considers “a supply of human sperm” under the heading of prescription drugs and biologicals deemed “zero-rated supplies” for purposes of GST application.

B. PROPOSED LEGISLATION

In response to growing public concerns, the Government of Canada appointed the Royal Commission in October 1989.52 The mandate empowered the Royal Commission to examine: “[t]he implications of new reproductive technologies for women’s reproductive health and well-being,” “the causes, treatment and prevention of male and female infertility,” various reproductive and related technologies; “social and legal arrangements, the status and rights of people using or contributing to reproductive services,” and “the economic ramifications of these technologies.”53 The Royal Commission set forth an “ethic of care” framework and a guiding, though inexact, set of eight ethical principles for decision-making: “individual autonomy, equality, respect for human life and dignity, protection of the vulnerable, non-commercialization of reproduction, Quebec, Newfoundland, and the Yukon, under family law, have regulated the use of donor sperm.54 These provinces have legislated the presumption that the male partner of a woman inseminated with donor sperm is deemed the father of the child if he consented to the donor insemination. Quebec is the only province to have regulated the use of donor eggs. The gestational mother in Quebec is deemed to be the mother for legal purposes.55 Several provinces have also introduced legislation regulating the exchange of human tissues, ostensibly for the purpose of controlling organ transplantation. The legislation in most provinces involves the same definition for human tissue: “includes an organ, but does not include any skin, bone, blood, blood constituent or other tissue that is replaceable by natural processes of repair.”56 Canadian courts, however, have not yet had the opportunity to consider the application of this provincial legislation to the donation of gametes and embryos. It thus remains questionable whether courts will interpret gametes (sperm and ova) as “human tissue.” One might argue that gametes are genetically unique and “replaceable by natural processes of repair,” like blood. On the other hand, while embryos are genetically unique, they are not exactly replaceable. We will further discuss human tissue legislation later in this chapter.
appropriate use of resources, accountability, and balancing of individual and collective interests’; in doing so, the Royal Commission promoted “mutual care and connectedness” between individuals, families and communities. The Royal Commission further elaborated, “[t]he ethic of care means that a large part of ethical deliberation is concerned with how to build relationships and prevent conflict, rather than being concerned only with resolving conflicts that have already occurred.” The interests of individuals and communities thus may be considered interdependent.

Under an “ethic of care” framework, the Royal Commission analyzed much empirical evidence and formalized its position on the regulation of new reproductive and genetic technologies in Canada. In November 1993, the Royal Commission made public 293 recommendations, concluding that “decisive, timely, and comprehensive national action is required with respect to the regulation of new reproductive technologies.” In particular, the Royal Commission called for legislation to set clear boundaries around acceptable and non-acceptable uses of new reproductive and genetic technologies and to regulate and monitor the use of acceptable practices and developments in this field. To achieve this goal, the Royal Commission stated that the federal government should use its power under the Criminal Code to prohibit practices that “because of their unsafe or unethical character [are] considered unacceptable under any circumstances.” In addition, the Royal Commission recommended the establishment of a national regulatory commission charged with the responsibility of setting and enforcing standards for those practices deemed acceptable. The major functions of this proposed national commission were to be: “licensing and monitoring; guideline and standard setting; information collection, evaluation, and dissemination; records storage; consultation, coordination, and intergovernmental cooperation; and monitoring of future technologies and practices.”

In July 1995, the federal Minister of Health, the Honourable Diane Marleau, called for an interim moratorium on specific applications of new reproductive and genetic technologies, and announced the appointment of an advisory committee to monitor compliance with the moratorium. In June 1996, the federal government introduced Bill C-47, An Act Respecting Human Reproductive Technologies and Commercial Transactions Relating to Human Reproduction (in short, The Human Reproductive and Genetic Technologies Act), providing for criminal sanctions for the most serious acts including those named in the moratorium. The Bill would prohibit “practices that commercialize reproduction or are inconsistent with the principles of human dignity, including the buying and selling of eggs and sperm, sex selection for non-medical reasons, and commercial surrogacy.”

Bill C-47, if enacted, would have prohibited specific genetic manipulation, the payment of surrogate mothers, the purchase and sale of reproductive materials, and the use of ovum without consent. Section 3 lists the Bill’s objects:

(a) to protect the health and safety of Canadians in the use of human reproductive materials for assisted reproduction, other medical procedures and medical research;
(b) to ensure the appropriate treatment of human reproductive materials outside the body in recognition of their potential to form human life; and
(c) to protect the dignity of all persons, in particular children and women, in relation to uses of human reproductive materials.

The Bill C-47 would prohibit any person from knowingly [to paraphrase s. 4(1)] manipulating ova or embryos; fertilizing animals with human sperm, or vice versa; fusing animal and human embryos, or implanting animal embryos into humans, or vice versa; altering the genetic structure of gametes and embryos if such alteration is capable of transmission to subsequent generations; retrieving the ovum or sperm from a fetus or cadaver with the intention of maturing, fertilizing or implanting the ovum in a woman or outside the human body; using techniques to ascertain and/or select the sex of the embryo, other than for reasons related to health; maintaining an embryo outside the human body; or causing the fertilization of an ovum outside the human body for purposes of research. Sections 4(2) and (3) would also prohibit a person from offering or giving consideration to carry out any procedure above. Moreover, s. 5 would preclude any person from giving or offering consideration to a woman to act as a surrogate mother, or to any person acting as an intermediary in obtaining such services. Section 6(1) would also prohibit the selling, purchasing, bartering, or exchanging of gametes, embryos and fetuses. Furthermore, the donor’s consent for the specific use of sperm or ovum would be required under ss. 7(1) and (2). It may also be implied that the consent of both donors is necessary for the specific use of embryos for research or implantation in a woman. Section 2 defines a “donor” as “the person who produces the ovum or sperm, whether or not for purposes of donation.” Bill C-47 would also establish a range of punishment from serious fines to imprisonment for a term not exceeding 10 years.

Bill C-47 received a range of responses, including much criticism of the government’s use of criminal prohibitions. For example, the Canadian Bar Association
The CBA expressed concern over the "complexity, overbreadth and lack of precision" of the legislation in particular given the absolute criminal prohibitions. The CBA recommended a "simpler, clearer, and more precise definition of offences," with the integration of popular terms and scientific description.68 The law, the CBA noted, must be kept abreast of “evolving scientific and social norms.”69 Bill C-47 was also criticized for its lack of focus and unenforceability.70 According to another commentator, a regulatory framework seems preferable to the use of criminal law sanctions, which may create an underground market for human reproduction.71 A regulatory framework might better support women’s reproductive autonomy, while avoiding problems in reaching a public consensus, the unavailability of donors, and the potential exploitation of women within an underground market.72

At the same time as the introduction of Bill C-47, the federal government published a White Paper, entitled New Reproductive Technologies: Setting Boundaries, Enhancing Health73 promising to establish a regulatory body and framework within which the regulation of acceptable practices would take place. The White Paper set forth boundaries for public discussion about an appropriate framework within which the regulation of acceptable practices would take place. The White Paper set forth boundaries for public discussion about an appropriate “legislative and regulatory infrastructure.”74 The paper identified several guiding ethical principles for a policy framework: balancing individual and collective interests; equality; protecting the vulnerable; appropriate use of medical treatment; non-commercialization of reproduction and reproductive materials; and accountability.75 A two-step enactment process was proposed for legislation that would eventually combine prohibitions (under Bill C-47) and regulatory controls to provide for "a comprehensive management regime for new reproductive and genetic technologies."76 Any such regime would promote a multidisciplinary approach, and would be established under an agency removed from central government.77 The proposed regime would centre on the issuance of licences for various new reproductive and genetic technologies and related practices, and the establishment of appropriate standards by a range of enforcement mechanisms, as well as information registries and health surveillance procedures. In what seems to be a response to the uncertainty over division of powers, or a new trend of intergovernmental co-operation, the Federal government offered to suspend federal regulatory controls in provinces with substantially similar controls. This type of option would seem to increase flexibility in federal-provincial relations while upholding general uniformity in the regulation of new reproductive and genetic technologies.

Under the various pressures of an upcoming federal election, however, the proposed regime failed to materialize and Bill C-47 died on the order paper. It appears that the voluntary moratorium will continue in effect until the enactment of appropriate legislation. The issue thus remains alive as to whether a prohibitory regime under criminal law, a regulatory regime, or some combination, would best provide a flexible means for social control of RTs — one that best adapts to changing technologies and social norms.

C. CONSTITUTIONAL CONSTRAINTS

Prior to legislative drafting, governments must consider constitutional dimensions. RTs must be regulated according to the division of powers of the Constitution Act, 1867,78 and must also meet the guarantees under the Charter.

1. Division of Powers

Sections 91 and 92 of the Constitution Act, 1867, set forth the division of powers between the federal and provincial governments. Section 91 distributes legislative jurisdiction to the federal government as a matter of “national interest and concern” under the criminal law [s. 91(27)], trade and commerce [s. 91(2)], taxation [s. 91(3)], federal spending (as inferred from various sections), and treaty powers (as inferred), as well as the residual category of peace, order and good government.79 Under s. 92, the provinces have legislative jurisdiction for matters of property and civil rights [s. 92(13)], hospitals [s. 92(7)], and the residual category of matters of a merely local or private nature in the province [s. 92(16)]. The courts have generally recognized that Parliament or the provincial legislatures have jurisdiction over a specific area if it falls in “pith and substance” under an enumerated category. However, the constitutionality of federal or provincial legislation is not undermined where the legislation has an incidental effect on other enumerated categories. As well, the courts have recognized
that a matter may have a “double aspect” in that it falls under provincial jurisdiction for one purpose, and federal jurisdiction for another purpose. 89

It has been argued that the very fact the federal government initiated the Royal Commission is evidence enough to pull it under federal jurisdiction as a “national concern.”80 Parliament may also find the power to regulate RTs under other areas, including criminal law, trade and commerce, taxing, federal spending, and treaty powers. Parliament could possibly regulate reproductive technologies under the Canada Health Act.81 However, even if the federal government can regulate RTs under one or more of these categories, the provinces may nonetheless regulate incidental effects under, for example, their powers over hospitals and health plans.

