I will begin by explaining the context of the two-year study of legal aspects of medically assisted procreation sponsored by the Law Reform Commission of Canada (L.R.C.). I will then summarize some major findings, and conclude with some of our recommendations.

The views of the Commission are contained in a Working Paper, soon to be released. Our study of medically assisted procreation flows from prior and continuing work of the Law Reform Commission. We began as an institution in 1971, when Parliament charged us with a broad mandate to study the federal laws of Canada, so as to recommend modernization, improvement, and reform. Over the years, we have devoted attention to national health law issues implicating fundamental values of Canadian society that our legal system is designed to protect.

Primary among these values are liberty, justice and equality. These are fundamental not simply because they have intrigued the classical philosophers, nor simply because they have fuelled sweeping revolutions. Rather, we today hold them as fundamental values, because they have been bequeathed to us as ideals of the democratic state and as workable principles of law. This is the promise of the Canadian Charter of Rights and Freedoms.

Equality: what does the societal commitment to it mean in terms of access to the technologies? Liberty: if it denotes the right to be free from forced obstetrical interventions or from non-consensual, eugenic sterilization, does it include a procreative right to contract for surrogate mother arrangements? Justice: what is fair, caring treatment of frozen surplus human embryos, if we do not consider them as tissue or as children for purposes of donation, divorce, or inheritance?

The questions are many; the answers, scant or elusive. Still, I would submit that if we allow some of the fundamental values now enshrined as legal principles in Canada to be our guides, they will prove able. They help to frame questions and analyses that distil answers. They tend to gain cogency and speak their particularized meaning, when complemented and challenged by other fundamental values and principles. The clash of these values has resounded in debates in the last decade over national protection of life concerns like brain death, euthanasia, psychosurgery, status of the foetus, and human experimentation.

In our work, we have found that medically assisted procreation resembles such issues. It fits the familiar pattern of unremitting medical innovation making anachronisms of societal rules and conventions. Society again seeks to apply bioethical, theological, and humanitarian perspectives, to help save patients and humanity from being tyrannized by beneficial medical technology. There are also the tragic figures — the families of Baby M, Baby Dawson and Karen Ann Quinlan — caught beyond our legal, medical and bioethical frontiers. Their personal struggles fascinate and horrify, in part, because they touch universal values that bind our communities.

Medically assisted procreation bears many of these tell-tale signs. Yet, it differs. Its internal dynamics pivot around a primordial yearning to create that child-parent relation, which nurtures much of human identity.

It is within these contexts that the Law Reform Commission has studied medically assisted procreation. We find, in other vibrant health law controversies of the day, both likenesses and differences in the questions, values, and principles at issue here and in the search for equality, autonomy, fairness, and the protection of life. Our study thus flows from the
broader effort of Canadian society, to define the roles and requirements of law in the face of modern riddles posed by revolutions in the biomedical technologies over the last quarter century.

Against this background, let me turn to some of our findings. Through our research, we generally sought to discern the relevant medical facts, the evolving law in Canada and abroad, and the role of government.

**Medical Findings**

Our study focuses on artificial insemination, in vitro fertilization (IVF) and surrogate motherhood, as innovative procedures to treat infertility and the risk of genetic disease transmission. Perhaps because of our bias for the protection of life, we were appalled to learn that sperm from an HIV positive donor in Vancouver had been used to inseminate 40 women, two of whom recently found to be HIV positive. As will be shown, this is not an isolated incident.

The benefits of IVF also captured our attention. As a less established, more complicated and invasive procedure than artificial insemination, information on IVF benefits is important. Yet, the information conveyed by so-called “IVF success rates” strikes us as inherently confusing: first, because clinics do not speak the same language — they share no standard or uniform method of reporting; secondly, because doctors and patients do not speak the same language. How meaningful, then, is an unqualified 20% success claim? Does it refer to live births or to chemical, clinical, or viable pregnancies, per hormonal treatment, per egg retrieval, or per embryo transfer?