The federal and provincial governments have not yet formally addressed issues of standardization and uniformity for the definition and treatment of infertility, access criteria, and funding of RTs. It remains to be seen in which ways mutual co-operation will be required of federal and provincial governments, in light of the Constitution Act, 1867. A regulatory framework at the federal level may address not only the rapidly changing RTs and social norms, but also changing tensions between federal-provincial relations. It seems, nevertheless, that many unfolding issues concerning the regulation and effects of RTs, and particularly the uncertainty in the use and disposition of human “materials,” are best a matter for legislatures (as a more representative body) and not the elite institutions of courts.

2. The Charter

The Charter guarantees rights and freedoms except where the government can show reasonable and demonstrable justification in a free and democratic society. The Charter only applies to government conduct and legislation; it does not directly concern private activities.82 The governmental regulation of RTs may face Charter scrutiny under various sections, including s. 7 (the right to life, liberty and security of the person) and s. 15 (equality). There are a number of issues involving the use of RTs which are likely to require Charter analysis, among these are: the “right” to biological parenthood through the use of and access to RTs, and whether or not the rights and interests of surrogate mothers, gamete donors, embryos and fetuses may be recognized under the Charter. In the absence of Canadian jurisprudence, some limited guidance may be gathered from American and other foreign jurisprudence on similar constitutional issues. We will address Charter issues, specifically the issue of access through a right to biological parenthood, and the issue of legal status of gametes and embryos, as they arise over subsequent sections in this chapter.

D. COMMON LAW

Canadian courts at common law have not yet had the opportunity to directly consider the regulation of reproductive technologies. However, several cases have dealt indirectly with the standards for medical practice concerning reproductive technologies and the status and quality of sperm donation. In Korn v. Potter83 the British Columbia Supreme Court affirmed a human rights tribunal decision that a physician’s refusal to provide artificial insemination to a lesbian couple was discriminatory on the basis of sexual orientation. The Court noted that discrimination could not be sanctioned merely on the basis that other physicians provided the same services.

In ter Neuzen v. Korn84 the Supreme Court of Canada considered the case of a woman who underwent artificial insemination and contracted HIV through the donated semen. She claimed negligence against her physician, and that the prevailing medical standards were inappropriate. She also argued the existence of an implied condition or warranty under contract law and the Sale of Goods Act.85 The Court affirmed the presence of two fundamental aspects of a claim of professional negligence: (1) breach of duty arising from the failure to be aware of the risk of HIV infection through the use of artificial insemination; and (2) breach of duty with respect to the screening and follow-up of donors. The Court also, for the first time, faced the issue of whether an implied warranty exists at common law that semen be of merchantable quality and fit for its purpose. The Court first rejected the argument under the Sale of Goods Act, which only applies if a contract existed for the sale of “primarily” goods rather than medical services.86 The Court then considered the specific nature of the contract and the relationship between the parties in order to determine whether the parties intended to imply such a warranty at common law. The Court noted the medical context and vulnerability of physicians, stating that “it must be recognized that biological products such as blood and semen, unlike manufactured products, carry certain inherent risks.”87 The Court held that no implied warranty of fitness and merchantability could exist in the circumstances, and if such a warranty did exist, it would be met by the physician’s reasonable care.88 The

89 For an interesting and detailed discussion, see Jackman, ibid.
80 Ibid., at 5.
82 See Eldridge v. British Columbia (A.G.), [1997] 3 S.C.R. 624 (equality of rights for disabled’s access to sign language interpreters as covered under a publicly funded scheme and where the Medical Services Commission has discretion over the expenditure and thus provision of medical care services).
Supreme Court thus affirmed the Court of Appeal ruling, sending the case back to trial.

III. SPECIFIC ISSUES OF CONCERN

A. ACCESS TO REPRODUCTIVE TECHNOLOGIES

Most individuals who seek access to RTs, do so because they wish to have a child and are either unable or unwilling to do so through sexual intercourse. Not all individuals who want to use RTs will be able to do so. Access to reproductive technologies may be limited by a number of considerations including, for example, formal or informal medical criteria and the high cost of treatment. In some circumstances, decisions about access to RTs will be made by physicians who screen applicants according to criteria established by private infertility clinics or set out in professional guidelines. Provincial health insurance legislation may also provide a barrier to access by excluding certain forms of RTs as an insured service under provincial health care insurance plans. Legislatures may also enact legislation specifying who may have access to RTs and in what circumstances. Where individuals encounter such barriers which limit their access to RTs, the barriers may be challenged under the Charter and/or provincial Human Rights Codes. While challenges under human rights legislation may provide recourse to individuals where the barrier to access is private action—for example, the decision of a physician—a Charter challenge will only be available where access is limited by government action. We now focus on a few of the more likely Charter challenges under ss. 7 and 15 and their relevance to the regulation of RTs.

B. EXISTING BARRIERS

An individual or couple with the goal of increasing their chances for successful reproduction may approach a physician in a private fertility clinic or public hospital. The physician or clinic performs an assessment using a set of eligibility criteria to screen access to reproductive technologies. The physician or clinic must also determine whether the individual or couple would benefit overall from such assistance. The criteria typically centre on the potential benefits and risks to the health and safety of participants based on various medical factors, including the condition of infertility and the participant’s age. A number of studies have also identified other non-medical factors that some physicians have adopted as criteria to limit access to in vitro fertilization. These criteria include questions concerning an individual woman’s or couple’s ability to parent. Factors some practitioners considered relevant to successful parenting included: psychological immaturity; below average intelligence; physical disability; other children living with the prospective parents; low income; and place of residence.

Also included were questions about the couple’s or individual’s marital status, the presence of a partner, and sexual orientation. Individuals and couples may also face discriminatory barriers based on race and ethnicity.

Access criteria tend to vary among clinics and across provinces, raising concerns over the uniformity of standards and mobility barriers based on class. The infertile may face additional impediments of treatment costs and physical location of fertility clinics. High treatment costs can prohibit the infertile, who lack the financial means and do not qualify for private or public health care insurance, from having access to RTs. Many individuals and couples who seek access to RTs depend upon health care insurance as their only economic means of funding access to RTs. However, few RTs are paid for under provincial health insurance schemes. In Ontario, for example, the Ontario Health Insurance Plan (“OHIP”) guidelines regulate such funding and thus establish access barriers. Women may access public funding for in vitro fertilization if they show “complete bilateral anatomical fallopian tube blockage.” This effectively means deference to medical expertise and proof of bilateral blockage. Moreover, OHIP only provides funding for up to three complete cycles of in vitro fertilization, and does not fund micro-manipulation techniques for the treatment of male infertility, such as intracytoplasmic sperm injection. It seems, therefore, that the definition and condition of infertility as a treatment response, as we previously discussed, shapes accessibility to health care funding.

IV. POSSIBLE LEGAL CHALLENGES

Any regulatory framework which limits access to RTs may face challenges under the Charter. The Charter may be invoked to challenge statutory provisions and regulations that limit access directly on the basis of medical factors as well as those which restrict access indirectly on the basis of listed services under provincial health insurance plans. We can identify at least three clusters of constitutional arguments which could be invoked in order to gain access to RTs. Broadly speaking, an argument for a positive “right to procreate” may be constructed on the basis of s. 7 rights to liberty. Alternatively, access to reproductive technologies could be sought using s. 7 on the grounds that it includes the right to health care and that access to RTs is an intrinsic component of such a positive right to health care. Both these grounds require an affirmation of some positive right, i.e., either the right to procreate, or the right to health care. A third basis from which to challenge access to RTs is s. 15. Where government legislation or action provides some individuals access to RTs but not others, it


92 Royal Commission, ibid., at 552.

may be possible to claim discrimination where such access is denied to individuals who are members of an enumerated or analogous class under s. 15. This line of argument would claim access to RTs as a negative right. The categorization of positive and negative rights is important in light of the Supreme Court of Canada’s reluctance to recognize socio-economic rights under the Charter generally, and specifically, under s. 7.

A Charter challenge places the onus on the parties seeking access to RTs to show that a right or freedom has been infringed in legislative purpose or effect. Once the infringement is established, the focus turns to s. 1 of the Charter where the onus shifts to the government to show that the legislation is reasonable and demonstrably justified in a free and democratic society. The person seeking access under s. 7 of the Charter must also demonstrate that the deprivation of life, liberty or security of the person is not in accordance with the principles of fundamental justice. Where a prescribed law, in purpose or effect, amounts to such a deprivation, then the analysis shifts to s. 1.

Section 7 of the Charter states that: “Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.” The first analytical step is to determine whether life, liberty or security of the person has been deprived by legislation or government conduct. In light of recent trends in Canadian courts, the regulation of access to RTs is unlikely to fall within the rights not to be deprived of life. In other words, Canadian courts have not shown any interest in supporting a right to biological parenthood as essential to one’s life.

A more fruitful line of argument might be to establish a positive right to procreate under Canadian constitutional law. A 1993 Report by the LRC of Canada discusses a positive right to procreate and concludes: “it seems likely that either liberty or security of the person, or both, will be found in a future case to include the right to procreate.” The Charter does not expressly include a right to procreate; however, it has been argued if such a right exists in Canada, it is most likely to be protected within s. 7 of the Charter and more specifically could be encompassed by the right to liberty or security of the person.

Section 7 has been raised in a reproductive context in two cases before the Supreme Court of Canada: R. v. Morgentaler and E. (Mrs.) v. Eve. However, it is only in the former that the Court addressed substantive interests involving reproductive claims. Relying on an expansive interpretation of the right to liberty, Wilson J. stated that the right to liberty in s. 7 of the Charter “guarantees to every individual a degree of personal autonomy over important decisions intimately affecting their private lives.” With respect to the decision whether to terminate a pregnancy, Wilson J. argued that:

95 Ibid., at 164.
98 Morgentaler, supra, note 96 at 171. In R. v. Jones, (1986) 2 S.C.R. 284 at 318, Justice Wilson affirmed that this broad conception of liberty ought to be protected by s. 7. In Jones, the plain...

In protecting a sphere of reproductive liberty in relation to a woman’s abortion decision, Wilson J. acknowledges that such a choice falls within the realm of decisions which are protected from state interference by the right to liberty. In articulating the conception of liberty protected by the Charter, Wilson J. relied upon a series of American cases which have held that the right to privacy, while not expressly enumerated in the American Constitution and its Amendments, is an aspect of the right to liberty and includes the right to procreate. One could argue that Wilson J.’s conception of liberty in Morgentaler supports the view that a general prohibition on the use of RTs would constitute an infringement of s. 7 as such a prohibition could infringe personal autonomy over important decisions that fundamentally affect the way a woman thinks about herself and her relationship to others.

In E. (Mrs.) v. Eve, the Supreme Court of Canada considered whether a court had the power, pursuant to its parens patriae jurisdiction, to authorize the contraceptive sterilization of a mentally disabled woman and whether such a sterilization would be in the woman’s best interests. In concluding that courts do not have jurisdiction to authorize a non-consensual sterilization for non-therapeutic purposes, La Forest J. writing for the Court stated that:

99 Morgentaler, supra, note 96 at 171.
100 Skinner v. Oklahoma, 316 U.S. 535 (1942) at 541, holding that the forced sterilization of habitual criminals violated the equal protection clause. In his opinion, Douglas J. characterized the right to reproduce as “one of the basic civil rights of man.” Eisenstadt v. Baird, 405 U.S. 438 (1972) at 453, in which Brennan J. for the majority recognized that the right to privacy includes “the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child”; Griswold v. Connecticut, 381 U.S. 479 (1965) recognizing that the right to personal privacy includes the choice to use contraceptives to avoid procreation; Roe v. Wade, 410 U.S. 113 (1973), recognizing the right to abortion as an aspect of the right to privacy.
son. Accordingly, the procedure should never be authorized for non-therapeutic purposes under the *parens patriae* jurisdiction.¹⁰¹

In coming to this conclusion, La Forest J. did not find it necessary to rely on the *Charter*. Therefore, whether there is a constitutionally protected right to procreate has yet to be determined. However, throughout his decision, La Forest J. did suggest that there was a “growing legal recognition of the fundamental character of the right to procreate”¹⁰² and that a non-consensual sterilization would constitute a deprivation of this right. As noted by the LRC:

Justice La Forest pointed out the “growing legal recognition of the fundamental character of the right to procreate,” “the great privilege of giving birth,” and “[t]he importance of maintaining the physical integrity of a human being … particularly as it affects the privilege of giving life.” He characterized the proposed sterilization as a “grave intrusion on a person’s rights” and an “irreversible and serious intrusion on the basic rights of the individual.”¹⁰³

It remains to be seen whether Canadian courts will accept an interpretation of s. 7 that supports individual autonomy in procreation. Moreover, even if the courts were to find a right to procreate protected by s. 7 of the *Charter*, this right may be viewed as a negative right — the right to be able to procreate without state interference — and not a positive right to medically assisted procreation.

Unless the *Charter* protects a right to procreate, arguably, the question of whether government has a positive obligation to make RTs generally available does not arise. This is not to suggest that if the government does enact legislation or regulations, or take action to provide or regulate RTs, that such action will not be subject to *Charter* scrutiny particularly under s. 15. It may be argued by some however, that s. 7 should be interpreted as creating a positive right to basic social services, including the right to health care.¹⁰⁴ The claim is that such services are fundamental to protecting the values of life, liberty and security of the person enshrined in the *Charter*. However, even if s. 7 of the *Charter* is found to guarantee the right to health care, it is unlikely that access to RTs would be included under the framework of protected services. Rather, it is likely that a distinction will be drawn between basic health care services which are necessary to sustain life and basic well-being, and those services such as RTs, whose absence, while impoverishing one’s quality of life, do not threaten life itself. Therefore, it is not likely that the courts will interpret the *Charter* in a manner which requires legislatures to provide access to RTs. However, where governments do undertake to legislate with respect to the delivery of RTs, the *Charter* may be invoked to ensure that this is carried out in a manner consistent with s. 15.

Section 15 of the *Charter* provides a basis upon which to argue for non-discriminatory access to reproductive technologies. Section 15(1) states that “[e]very individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.”¹⁰⁵ A law must not discriminate on enumerated or analogous grounds by design or by impact against particular individuals or groups. One could argue that the infertile as a group are discriminated against as a matter of “physical disability.” Grounds for access would entail arguing that this group is prevented by the state from having children despite the existence of a remedy in the form of medical treatment using RTs. However, even if the court finds infertility to be a physical disability and that the infertile are discriminated against as a class, this need not result in mandatory access to RTs. The court may hold that alternative remedies (such as adoption, for example) are available to mitigate this form of discrimination. Where access to RTs is available only as an uninsured medical service, there may be grounds to challenge the lack of provision of publicly insured access on the grounds of socio-economic discrimination. However, since s. 15 properly applies only to areas of positive state action, it would be difficult to employ unless it could be found that the decision not to fund access to RTs was deliberately discriminatory.

A more likely line of argument, therefore, would be to apply s. 15 to those individuals and groups who are currently denied access to RTs under provincial eligibility criteria, where, for example, provinces provide and insure access to some but not to other couples or individuals. Access criteria which rely upon a particular definition of infertility may be more susceptible to challenge under s. 15. Where these definitions appear to rule out or exclude certain groups, for example, single lesbians, or lesbians in a conjugal relationship, but allow access to married heterosexual couples there may be grounds for a finding of discrimination.¹⁰⁶ The infertile may claim analogous grounds under s. 15(1), particularly on the basis of social, political and legal disadvantage.¹⁰⁷ To the extent that infertility, by whatever cause, constitutes a disability, by providing access to RTs to some groups but not others, the state may be construed to have favoured the reproductive opportunities of some groups over others either by action or non-

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¹⁰¹ *Supra*, note 97 at 431.


¹⁰³ *Law Reform Commission, supra*, note 94 at 163.


¹⁰⁶ See Royal Commission, *supra*, note 91 at 426-38. Another issue not yet considered by the courts is whether or not gay men can legally access RTs, for example, by way of surrogacy arrangements, in hopes of creating a new form of family.

action. Economic arguments of budget constraint may not be used to systematically favour particular groups over others.

Provincial authorities (and indeed hospitals) may not be protected against charges of discrimination by resorting to the argument that access criteria are based on strictly medical-scientific factors. Some argue that where access criteria for in vitro fertilization, for example, are based strictly on medical infertility, then discrimination is unlikely to occur. 108 Such arguments ignore the bias inherent in these criteria, which may mask the subjective preferences and social prejudices both of those who devise such criteria as well as those medical practitioners who apply them. The Royal Commission formally recommended that: “access to in vitro fertilization treatment be determined on the basis of legitimate medical criteria, without discrimination on the basis of factors such as marital status, sexual orientation, or economic status.” 109 It remains unclear how the Royal Commission would separate, if possible, criteria involving both biological and social dimensions. In any event, the Royal Commission has provided guidance in its sharp criticism of discriminatory barriers to access RTs.

A recent case has been brought before the Nova Scotia Supreme Court involving s. 15 challenge to the access criteria applied under the Nova Scotia Health Services and Insurance Act 110 for the provision of in vitro fertilization and intracytoplasmic sperm injection. 111 The plaintiff argued that the failure to provide intracytoplasmic sperm injection constituted discrimination on the grounds of disability. In Cameron v. Nova Scotia (A.G.), 112 Kennedy C.J. presented a lengthy discussion on the relative ineffectiveness and newness of in vitro fertilization and intracytoplasmic sperm injection before ruling that these procedures are not “medically necessary” or “medically required.” 113 It was noted that the policy underlying the Nova Scotia Health Services and Insurance Act, as a product of consultation between the government and the medical society, represents a reasonable method for the establishment of health priorities and the allocation of limited funding. 114 In response to the couple’s Charter ss. 7 and 15 arguments, it was held that the policy makes a distinction in law that is not discriminatory on the basis of physical disability. Justice Kennedy stated: “the non-funding is based on the nature of the treatment being sought, rather than the personal characteristics of those persons seeking the funding, the infertile.” 115 It was further noted that to find that public funding of particular medical services falls under Charter s. 7 (right to life, liberty or security of the person) would expand the parameters of judicial review. 116 In finding that Charter ss. 7 and 15 were not infringed, Kennedy C.J. did not undertake a s. 1 analysis. This case illustrates the kinds of grounds upon which s. 15 may be used by individuals to gain access to RTs, and underlines the relevance of constitutional jurisprudence to the problem of access to RTs in Canada.

If s. 7 or s. 15 of the Charter have been infringed by prescribed law, then the onus shifts to the government under s. 1 to show that its limits are reasonable and demonstrably justified in a free and democratic society. 117 Canadian courts have not yet had the opportunity to scrutinize access criteria under the s. 1 Oakes test of rational connection, minimal impairment and proportionality. 118 For example, the purpose or objective of government legislation might be to ameliorate discrimination against infertile women and men as a group who have suffered an historical disadvantage. 119 It may be that “medically required services” under a public insurance scheme must be available to the infertile in the context of a health care system with finite resources. It has also been argued that such a determination should include the medical effects of the condition, the effectiveness of treatment, alternative treatments and relative costs. 120 On the other hand, one might argue that access to RTs as a “required service” to overcome the condition of infertility should be available to the rich and the poor alike on the basis of reasonable access to a publicly-funded health insurance system.