The likelihood of confusion is compounded by the reality that all patients do not progress from one phase of an IVF treatment cycle to the next. For example, consider 200 patients entering a program with a stated “20% per embryo transfer success rate”. Most might reasonably assume that 20% of the 200 (40 patients) will take home a baby. In fact, because hormonal and egg retrieval treatments are not effective on all patients, an estimated 40 will drop out at the hormonal treatment phase, and 24 at the egg retrieval phase. This would bring 136 patients to the embryo transfer stage. There, applying the 20% embryo transfer figure means that 27 of the initial 200 — not 40 — patients are likely to become pregnant. Fewer than 27 will actually take home a baby due to apparently higher IVF rates for still births and miscarriages. Yet, if the full statistical subtleties and realities each IVF patient faces are not thoroughly explained beforehand, the ambiguity and confusion inherent in success rate claims would seem to make them fertile grounds for abuse.

**Legal Findings**

Canadian law may offer some help by, its proposition that a full standard of disclosure applies in respect of informed consent to elective, innovative medical therapy. But as helpful as this case law suggestion is, it also underlines the difficulty patients face in societal transition towards a clear, coherent, comprehensive legal regime for medically assisted procreation. For one obvious conclusion that emerges from our legal survey is that Canada has yet to articulate such a regime. This contrasts with obvious advances in this regard in Australia, Germany, Spain, and Britain.

Hence, Canada now depends on a veritable patchwork of laws — ranging from adoption, medical records, quarantine, and human rights statutes to general medico-legal principles, civil and criminal code provisions — to address the bewildering challenges of medically assisted procreation. Those specific provisions that address these issues are helpful rarities.

Because we chiefly rely on this patchwork regime of laws not designed for these technologies, however, important legal questions that they present often remain unresolved. For example, if it is clear that the Criminal Code provisions on kidnapping and child abduction generally do not address surrogate mother contracts, it is less clear whether gametes fall under the sales prohibitions of existing tissue transfer laws. These legal uncertainties and voids imperil the rights, interests and welfare of children, women, and other affected parties.

**Role of Governments**

In our view, the state in a democratic society bears the burden and privilege of reforming the law, removing unnecessary legal ambiguity, and seeking a just allocation of rights, duties and protections. Its law reform roles complement its duties as lawmaker and arbiter of legal disputes. Beyond these basic legislative and judicial functions, the state may influence medically assisted procreation in various capacities: through provincial government roles, such as administering birth records and filiation law or
providing fertility services; and through federal 
government roles, such as funding infertility 
research, policing unsubstantiated health 
claims, and/or certifying the safety of fertility 
drugs.

In addition, the federal government has an 
important role to play in promoting the national 
interest. First, the federal government, since 
confederation, has been involved in the 
protection of life through its criminal law 
powers. This means it has been vested with 
responsibilities for protecting human integrity 
and human life forms. Secondly, the federal 
government has the power and the duty to 
protect and promote equality and other 
fundamental Charter rights. Thirdly, the 
importation and exportation of human gametes 
or embryos, apart from raising national public 
health concerns, involve international and 
interprovincial transfers over which the federal 
government has responsibilities. Finally, the 
creation of this Royal Commission also 
highlights the federal role in advancing national 
debate and inquiry, and in fostering coherent 
national policy and law. These public roles and 
duties persuade us that between the polar 
extremes of the intruder in private procreative 
choice and the defender of the public interest, 
government today should play a diversity of 
roles to nurture procreative and family health.

Recommendations

On the basis of such findings, we conclude that 
legal and public policy reforms are in order. 
While the precisions will be detailed in our 
forthcoming Working Paper, permit me to profile 
five areas of recommendations.

Commerce and “Surrogate Mother” Contracts

First, we are strongly of the view that the 
human body, human gametes and embryos, and 
on-profit entities that operate on a principle of 
reimbursement for reasonable expenses.

We would also dissuade parties from making 
so-called “commercial surrogacy” contracts. As a 
matter of law and public policy, such contracts 
should be null and void. Knowledge that these 
contracts are unenforceable should help to 
discourage them. As for further discouragement, 
we are of two minds about using the criminal 
law.

On the one hand, we are persuaded that 
imposing criminal liability on parties to 
surrogacy contracts may do more harm than 
good, and may not prove effective. On the other 
hand, a majority of Commissioners recommends 
that paid intermediaries assisting these contracts 
be subject to criminal liability. This reflects the 
view that the stigma, deterrence and enforcement 
potential of the criminal law promise to exact the 
most telling effect on mercantilist intermediaries 
who promote the commercial transfer of parental 
rights and responsibilities. A minority of 
Commissioners would decline using the criminal 
law even against commercial intermediaries, on 
the view that regulation may contain the ills of 
commerce.