A. INFORMED CONSENT

Access to RTs by infertile individuals requires adequate information and counselling upon which to base a decision and consent to treatment. Consent to RTs involves a two-way process where formal or informal access criteria are applied by physicians, and where women and men have the opportunity to choose freely to accept the use of RTs. Inadequate or lack of relevant infor-

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108 Law Reform Commission, supra, note 94 at 196. The Royal Commission supports the separation of medical and social factors; supra, note 91 at 174.
109 Royal Commission, supra, note 91 at 554.
110 R.S.N.S. 1989, c. 197.
112 Ibid.
113 Ibid., at para. 86.
114 Ibid., at para. 171.
115 Ibid., at para. 154.
116 Ibid., at para. 160.
117 The basic framework for a s. 1 analysis has been set forth in R. v. Oakes, [1986] 1 S.C.R. 103.
A limitation to a constitutional guarantee will be sustained once two conditions are met. First, the objective of the legislation must be pressing and substantial. Second, the means chosen to attain this legislative end must be reasonable and demonstrably justifiable in a free and democratic society. In order to satisfy the second requirement, three criteria must be satisfied: (1) the rights violation must be rationally connected to the aim of the legislation; (2) the impugned provision must minimally impair the Charter guarantee; and (3) there must be a proportionality between the effect of the measure and its objective so that the attainment of the legislative goal is not outweighed by the abridgement of the right. In all s. 1 cases the burden of proof is with the government to show on a balance of probabilities that the violation is justifiable.
119 See Law Reform Commission, supra, note 94 at 189.
120 See Cameron, supra, note 111.
mation concerning the potential benefits, costs, and risks of RTs, as well as prejudiced forms of communication, might influence an individual’s choice to use RTs. It is important, therefore, that the communications between physicians and prospective patients remain mutually open and accessible. Consent to RTs depends upon these communications. Moreover, it is through such communications, necessary for informed consent, that non-visible discriminatory factors may become influential. In current practice, physicians may, under the facade of “legitimate medical criteria,” inquire about the person’s lifestyle, including sexual history and orientation. Keeping in mind that two chapters in this text are devoted to consent, we now explore specific issues in the context of RTs.

The common law in Canada requires that a physician obtain a patient’s informed consent prior to performing a medical procedure on that patient. This means that the patient must be informed about the benefits and risks of treatment, alternative courses of action, and the consequences of not having the treatment. Moreover, the standard for disclosure is not what the reasonable physician would see fit to disclose, but what the reasonable person in the patient’s position would want to know. The relevant information for in vitro fertilization, for example, would include success rates of the procedure, including a clarification of the meaning of success rates (i.e., conception or live birth). Patients should also be informed about the potential for multiple births and the possibility of low birth-weight babies in addition to other social factors and financial costs. The precise nature of the information to be communicated by the physician to the patient under informed consent in the context of reproductive technologies has not been established by case law.

The physician may inform the patients directly, or refer them to counselors. Independent counselling might avoid some concerns over a physician’s potential bias in providing treatment services. Moreover, independent counselling may support the timely provision of needed information on new and changing reproductive technologies. The Royal Commission recognized the importance of patients having “time to discuss and fully comprehend the meaning and implications of consent,” and that consent should be revocable “at any stage of treatment without jeopardizing future care or treatment.”

The Royal Commission recommended a standardization of informative materials, including alternatives to treatment, such as adoption and living without children.

B. STATUS OF GAMETES AND EMBRYOS

A couple that decides to reproduce using RTs may part company, or one or both of them may die, at some stage of reproduction. They might have placed their gametes (sperm and ova) separately in storage banks, or have already generated an embryo also frozen and stored in a bank. In difficult cases, courts may be called upon to determine the status of gametes and embryos, and who should have an interest in, and dispositional control over them — that is, who should have the power to control human reproductive materials and ultimately, human reproduction along specific genetic lines. The law may protect the rights and interests of the producers (the genetic contributors) of reproductive “materials,” the non-genetic “parents,” the biomedical researchers and clinical physicians who transfer the materials and help generate products of conception, hospitals and the owners of storage and handling facilities, the interests of these “products” as potential life forms, and the interests of society at-large. The law might be called upon to address such issues in the staging and evaluation of life-forming processes, from pre-conception arrangements to the definition of death. The framing of the legal issues which arise will depend upon whether or not gametes and embryos are considered as property, persons, or something in-between. The following section explores law’s responses to the status of reproductive “materials” (sperm and ova) and the “products” of conception (zygotes, embryos, and fetuses). The primary issue of the status of gametes and embryos implicates a range of existing law including: property, contracts, wills and trusts, tort, criminal law and constitutional law.

1. A Property Approach

One approach to the characterization of gametes and embryos focuses on the concept of property. Property refers not to physical objects, but to “rights of control or domination” over objects or activities. A traditional property approach treats sperm, ova, and embryos as objects to be controlled like any other. The reason for this treatment as objects centres on their generation as a product

122 Reibl v. Hughes (1980), 114 D.L.R. (3d) 1 (S.C.C.) provides the authoritative statement on the law of informed consent in Canada. See also the Ontario Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A., which supersedes the common law in its broad application to treatment. Section 2 of the Act defines treatment as “anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose includes [sic] a course of treatment or plan of treatment.”

123 Ibid.

124 The following section focuses on gametes, zygotes (pre-embryos), and embryos. For a more detailed discussion on fetuses, see chapter 9, “State Intervention in the Lives of Pregnant Women.”

of one’s body and the fact that they are alienable from it. According to some proponents of a property model, each individual is said to have dominion and control over her or his body, including its derivatives such as blood, sperm, ova and embryos. It has also been argued that each individual should have the right to exclusively control the uniquely identifying information contained in her or his genes. The argument in favour of viewing the body and its parts as property is supported by the understanding that property is considered uniquely personal and therefore private. If my body and its parts do not belong to me, then to whom do they belong? The primary motivation in favour of regarding gametes and embryos as property therefore, is to ensure that the individual or individuals who generated them has the full power to control their ultimate use.

Alternatively, some academics argue in favour of quasi-property approaches where, for example, gametes would have special status as property. A quasi-property approach might affirm personal control and rights over disposition of gametes and/or embryos, but deny the right to alienate these materials for commercial purposes or for remuneration. By considering policy issues in relation to the specific facts of the case, one might locate the status of gametes and embryos somewhere along the spectrum ranging from traditional property, to a unique form of quasi-property with the potential for life. By the former characterization, the individual’s ownership of gametes would focus on possession to the exclusion of all others; as such, gametes would be alienable according to the expressed wishes of their owners. Moreover, an object may be property (in its weakest form, without all traditional incidents) for some purposes but not others. The potential suspension of reproductive stages, and the recognition of a form of potential life, generates obvious concerns of de-humanization. By removing embryos and ova from the body, the only place where they had existed prior to the advent of RTs, a de facto condition of objectification is created. While the legal characterization of human reproductive materials has not been considered in Canada, it has in other jurisdictions.

In Hecht v. Superior Court of the State of California for the County of Los Angeles (Kane), the California Court of Appeal held that cryopreserved sperm was a “unique category of property” as part of the estate of the deceased donor. The value of the donor’s sperm arose from its potential to generate life upon fertilization, thus providing the donor an interest “in the nature of ownership.” In Davis v. Davis, the court directly confronted the issue of whether cryopreserved pre-embryos are property. The Davis couple underwent in vitro fertilization, storing their pre-embryos for later use. They eventually divorced, leading to a custody battle over the “frozen” pre-embryos. Ms. Davis sought to implant the embryos. She argued the “best interests of the child” test, and that the pre-embryos were in fact “living persons.” In opposition, Mr. Davis contended that the pre-embryos were under joint control. Justice Young of the Tennessee Circuit Court ruled in favour of parens patriae jurisdiction and the family law approach emphasizing the “best interests of the child,” and thus rejecting a traditional property approach. In rejecting the “bailment” approach of York v. Jones, Justice Young focused on a “minority” scientific opinion, suggesting that the differentiation of cells in such embryos means that they are fully constituted, “living persons.” When faced with legal classification, Young J. relied upon medical science, in the absence of much discussion about the problems of deference to medical science and the lack of critical inquiry and challenge.

By the time the case reached the Court of Appeal, both parties had remarried. Ms. Davis no longer wished to implant the pre-embryos, but instead wanted to donate them to other women. Thus, the facts and perhaps the support of public policy had changed direction. The Court of Appeal reversed the previous ruling, awarding instead joint control over the pre-embryos. In the Davis case, the ex utero pre-embryos were frozen at an early stage of development. The American Court recognized that Mr. Davis had a “constitutionally protected right not to beget a child where no pregnancy has taken place.” Some academics have argued that the Davis analysis sounds “suspiciously property-like.” And yet, the court’s reference to the fact that the embryos had been created but not yet implanted supports Ms. Davis’ reproductive contribution in relation to the father. At the same time, the court recognized the father’s contribution and his wish not to proceed. In the end, the husband received a complete “veto” over

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126 See Litman & Robertson, Genetic Material, ibid., at 60; Litman & Robertson, Reproductive Technology, ibid., at 250.
127 For example, see Moore v. Regents of the University of California, 249 Cal.Rptr. 494 (Ct. App. 1988), in Litman & Robertson, Reproductive Technology, ibid., at 251-53.
128 See Litman & Robertson, Reproductive Technology, ibid., at 232, 247 (the authors support a sui generis approach, using examples such as law’s dealing with human corpses).
129 Litman & Robertson, Genetic Material, supra, note 125 at 67.
130 20 Cal.Rptr. 2d 275 (1993).
131 The court in Hecht ibid., cited for persuasive support, among others, the decision of Paraplaix v. CECSO T.G.I. Creteil, August 1, 1984, Gazette du Palais, September 15, 1984 (France) (widow sought disposition of decedent’s sperm stored in a sperm bank). See, infra, note 186.
133 717 F. Supp. 421 (E.D. Va. 1989) (a property-based approach where the court upheld the transfer of pre-embryos between fertilization institutes).
134 See Litman & Robertson, Reproductive Technology, supra, note 125 at 259. The authors note that scientific arguments are not determinative of this particular legal issue. See Trembly v. Duigle, 1989) 2 S.C.R. 530 at 553. See generally, RJR-MacDonald Inc. v. Canada (A.G.), 1995] 3 S.C.R. 199.
135 See Litman & Robertson, Reproductive Technology, supra, note 125 at 260.
the disposition of the frozen ex utero pre-embryos. The Tennessee Supreme Court affirmed the Court of Appeal decision. The court, however, noted that "pre-embryos are not, strictly speaking, either "persons" or "property," but occupy an interim category that entitles them to special respect because of their potential for human life." The court focussed on the Davis' interest in "the nature of ownership, to the extent that they have decisional authority," in light of a balance of opposing interests by the two genetic contributors. The court in Davis thus seems to suggest two exceptions to the right of one progenitor to veto parenthood: (1) where one parent cannot otherwise become a parent; (2) a prior agreement between the parties indicating their clear intentions for the disposition of embryos.