Access and Human Rights

Secondly, we believe that government should 
play a supportive role in nurturing procreative 
and family health. It must do so consistent with 
human rights.

The Supreme Court of Canada has yet to 
pronounce on the full meaning of procreative 
liberty and equality. In our analysis, however, 
we assume that individuals have procreative 
rights and freedoms that are likely protected by 
the Charter and by human rights statutes. We 
also assume that society has pressing and 
substantial interests in the material and 
psychological well-being of children born by 
medically assisted procreation.

The societal interests in protecting children 
and in promoting human rights are sometimes 
portrayed as colliding in the context of questions 
over access to these procreative technologies. 
Should government, in the name of protecting 
children and the traditional family, limit access 
to married individuals? Should stable couples 
and single parents, of either sexual orientation, 
also have access? The issue is divisive, as 
en evidence by the opposing views taken by the 
Canadian Advisory Council on the Status of 
Women and Quebec Status of Women, on single 
women access. Abroad, most jurisdictions would
not require marriage as a criterion for couples to participate; however, many would exclude single women and homosexuals.

Our understanding of human right principles and persuasive trends in Canadian family law has led us to conclude the following: we recommend that individuals should have an equal right of eligibility to benefit from medically assisted procreation services. Reasonable limitations on access — legitimately undertaken for economic or allocation of scarce resources purposes — (a) should not be used as a pretext for discrimination on the basis of family status, marital status or sexual orientation, and (b) should otherwise accord with basic human rights and fundamental principles of justice.

Registries and Success Rates

Thirdly, reforms are warranted to improve the quality of statistical information. For example, the current lack of easily accessible statistics — on annual procedures performed, general outcomes, interprovincial and international transfers — disables the public, government analysts, and even medical professionals from rigorously evaluating IVF in Canada. This contrasts with developing national registries for organ transplants.

More fundamentally, the current fashion of reporting IVF success rates has grave implications for patient autonomy, plain fairness and informed decision making. The omissions, ambiguities and inconsistencies in current IVF success rate claims frustrate the goal of clear and accurate doctor-patient communications. At best, the practices only foster confusion. At worst, they seem inherently misleading, breed false expectations and the uninformed assumption of risks. This is because the inaccuracy distorts the patients’ consent, by distorting the risk-benefit calculus on which patients reasonably rely to protect themselves through their legal right to informed consent. Beyond any physical, emotional or financial harms these practices may foster, they seem corrosive of the patients’ trust.

We, accordingly, recommend that the reporting of IVF success rates be standardized, as part of required routine reporting of specified information to a central registry. We consider this a measured response, when contrasted with recent U.S. governmental prosecution of clinics for unfair, deceptive promotion of success rates.15

Public Safety — Screening and Imports

Fourthly, reforms are warranted to protect human life and the public health. In our view, the recipients of donated gametes and the public share a compelling interest in proper donor screening and documentation. The failure to keep accurate medical records may mean we cannot trace contaminated gametes from donors, to recipients, to offspring. Indeed, lax, inconsistent, and sometimes scientifically unfounded donor screening practices for genetic and infectious diseases have been documented in Canada and abroad.16 The want of minimal uniform standards may also prove injurious. Indeed, recipients of donor semen have been infected with chlamydia, gonorrhea, herpes, and the HIV and hepatitis B viruses in Vancouver, Australia, Denmark, and Britain.17

A more recent report comes from New York City, where HIV infected semen from six donors was used in 178 women.18 One woman was recently found seropositive. We are not immune from U.S. practices because we have been importing semen since at least the early 80’s, when a national call for federal import quality controls was first sounded.19

Must Canadian society await further insemination tragedies before enacting minimal national requirements to protect potential recipients, offspring and the public health? We think not. We recommend the immediate development of national regulations for donor screening, and for the collection, processing, storage, documentation and international transfer of gametes and embryos.20 As part of related protection of life concerns, we recommend that legal ambiguity over the status of frozen gametes and embryos be minimized through informed consent documents that specify the agreed (a) conditions of donation or deposit (b) potential uses, and (c) disposition in case of death, divorce or like eventuality.