In Canada, the courts have yet to decide on the issue of whether or not reproductive materials should be considered as "property." Federal legislation, such as the Food and Drugs Act and the Excise Tax Act tend to invoke the language of property in that sperm may be "possessed" and "owned." It can be argued that gametes and embryos are human tissues and therefore fall under human tissue legislation. The Human Tissue Gift Act, limits the transfer of human "tissue," which "includes an organ, but does not include any skin, bone, blood, blood constituent or other tissue that is replaceable by natural processes of repair," providing for "gifts" only. The Quebec civil law basically adheres to the principle that the human body is not for sale; the law has not yet decided upon such issues as ownership of body parts. The Civil Code of Quebec ("CCQ") does not specifically address the issue of the ownership of donated embryos. Article 19 of the CCQ states that "[a] person of full age who is capable of giving his consent may alienate a part of his body inter vivos, provided the risk incurred is not disproportionate to the benefit that may reasonably be anticipated." This form of risk balancing requires judges to carefully consider external sources in order to avoid, if possible, indeterminacy.

Under s. 223(1) of the Criminal Code of Canada, "a child becomes a human being ... when it has completely proceeded, in a living state, from the body of its mother." A fetus, and thus, by extension, gametes and embryos, cannot be considered a legal person for the purposes of criminal law. In the context of striking down an abortion provision under the Criminal Code, the Supreme Court of Canada indicated that a fetus does not have a separate s. 7 right from its mother. Embryos and fetuses do not have legal rights until they are born alive. Canadian common law has also endorsed the born alive rule. In Winnipeg Child and Family Services (Northwest Area) v. G.(D.F.), a seven-member majority of the Supreme Court of Canada invoked the "born alive" rule and refused to restrict the activities of an expectant mother in favour of a societal interest to protect an unborn child. The majority noted "Any right or interest the fetus may have remains inchoate and incomplete until the child's birth." In dissent, Sopinka and Major J. contended that the born alive rule was a legal anachronism — "a common law evidentiary presumption rooted in rudimentary medical knowledge that has long since been overtaken by modern science." The dissenters noted that the state of medical knowledge has since changed to undermine the rule. The born alive rule is well established at common law, and therefore it is unlikely that gametes and embryos will be considered legal persons. Whether they are property or something in-between however, has yet to be determined.

In private law, such as family, child welfare, and succession law, it seems that more emphasis is placed on the best interests of the future child, so long as it is born alive. It is a question whether this emphasis on the best interests of the child might also apply to the preliminary stages of human development. In the context of child welfare and family law, several issues might arise where the interests of the fetus conflict with those of the mother's freedom to refuse medical treatment or to make certain lifestyle choices that place the fetus at risk. For example, the courts have held that a fetus cannot be considered a child for purposes of apprehension by child welfare authorities. The interests of the fetus, and therefore, the in utero embryo, are to be determined by the mother.
The law in relation to gametes and embryos might yet vary with the extent of their perceived "humanness."

Under succession law, if a pregnant woman's husband provides that his estate be divided equally among all children, and he subsequently dies, the in utero child will be deemed to have already come into existence,154 and therefore has a right to inherit property. Similarly, intestate succession legislation supports inheritance for those conceived at the time of the intestate's death.155 Moreover, the common law has provided similar relief in the interests of the child conceived at the time of an accident causing the child's parent(s)' death.160

In the law of negligence, the child may generally claim for injuries wrongfully committed while in its mother's womb; the child need not be alive at the time of the wrongful act.151 Canadian tort law requires that the child be subsequently born in order for her or him (or someone on her or his behalf) to claim negligence.162 The common law confers specific rights only upon persons born alive, and not embryos or fetuses that fail to exercise their potential for life.152 The Supreme Court of Canada in Tremblay v. Daigle,164 confirmed this position in the context of a man's attempts to prevent a former partner from having an abortion. The Court interpreted the Quebec Charter of Rights and Freedoms165 to mean that a fetus is not a human being; the Quebec government had not shown "a clear intention ... to consider the status of a fetus."166 Moreover, due to the nature of embryos as forms of potential life, Canadian courts might require clear legislative intention to regulate them. Sperm or ova alone, on the other hand, cannot exercise any potential for life.

Gametes and embryos might be considered more like property than persons, or vice versa, depending upon the stage of development and the context of the owner's assertion of control.155 Some commentators argue that the property approach "may well be able to accommodate competing interests in a more responsive and responsible manner than the law pertaining to persons."166 Yet, the property and quasi-property approaches seem inadequate in that they objectify human reproductive "materials" and disregard important social and moral dimensions such as the sanctity of human life and the power relationships in human reproduction. Moreover, the concerns over commodification and commercialization would appear to outweigh any arguments in favour of treating gametes and embryos as a form of property – and to be controlled and dominated as objects. The use of a property approach, even in the absence of the language of "property" and "ownership," does not provide a convincing solution,168 but merely hides the substantive problems discussed above. Moreover, the category of property has been much criticized as disregarding such feminist concerns as "the objectification of women; the economic exploitation of women; the denigration of human reproduction and the treatment of women as 'baby-making machines'; women's alienation from their bodies; the commodification and destruction of human values."169 It would, therefore, seem odd to consider gametes and embryos strictly as traditional property. Courts in Canada and other common law jurisdictions have so far shown no indication that gametes and embryos have full status as legal persons.170 To do otherwise, the courts would oppose the reproductive freedom of the parents. It remains to be seen how Canadian courts might work beyond traditional property conceptions of gametes and embryos.

2. The Personhood Approach

We have briefly touched upon the personhood approach throughout our description and critique of the traditional property approach. The personhood approach basically treats gametes and embryos as full legal persons, with all rights and interests that other living persons might enjoy. This approach emphasizes one's personal control over unique genetic information as essential to one's personality and liberty; human beings are considered inviolable and inalienable. This approach differs from a property approach in two major respects: (1) it does not support commercialization, and (2) information is considered to be

158 See art. 838, CCQ (the beneficiary of the will need only be conceived at the time of the testator's death and afterwards born viable). See also the Wills Act, R.S.M. 1988, c. W-150, s. 25.3 [en. R.S.M. 1989-90, c. 44, s. 5]. See also family relief legislation that also provides similar benefits for "dependants" conceived at the time of death; See Intestate Succession Act, R.S.A. 1980, c. I-9, s. 10. See also H. Shapo, "Matters of Life and Death: Inheritance Consequences of Reproductive Technologies" (1997) 25 Hofstra L. Rev. 1091; K. Guzman, "Property, Progeny, Body Part: Assisted Reproduction and the Transfer of Wealth" (1997) 31 U.C. Davis L. Rev. 193.

159 Ibid.

160 For a wide range of examples of legislation and case law, see Litman & Robertson, supra, note 155 at 237-38. For example, see Fitzsimonds v. Royal Ins. Co. of Canada (1984), 29 Alta. L.R. (2d) 394 (C.A.) (definition of "dependant" in an automobile insurance policy). For example, see Cherry (Guardian) v. Borsman (1990), 75 D.L.R. (4th) 668 (B.C.S.C.); affd (1992), 94 D.L.R. (4th) 487 (C.A.).


162 G(D.F.), supra, note 151.

163 Litman & Robertson, supra, note 155 at 238. See Borowski v. Canada (A.G.), supra, note 150. A dilemma, however, might arise in the court's insistence upon hearing concrete cases with live issues. The Supreme Court of Canada in Borowski dismissed the appeal as moot — the fetus had not survived.


166 Supra, note 164 at 555. The Court noted the private nature of the case and thus refused to consider the status of the fetus under the Charter. For more detailed discussion, see chapter 9 "State Intervention in the Lives of Pregnant Women." See also Litman & Robertson, supra, note 155 at 238-40.

167 See Litman & Robertson, ibid., at note 86.

168 Ibid., at 244.

169 Ibid., at 267-68.


171 See Litman & Robertson, supra, note 155 at 235-42.
common to all persons, rather than a “thing” to be appropriated.\textsuperscript{172} The personhood approach however, must contend with the problem that gametes and embryos can be separated from the person(s) who generated them and be implanted in third persons. Can these still be viewed as extensions of the person who generated them, or should these be seen as autonomous persons imbued with the full range of the rights of persons? Under a personhood approach, destruction of gametes and embryos would be tantamount to murder, while their commercial exploitation may be the equivalent of slavery.

Quebec civil law considers the control over one's body in light of “rights to personality” and individual liberty.\textsuperscript{173} In civil law, a personality rights approach seems more accepted for personal control over one’s body and its contained information. The CCQ holds that every human being has, among others, the right to life, personal security, inviolability, and the integrity of the person.\textsuperscript{174} Marie Hirtle notes that the “multiple personality rights found under Quebec civil law would ... confer the right to follow, to examine, and to control information concerning and originating from a person.”\textsuperscript{175} The basic presupposition is that “the human body is dissolubly both person and thing.”\textsuperscript{176} This bespeaks the in-between approach, where gametes and embryos are treated as somewhere between property and persons, depending on the specific context. This is the \textit{sui generis} approach discussed below.

3. \textit{Sui Generis} and Other Approaches

Rather than treat gametes and embryos as one of the two extremes — as objects (property) or as subjects (persons) — the courts may consider some type of \textit{sui generis} or relational approach on a case-by-case basis.\textsuperscript{177} It has been said that “the emerging trend is to characterize the legal status of the embryos \textit{ex utero} and gametes as \textit{sui generis}.”\textsuperscript{178} \textit{Sui generis} means “its own type” or “class by itself.” In other words, such an approach denies any analogy between this class of objects and any other type of relationship or entity. In using this approach, the focus remains on the factual setting and “particularly, on the relationship between the parties, and not the genetic material itself.”\textsuperscript{179} A \textit{sui generis} approach, whether considered under the concept of property or personhood, supports a more flexible consideration of relations among persons and things. It also emphasizes the application of policy interests on a case-by-case basis. On the other hand, while a \textit{sui generis} approach might escape the traditional constraints of a property approach, it does so only to rely upon the discretion of courts.

This approach may be criticized as simply begging the question to what class do gametes and embryos belong? In order to fill the legal void and arrive at a reasoned outcome, the courts may determine that these materials or relationships are “like” persons or property, thereby falling back on familiar statuses or relationships in an effort to arrive at a more certain legal outcome. The \textit{sui generis} approach may ultimately become self-defeating and result in a body of inconsistent analogies applied in different cases.

A possible way out of this dilemma may be offered by the relational approach, which acknowledges that these materials differ from existing categories but recognizes the intrinsic interests which are generated by the manner in which these materials emerge and the purposes to which they are applied. The relational (or relationship) approach provides an alternative to that of traditional property, personhood, and \textit{sui generis}. The relational approach focuses on relationships and the conditions that foster capacity to form relationships.\textsuperscript{180} Rather than focussing on individualistic conceptions, such as rights, the relational approach acknowledges relationships among individuals and communities, for example, those of power, responsibility, trust, obligation, respect, and caretaking.\textsuperscript{181} In doing so, the law might sensitively adapt to changing societal values and advances in RTs, and perhaps better address issues of “control, decision-making authority, and responsibility” for potential human life.

Although the relational approach provides a critical alternative to the traditional property and personhood approaches, choices and decisions must yet be made about the status and disposition of gametes and embryos, and the relationships among the women and men who contribute genetically or non-genetically to human reproduction. The choices and decisions resulting from the resolution of legal disputes in practice, will create hierarchies of relationships deemed worthy of legal recognition and status. A relational approach, however, may appear useful in allowing courts to better recognize relationships of power and control over the lives of genetic contributors and gestational providers, especially those women who bear additional responsibilities,\textsuperscript{182} as well as in recognizing gametes and embryos as potential human life. As the Royal Commission states, it is “essential to ensure that zygotes (and presumably, gametes) are


\textsuperscript{173} Ibid., at 85.

\textsuperscript{174} See also R. v. Morgentaler, [1988] 1 S.C.R. 30.

\textsuperscript{175} Supra, note 172 at 108.

\textsuperscript{176} Ibid., at 116.

\textsuperscript{177} The \textit{sui generis} approach, however, cannot be “policy neutral”; the policy choices merely embody the subjective views of one judge, participant or another. However, for an opposite opinion, see M. Litman & G. Robertson, “Reproductive Technology: Is a Property Law Regime Appropriate?” in Royal Commission on New Reproductive Technologies \textit{Overview of Legal Issues in New Reproductive Technologies Research} vol. 3 (Minister of Supply and Services Canada, 1993) at 268.


\textsuperscript{179} Ibid., at 55.


\textsuperscript{181} Ibid.

\textsuperscript{182} Ibid.
treated with respect because of their connections to the human community.”

Having discussed various conceptual frameworks for the status and control of gametes and embryos, we now analyze specific legal issues related to the control and use of gametes and embryos.

C. CONTROL AND USE OF GAMETES AND EMBRYOS

1. Gamete and Embryo Donation

A woman may wish to reproduce using the sperm or ova of known or anonymous donors in a number of circumstances including: the absence of a male partner, the existence of male factor infertility in her partner, or the desire to avoid the transferring of infectious diseases or genetic conditions to offspring. Ovum and embryo donation can be used in cases of female factor infertility, or for example, where two women choose to share the genetic and gestational aspects of pregnancy. In some cases sperm and ovum may be treated or otherwise manipulated to facilitate fertilization. We now consider the regulation of gamete and embryo donation in Canada, highlighting differences encountered in their regulation. The analysis will illustrate a range of solutions depending upon the choice of conceptual framework to be applied to gametes and embryos: whether they are treated as property, persons, or something in between (sui generis).

(a) Gametes

In Canada and elsewhere, the special nature of human tissues, and specifically, gametes (sperm and ova), has resulted in attempts to regulate their transfer. In Canada, the federal government now regulates the processing and distribution of semen for assisted conception.14 This legislation uses the language of “donor” to address the distribution of sperm and ova. The province of Quebec regulates the donation of both sperm and ova, and deems the gestational mother to be the legal mother for legal purposes.15 As well, in most provinces, legislation exists to control the transfer of human tissues for organ transplantation.16 As we have discussed previously, one might argue that human tissue legislation includes the donation of gametes and embryos. These particular human tissues however, are unique in their potential to create life and are not “replaceable by natural processes of repair.” In varying degrees, sperm, ova and embryos deserve special consideration as human tissue necessary for reproduction. Although human tissue legislation might or might not apply to gametes and embryos, Canadian courts may find it useful to draw parallels to the statutory provisions of such legislation.

The transfer of human tissue is generally considered as a gift, not a sale. Section 10 of the Ontario Human Tissue Act states, “[n]o person shall buy, sell or otherwise deal in, directly or indirectly, for a valuable consideration, any tissue for a transplant, or any body or part or parts thereof other than blood or a blood constituent, for therapeutic purposes, medical education or scientific research, and any such dealing is invalid as being contrary to public policy.” Similarly, art. 25 of the CCQ states, “[t]he alienation by a person of a part or product of his body shall be gratuitous; it may not be repeated if it involves a risk to his health.”

Several provincial statutes regulate who may donate human tissues generally, and gametes specifically. Article 538 of the CCQ provides that a person may donate gametes for “[p]articipation in the parental project of another person by way of a contribution of genetic material.” Section 3(1) of the Ontario Human Tissue Act states that a person may consent to an inter vivos gift for transplant, if she or he is at least 16 years old, mentally competent, and able to make a free and informed decision. Section 4(1) of the Human Tissue Act provides that a person, if she or he is at least 16 years old, may consent to a post mortem gift, “in writing signed by the person at any time; or orally in the presence of a least two witnesses during the person’s last illness.” The gift can be made “for therapeutic purposes, medical education or scientific research.”

The common law also tends to distinguish between the various forms of a gift inter vivos and a gift causa mortis. Gamete donation may occur during the donor’s lifetime, or after her or his death. These two scenarios have traditionally created different responses under the law of property. The transfer of reproductive “materials” and the use of RTs, however, require a more complex approach to legal analysis than traditionally applied under the law of property.

Gametes from a donor who has since died may be used for reproduction. Persons can now store their gametes in sperm or ova banks, for subsequent donation after death. It seems that courts will recognize the special nature of gametes, and requirements and conditions for the exchange of human tissue, especially in the case where contributors have since died.17 As a matter of public policy, however, some argue the gametes of deceased donors should not be used for reproduction because of the possible effects on children born without live genetic parents. Ethical issues also arise when gametes are retrieved from donors who are deceased persons or fetuses. For example, a woman might wish to

143 Royal Commission, Proceed With Care: Final Report of the Royal Commission on New Reproductive Technologies (Ottawa: Minister of Supply and Services Canada, 1992) at 17.
144 Processing and Distribution of Sperm for Assisted Conception Regulations, SOR/96-254 under the Food and Drugs Act, R.S.C. 1985, c. F-27.
145 CCQ 1991, c. 64, art. 19, 538-42.
146 For example, see Human Tissue Act, R.S.O. 1990, c. H-2, s. 1; Human Tissue Act, R.S.A. 1980, c. H-12, s. 1(b); Human Tissue Gift Act, R.S.B.C. 1996, c. 211, s. 1. But see also CCQ 1991, c. 64, art. 19, which states that a person may “… alienate a part of his [sic] body only if that part is capable of regeneration and provided that no serious risk to his [sic] health results.” Article 20 of the CCQ requires that “[t]he alienation must be gratuitous unless its object is a part of the body susceptible to regeneration.”
147 Ibid. It is unclear whether or not gametes will fall under human tissue legislation.
148 Similar provisions can also be found in Human Tissue Act, supra, note 185, s.10; Human Tissue Gift Act, supra, note 185, ss.10, 11.
use sperm from a dead male partner, or a man might wish to use ova from a dead female partner to be fertilized by in vitro fertilization and implanted in a gestational mother.

Under Ontario’s Human Tissue Gift Act, where the deceased person has not given consent and dies, or cannot give consent by reason of injury or disease, and the person’s death is imminent, s. 5(2) provides a lengthy hierarchal list of persons, beginning with spouses, children and relatives, who may, on behalf of that person, consent to transplantation. Section 5(2)(f) provides that where no spouse or relatives can be found, transplantation may be authorized by the “the person lawfully in possession of the body other than, where the person died in hospital, the administrative head of the hospital.” Under s. 5(3), consent cannot be given if there is reason to believe that the deceased person would have objected. If ova and sperm fall under the Human Tissue Gift Act, post mortem reproduction may be considered legal in Ontario. However, this might be considered morally unacceptable where retrieval of sperm and ova requires an invasive procedure on a “brain dead” person, in contrast to retrieval from existing supplies in storage banks. Further issues arise as to whether or not the deceased should be considered the legal father or mother for purposes of birth registration or inheritance. In these cases, and in the absence of specific legislation, Canadian courts may draw analogies to organ transplantation under the Human Tissue Gift Act and the law of adoption.

For post mortem reproduction, the main issue is whether the deceased intended to have children after death. Although Canadian courts have not addressed this, courts in other jurisdictions have. In Parpalaix v. CECOS, the French Tribunaux de grande instance discussed the dispositional control over the donor’s sperm deposit, and the issue of whether the donor intended to have children during his lifetime or after death. The Tribunaux held in favour of the deceased donor’s wishes to have children after death. In Hecht v. Superior Court of the State of California for the County of Los Angeles (Kane), the California Court of Appeal recognized the deceased donor’s expressed intentions. In Hecht, the court held that the donor had an ownership interest under at least an “interim category,” if not personal property law. In the case of R. v. Human Fertilisation and Embryology Authority, ex parte Blood, the English Court of

Appeal considered a woman’s attempts to use the sperm she obtained from her comatose husband. The husband died shortly afterwards. The Human Fertilisation and Embryology Act 1990, clearly required expressed written consent of a donor for the taking and use of his sperm, including for posthumous reproduction. No written consent existed in this case.