National Reforms, National Structures

Fifthly, we believe that such reforms will prove most effective if implemented nationally. Guidelines from national medical groups and the recent reforms proposed by the Uniform Law Conference proceed in this direction. The public process and report of this Royal Commission shall also shape Canadian public policy and law.

To continue this direction, we recommend
that the federal, provincial and territorial governments seriously examine the possibility of establishing a national organism for implementing reforms. The organism might be charged with such responsibilities as establishing national IVF reporting standards and a national registry, advising government, encouraging studies on the long-term medical and psychological effects, overseeing the licensing of clinics and gamete and embryo banks.

In urging this approach, we believe that both the consuming public and health service providers have particular reasons for supporting national government standards. Consumers seem likely to welcome initiatives that enhance public safety, and that simplify and make accurate the technical information they need to make informed health decisions. Thus, minimal, uniform standards for IVF success rates and donor screening should help patients understand the benefits and risks of infertility treatments.

Service providers, as shown in the past, also have legitimate reasons for supporting reasonable government legislation and regulations. Fertility professionals who contribute to such initiatives help to standardize and to certify services for both the public and the profession. National regulations may thus help to (a) protect or upgrade professional integrity; (b) equalize minimal requirements to be met by every practitioner; (c) remove administrative and economic burdens of complying with inconsistent or conflicting regional requirements; and (d) facilitate patient-provider relations, by advancing public trust and confidence.

Conclusion

In conclusion, I wish to leave you with a few thoughts on the tension between the paralysing moral conundrums and compelling legal needs occasioned by medically assisted procreation. The tension speaks to how we, as a society, devise and implement just and able reforms in this delicate domain.

On the one hand, questions about the moral status of the frozen embryo or the proper role of positive genetics invite the deepest ethical musing, societal self-examination, and scrutiny of values. On the other hand, the race of technology, the quiet suffering of the needy, and a legal uncertainty that unacceptably compromises rights, duties, and protections — all compel society to fashion timely, even if imperfect, initial responses.

We would submit that the task of devising just and able reforms requires us not to be paralyzed by the deep, healthy moral questioning. Again, insights from prior national medico-legal riddles should prove helpful. We shall also be as obliged to draw on our most fundamental values and principles, as upon our ability to rethink the assumptions and values that modern practices unsettle. And our analytic mind should lead us to look beyond our communities, to borrow helpful foreign experiences.

In this sense, foreign experiences recently influenced our views on national safety standards. We had learned domestically that Health and Welfare Canada has national regulations for the donation, screening, storage and shipping of blood. We wondered whether similar standards might be developed for gametes. We then looked abroad, and learned of national and regional sperm bank regulations in foreign countries. We also wondered about borrowing from such models.

More recently, we learned of an experience that initially seemed foreign to our thoughts on these issues. Last year, Canada exported over 1200 frozen animal embryos and 2,000,000 doses of animal semen, under a national regulatory regime. It licenses some 48 domestic reproductive transfer services and requires permits for the import and export of fertilized and unfertilized gametes. This past June, Parliament updated this disease control regime, the Health of Animals Act. Should we not wonder about borrowing from this protection of life model, as well?

Our conclusion is simple. The demands of law reform and the societal challenges presented by these modern technological imperatives, together, oblige us to draw lessons from all reasonable, relevant models for structuring our national response to human medically assisted procreation.

On behalf of the Law Reform Commission of Canada, I thank you for the opportunity to share our thoughts and views. I shall be pleased to respond to any questions you may have.

Notes


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3. See Divorce Act, R.S.C. 1985, c. 3, (2nd Supp), ss. 2, (am. R.S.C. 1985, c. 27 (2nd Supp) s. 10; 1990, c. 18, s. 11), 16.
8. Crime Against the Foetus, supra, n. 2.
11. See, for example, The Children’s Law Act, S.N. 1988, c. 61, s. 12 (non-parenthood between anonymous sperm donors and children born of artificial insemination) and Uniform Law Conference of Canada, Uniform Child Status Act.
14. Ibid.
17. Ibid.
20. Compare, Biomedical Experimentation, supra, n. 9 at 54 (calling for sperm and embryo bank standards).
22. Ibid. at 23-24.