The commercialization of human reproduction raises obvious concerns, despite the law’s insistence that the transfer of gametes be treated as gifts only. Although Bill C-47 does not explicitly address the issue, it does provide some indirect constraints subject to interpretation. Section 6(1) would prohibit the sale, purchase, barter or exchange of sperm, ova, or embryos, or an offer to do so. Section 6(2), however, provides an exception to s. 6(1) for “the reimbursement of expenses incurred in the collection, storage or distribution of ova or sperm, except any such expenses incurred by their donor.” Although compensation for gamete donation is usually limited to reasonable expenses, the definition of “expenses” is a matter for interpretation.

Moreover, there has been much concern over the exploitation of women who exchange “spare” eggs (or ova) to be implanted in other women in return for compensation or reduced fees for in vitro fertilization or other medical services. In some medical practices, women patients are asked for the “designated donation” of ova in exchange for services or reduced rates. The Royal Commission would prohibit physicians from revoking services when a woman chooses not to donate spare ova. Moreover, a free market approach towards human reproduction has been criticized for devaluing and degrading gametes. It treats gametes as property and their producers as reproductive means. To address such concerns, the regulation of sperm and ova donation should maintain some flexibility for changing social norms.

Rather than suggesting an absolute ban on such exchanges, several commentators emphasized the importance of women’s informed consent to embryo donation in these circumstances. It is suggested that informed consent might ameliorate the power imbalances and exploitation that women may face due to socio-economic disparities. Others contend that truly informed consent is not possible in light of an already existing state of gender inequities. We have previously discussed the issue of informed consent. However, it is noteworthy to mention that Canadian courts have not yet faced the issue of revocation of consent by a gamete donor. One might argue that the option to revoke consent prior to actual implantation of gametes into recipients would empower women by making available choices in some circumstances.

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107 These scenarios are not so unusual given medical advances in physically maintaining “legally dead” (or “brain dead”) persons.

108 Supra, note 185.


110 Hecht v. Superior Court of the State of California for the County of Los Angeles (Kane), 20 Cal.Rptr. 2d 275 (1993).


112 Human Fertilisation and Embryology Act, 1990, ch. 37(5) (Eng.).

113 Ms. Blood did however, succeed in receiving the right to use her husband’s sperm for artificial insemination. Pursuant to another section of the Human Fertilisation and Embryology Act, 1990, the sperm could be exported abroad and Ms. Blood inseminated in a European Community state (ibid.).

(b) Embryos

Embryo donation raises different issues than those for gametes per se. Given their potential for human life, embryos, like fetuses, deserve special attention under existing law or a future regulatory regime. In addition, embryos involve two genetic contributors, each with a potential interest in the embryo. The common law may distinguish between in utero and ex utero embryos. The latter are located in a storage bank while the former are located in the womb of a gestational mother. Canadian courts, especially in the context of abortion, have acknowledged that women have full autonomy to make decisions over their bodies and to abort embryos or fetuses they may be carrying.209

The legal issues of control and parenthood, however, become more complicated in the context of RTs where the gestational mother differs from the genetic mother. The courts have yet to face the difficult issue of revocation of consent for the donation of an embryo by genetic parents to a gestational mother. Canadian courts, however, would likely favour the gestational mother in the control and disposition of an embryo that has already been implanted.

Embryo donation requires the informed consent of both genetic donors, if known. Consent should be clearly expressed, specific, and in writing. For embryo donation particularly, an agreement might cover disposition for such contingencies as the death of one or both donors. As well, an agreement could expressly address dispositional issues upon the revocation of consent by one or both donors. However, it is uncertain whether Canadian courts would enforce such an agreement given the special, unique nature of embryo donation. The issues also raise the arguments familiar in the debate over abortion: the pro-life versus pro-choice schools of thought. The courts, however, will likely emphasize the special nature of embryos as potential life forms and the autonomy of gestational mothers in making decisions that directly affect their lives.

A woman who separates from a male partner202 may seek custody of cryopreserved embryos in which she and her partner genetically contributed. The woman may wish to keep the embryos for herself for subsequent implantation. Or, she may wish to transfer the embryos (or dispositional authority) to a third party, for example, another woman or couple, or to simply destroy the embryos. If the male contributor is opposed to such a transfer or destruction, and if Canadian courts support joint control, then the woman would have no legal recourse.

The common law abroad has thus far supported joint control over embryo disposition. The special nature of embryos as potential life forms and the autonomy of gestational mothers in making decisions that directly affect their lives.

A different scenario arises where both the woman and man initially abandoned the cryopreserved embryos but later found that the embryo bank sought to donate them for implantation into other women. This situation, given the embryo’s development and potential for human life, may warrant a higher standard of consent by both genetic contributors for the specific purposes of the embryo implantation, as well as a specific threshold for abandonment.

Genetic parents, like those in Davis, can vary or revoke their consent for embryo donation. One or both genetic contributors might revoke consent for embryo donation, despite prior agreement to the contrary. In the case of one anonymous contributor, embryo donation may follow the same rules and principles applicable to gamete donation. Moreover, the intended gestational mother might revoke her consent to be the recipient. The disposition of embryos could become problematic when one or both of the genetic contributors die. The Royal Commission recommends that embryos not be stored beyond the death of one or both of the genetic contributors.203 Again, it remains to be seen how Canadian courts might decide these latter issues. As we discussed previously, s. 5 of the Human Tissue Gift Act provides for the post mortem transfer of dispositional authority to non-family members, provided that there is no reason “to believe that the deceased person would have objected.”204

202 842 S.W. 2d 588 (Tenn. 1992).
203 Royal Commission, supra, note 183 at 599.
204 The first publicized case to raise issues about the status and disposition of frozen embryos created through in vitro fertilization involved Mr. and Mrs. Rios, a wealthy California couple who received in vitro fertilization in Australia. Two embryos were frozen when Mr. and Mrs. Rios died in an airplane crash. Apparently the Rioses left no written instructions regarding the fate of the “orphan embryos” and a lengthy and heated debate arose about whether the embryos should be destroyed, made available for anonymous donation, or deliberately gestated in order to permit them to inherit an intestate share of the Rioses’ estate. For further discussion of this case and the issues it raises see: George P. Smith II, “Australia’s Frozen ‘Orphan’ Embryos: A Medical, Legal and Ethical Dilemma” (1985-86) 24 J. F. L. 27.
2. Donor Anonymity and Identification

The use of donor gametes raises issues of identification and anonymity. Some women may choose to bear a child using the sperm or ova of anonymous donors. An infertile couple may wish to combine anonymous donations of sperm and ova, with hopes of implanting the embryo into the woman partner as gestational mother. The availability of sperm and ova will depend upon the supply of and access to anonymous donor contributions, usually through sperm and ova banks. Embryos however, are rarely made available for donation.

The requirement of informed consent also applies to anonymous donors. The donor must be informed of the specific purpose of the donation and the potential benefits and risks. Anonymous donors, if they provide informed consent, generally waive their beneficial interests and right to control gametes and embryos, as well as future child support obligations and custody rights. Thus, donors receive anonymity in exchange for their own relinquishment of dispositional control and the guarantee that no legal claims will be found against them. Canadian courts, moreover, tend not to hold anonymous donors liable for the quality and fitness of the product. This position supports the policy interest of making available a large pool of sperm and ova for donation.

A more controversial issue arises if the donor wishes to remain anonymous, whereas the child seeks access to information that identifies her or his genetic parents. At some point the child's interest in obtaining social, cultural and medical information for her or his psychological or social well-being could override the policy interest to ensure a large supply of donor sperms and eggs. One possible resolution would centre on the child's access to non-identifying genetic information. This would, however, still lead to issues about the nature and extent of such information and its restricted availability. In serious medical cases where the child's health or life is at risk, key genetic information should be made available.

A registry is one possible solution to ensure limits to the number of offspring by donors and to guarantee that children geneticaally-related do not unknowingly reproduce. It might also be helpful for children to receive counselling prior to receiving registry information about their genetic parents. The existence of a donation registry, however, may lead to misuses or abuses of information by governments and private parties. In order to resolve these issues, Canadian courts will likely draw parallels to the statutory and common law respecting adoption.

Genetic and gestational parents, if they differ, may also have a legal obligation to tell their children about non-genetic links to donors. There seems to be a strong societal interest in children knowing the "genetic truth." If such obligations exist, and in the absence of relevant legislation, the courts will likely consider an appropriate age for the disclosure of the fact of donation and for the provision of specific information about the donor. In the absence of such disclosure, children might suffer from "genetic bewilderment" and social stigmatization.

Children may also attempt to claim support payments or inheritance from an identified donor. The issue remains whether common law courts will refuse to provide children with legal interests against donors or their estates. In deciding such legal issues, Canadian courts would likely consider the "best interests of the child" principle, and the policy interest in the availability of anonymous donation. Where the child wishes however, the donor might revoke his or her anonymity arrangement.

3. Freezing and Disposal of Gametes and Embryos

The freezing (or cryopreservation) of tissues provides new opportunities for the testing and screening of ex utero sperm, ova, and embryos for donation. Donated sperm, ova, and embryos may now be screened for HIV, other sexually transmitted diseases, and various genetic factors. Moreover, a physician's duty of care as a medical professional now requires reasonable efforts to test and screen donation, whether known or anonymous. This duty has now been specifically detailed and embodied in a federal statute dealing with the processing and distribution of semen.

In light of the sensitivity of the subject matter — potential forms of human life and uniquely identifying information — governments may impose limits on the condition and quantity of gametes and embryos stored and transferred between individuals and institutions. In Canada, for example, the federal government now regulates the processing and distribution of semen for assisted conception. Moreover, at common law, storage facilities might have a duty of care to screen and test frozen gametes and embryos for illnesses and genetic conditions. One might argue, however, that governmental regulation of the storage and handling facilities for gametes and embryos may lead to increased use of unlicensed artificial insemination and higher risks due to the absence of donor screening for illnesses and genetic disease. In other words, a regulatory regime that too strictly controls the storage and transfer of gametes and embryos could lead to an underground market for reproductive services and "materials."

The few common law cases so far decided, indicate the importance of the donor parties' intentions prior to the freezing and storage of gametes and embryos. The parties should also express their intentions with respect to such...
dispositional contingencies as the donors’ death or abandonment of donation. As previously discussed, human tissue gift legislation might apply to gametes and embryos once frozen and stored, assuming they fall under the Act. If so, ss. 5(2)(f) and (3) of Ontario’s Human Tissue Gift Act suggest that storage banks might have a dispositional authority (over “transplantation”) based on possession, if no other family member or relative can be found, and there is no reason to believe that the deceased person would have objected.

The abandonment of sperm, ova or embryo donations creates new issues of control and disposition. Storage facilities may assert control over abandoned gametes and embryos on the sole basis of possession. Also, those parties who assisted in the abstraction of such reproductive materials and products might attempt to gain dispositional control over them. The situation may also be similar where the donors of gametes and embryos die, without any expressed intentions and specific instructions for donation. The freezing of sperm and ova can therefore lead to complex issues of dispositional authority. Moreover, the disposal of gametes and embryos should occur by means which account for their status as potential (or early) forms of human life.

The commercialization of freezing processes and storage facilities for gametes and embryos raises serious concerns. The Final Report of the Royal Commission recommended:

No profit should be made from the selling of any reproductive material, including sperm, because of ultimately de-humanizing effects. Current commercial practices in storage and distribution of donor sperm contravene these values, and we recommend a licensed, non-profit system.

The Royal Commission warns against the commercialization of human reproduction and the commodification of gametes and embryos. Moreover, Bill C-47 would call for the licensing of such facilities and allow for the “reimbursement of expenses incurred in the collection, storage or distribution of ova or sperm, except any such expenses incurred by their donor.” The maximum storage period for frozen embryos has been variously debated. The Royal Commission suggested that it would be unethical to store beyond five years or after the death of either partner. One might also argue that time limits be applied to the storage of sperm and ova. Moreover, the personnel for such storage banks should be qualified in the handling, processing and distributing of such sensitive “materials.” The personnel also might be subject to government regulation. To ensure that qualified personnel are employed and that facilities are properly maintained and managed may require government licensing and regulation.

D. EMBRYO RESEARCH

Ovarian stimulation and ovum retrieval usually lead to the generation of a number of embryos, one or some of which are selected and implanted into a woman. It has been generally recognized that the treatment of “spare” embryos is an important matter of human dignity and integrity. As previously discussed, embryos, as potential human life, have moral status somewhere in between property and full personhood, and should be treated with respect. In light of the moral status of embryos and the potential risks to society, research on them may be totally prohibited, or at least, carefully regulated and monitored. Some have argued that ova should not be fertilized for the sole purposes of embryo research, except in unusual circumstances as determined by a regulatory body where knowledge cannot be attained by other means, and where such research would benefit society as well as future children. Others have argued that the fertilization of ova for research should be widely permitted in that it could advance scientific knowledge and benefit society.

The commercialization of embryo research has also been generally recognized as immoral. The selling and buying of sperm, ova, and embryos has been widely condemned in Canada and abroad. Proposed federal legislation, Bill C-47, would impose criminal sanctions for the sale, purchase, barter or exchange of gametes and embryos, whether for research or other purposes. It is acknowledged, however, that some expenses or compensation for losses incurred would be necessary to ensure minimum supplies for embryo research, if allowed. Article 25 of the CCQ states that “[a]n experiment may not give rise to any financial reward other than the payment of an indemnity as compensation for the loss and inconvenience suffered.” Some commentators support the allowance of “out-of-pocket” expenses and non-profit costs for storage, handling, transportation and transfer.

Bill C-47, by contrast, would allow for the “reimbursement of expenses incurred in the collection, storage or distribution of ova or sperm, except any such expenses incurred by their donor.” Existing and proposed statutory law for gamete and embryo donation, however, rather vaguely define such terms as expenses, compensation, or losses.

A primary issue of public concern is the age limit of embryos subject to research, in light of the initial development of nervous systems and possible human suffering. It has been recommended that any research be limited to emp-
bryos not older than 14 days from conception — which is also the stage at which implantation no longer becomes medically viable. As discussed previously in section IV.A “Informed Consent” of this chapter, donors must provide informed consent specific to the purposes of research on gametes and embryos. Consent for embryo donation for research purposes should be clearly expressed and in written form. Informed consent may require that donors be aware of specific research uses, as well as a range of options, including gestational use, donation to other women, or disposal. It has been recommended that “a very high level of disclosure” be required, including success rates and the range of possible negative outcomes where known.

Various concerns have also been raised over women and men being unaware of embryo research specifically, and biotechnology generally, in light of their social implications.

Some provincial statutes expressly regulate the use of such materials for research. For example, art. 22 of the CCQ stipulates that “a part of the body, whether an organ, tissue or other substance, removed from a person as part of the care he receives may, with his consent or that of the person qualified to give consent for him, be used for purposes of research.” Under s. 4(1) of the Ontario Human Tissue Gift Act, a person may consent to have his or her body or body parts removed and used for “medical education or scientific research.” According to ss. 5(2) and (3), where the deceased person has not given consent and dies, or cannot give consent by reason of injury or disease, and the person’s death is imminent, the Human Tissue Gift Act allocates dispositional authority according to a hierarchical list of family members, relatives, or other authorities in possession of the body. There must, however, exist reason to believe that the deceased person would have objected. In the case of embryos, proposed s. 7(3) of Bill C-47 would require consent by the “producers” of embryos for the specific purpose of research.

226 Ibid., at 17-18.
227 Ibid. Pre-implantation genetic diagnosis involves the use of in vitro fertilization and the testing of embryos for genetic abnormality prior to implantation in a woman’s body.

V. CONCLUSION

Reproductive technologies raise a myriad of legal, ethical and social issues with which society must contend. These include questions about who should have access to their use, how to control the disposition of excess embryos and whether women should be inseminated with the sperm of men who are now deceased. Finding answers to these issues is difficult, in part, because there is no social consensus concerning which acts and practices should be permissible. As we have suggested in this chapter, while some of the legal questions generated by reproductive technologies might be adequately resolved by applying existing common law principles and statutes to them, there is a widely held sentiment, that a direct legislative response is needed. Legislative intervention would ensure respect for the fundamental values of Canadian society, protect the public against risks to health and safety, and provide clear principles of law according to which potential disputes could be resolved.

The design of a legislative response to reproductive technologies in Canada remains a difficult enterprise. We need to assess the effectiveness of different types of law to answer problems raised by RTs. For example, the use of criminal prohibitions rather than more flexible regulatory regimes need to be considered. In addition, there may be a danger in assuming that new laws enacted by Parliament or legislatures can adequately address all of the problems raised by RTs. It has been argued that the challenge posed by RTs “is to harness the law so as to mediate between moral imperatives and the therapeutic or non-therapeutic benefits of the advancement of science.” How can we fashion a regulatory regime “which incorporates a review of the ethical and social consequences of the technology” in addition to ensuring its safety and efficacy? The fact of Canadian federalism further complicates the possibility of a national and uniform approach to the regulation of reproductive technologies. On the other hand, in the absence of a legislated regulatory framework, the development of case law may be more susceptible to differing interpretations and policy preferences in the different jurisdictions under Canadian federalism. Here, the traditional role of the federal government in regulating medical technology overlaps with the exclusive provincial role in the provision of medical services.

The commodification of gametes and embryos and the commercialization of human reproduction raise pressing concerns that cannot be left to market forces and an order of private law. Any regulatory regime must flexibly account for the social and biological dimensions of reproductive technologies, in light of the Canadian Constitution and evolving societal norms. At the same time, medical research and technological developments ought not be overly constrained or “chilled” because of regulation. Canadians will likely be affected by develop-

ments outside Canada's borders. Conflicting and inconsistent precedents both from Canadian and other common law jurisdictions are likely to leave a de facto situation of market regulation with private ordering as the default. Moreover, given the central role played by medical practitioners in offering and providing reproductive technologies, any form of piecemeal private ordering is likely to leave in place the medical model as the dominant model of decision-making. Once private ordering and market forces become entrenched it may be very difficult to put in place an alternative statutory regime and a distinctive form of administrative regulation.

The Royal Commission and other commissions and panels have raised concerns over reproductive technologies before the public. If reproductive technologies are a response to infertility, it should be recognized that infertility is as much a social condition as a medical problem. Bill C-47, which died on the order paper, provides an initial basis from which legislators might attempt to coordinate a comprehensive regulatory regime that respects the profound social consequences of reproductive technologies. Any such regime should carefully account for the responsible gatekeeping of new forms of family and the effects on personal and social lives. It remains to be seen whether a distinctive Canadian regulatory regime will be fashioned in this area.

The Human Genome Project is a massive scientific endeavor designed to sequence and eventually map the human genetic code. Once this mapping of the "genetic landscape" is complete, scientists will then concentrate on identifying the actual biological function of each gene. This will facilitate a revolution in medical diagnostics, screening, and therapies for genetic disorders.1

While the possible benefits of the project are immense, the sensitive nature of the data has potential for significant harms (whether unintentional or intentional). Indeed, concern for the proper use of genetic information has raised several key policy dilemmas. For example: what are the implications for autonomy and privacy?; what is the legal status of human genetic material i.e., is it property or person?; what are the social and legal implications of DNA forensic identification testing in criminal and family law cases?; is there a risk that insurance companies will inappropriately use genetic information for risk assessment?; and does genetic information have the potential to be used to justify discriminatory practices in employment settings?

This chapter seeks to review these and other issues. Through the review it will illustrate not only the different areas of law affected by the new human genetics but also the need for an over-arching ethical framework to address such problems.

II. BACKGROUND

A. GENETICS

Proteins are the building blocks of the human body. They are present in many forms throughout the human body and they can be found as enzymes, hemo-

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