

RECENT DEVELOPMENTS: LEGISLATIVE REFORMS IN REPRODUCTIVE TECHNOLOGY

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I. INTRODUCTION

The search for ways to alleviate infertility dates back to the Bible, but it is only since the freezing and storing of human genetic material became possible in this century that scientific techniques to assist conception have attracted the attention of jurists. Even then, relegated to the domain of science fiction, or limited to discussion of the possible illegitimacy of offspring, governments have been slow to react.

In spite of some sporadic studies commissioned ten years ago to examine the legal implications of artificial insemination, it was well after the birth of the first baby by *in vitro* fertilization that the legislative debate began. This debate, fuelled by the renaissance of the abortion controversy, has focused attention away from the therapeutic indications of reproductive technology as pertaining to the individual needs of the infertile. While it is appropriate that the focus be on the protection of human life, its translation in the numerous bills and commission reports around the world is either into open-ended State control or, more often, into categorical legal restrictions.

These approaches reflect the difficulty of balancing the respect for the autonomous decision-making of individual participants with the need for regulation of the scientific "reprotech industry". Consequently, the revolution is not so much based on the techniques themselves as on the challenge their utilization poses for law makers in terms of determining the scope of rights and freedoms provided under our laws. As will be seen in Part II of this study, framed in terms of claimed "rights", expectations and legal liability, these developments can only lead to the further medicalization of reproduction.

Concern for the protection of human gametes or embryos from possible abuse has been translated by the commissioned studies and bills into numerous pronouncements on the value of human life. An expanded role for national governments in the regulation of health institutions and in the scrutinization of participants is thereby extended to the control of the donation and disposition of human embryos. The State, while offering protection to the child-to-be and prohibiting or limiting certain contractual relationships, such as surrogacy, would play a much greater role in the reproductive life of its citizens under the proposed reforms, heralding what may be termed the "judicialization of pregnancy" examined in Part III of this study.

Current proposed reforms place the emphasis on greater legal intervention rather than on educating the public as to the moral and legal responsibility of choosing to become a parent or on encouraging or even mandating procreative responsibility with respect to the exercise of such choice — a choice that would foster a greater "parental conscience".

Reproductive technology may then serve as the final catalyst, or excuse, for the furtherance of these two trends: the already present medicalization of reproduction and the judicialization of pregnancy. Taking as an illustration current reports, proposed bills, or legislation already in force in Canada, Australia, England, United States and France, as well as

in the Council of Europe, we will see that in the name of protecting the “unconceived” or conceived-but-not-yet-implanted, State control of the person, namely the woman’s bodily freedom and autonomy, is expanding. Is it still possible to avoid the growth of a “reprotech industry” and yet prevent State screening of the private, personal and procreative lives of its citizens?

II. REPRODUCTIVE TECHNOLOGY AND THE MEDICALIZATION OF REPRODUCTION

A. *Introduction*

The institutionalization of reproductive technologies requires the elaboration of an administrative and regulatory framework at both the local and national levels. Not one of the jurisdictions under study would leave the administration of such technologies free from governmental regulation. Instead they advocate either direct legislative intervention or the development of professional norms. Therefore, the regulation and standardization of services is generally considered to be of primary importance. Indeed, the possibility of the exploitation of those seeking treatment, or of treatment being rendered by unqualified persons, makes such regulation necessary. However, the reports, in their attempt to find a basis for controlling access by individuals or couples to these procedures, have put forward a variety of medical and social criteria for eligibility.

Once accepted into a government approved programme, and having met the particular criteria for eligibility, further control could be exercised at an institutional level with regard to the quality of the genetic material of the participants. Long term evaluation of this quality would also be made possible since, as we will see below, there is unanimity in the reports on the issue of mandatory record keeping.

These two areas of regulation — access and record keeping — involve the larger questions of the right to personal privacy and of the liberty and responsibility of the person. Does the participation in such programmes constitute a partial, if not complete, forfeiture of such rights or responsibilities? To acquire access, must a potential participant conform to those social norms implicitly or explicitly contained in the proposed legislation?

B. *Regulation and Access*

1. *Introduction*

Legislative interest in questions specific to the rights of the individual to donate or control the uses of human genetic material overrides the issues of public policy, distributive justice, costs and benefits, and most importantly, the issue of access to these procedures. Nevertheless, at present, in most countries the clinics or individual physicians offering such techniques are not subject to governmental regulation or surveillance. It therefore remains to be seen what regulatory administrative structures and what criteria for eligibility are being recommended.

2. Administrative Structures

Common to all studies proposing administrative structures is a review of the legitimization or modification of current organization of services and second, of the persons who may offer these services.

(a) Organization of Services

Generally, recommendations regarding governmental surveillance or regulation center on questions of the possible statutory legitimization of reproductive technologies and of the banking of human genetic materials.

(i) Legitimization

The overwhelming majority of reports have not recommended that reproductive technology itself be formally legitimized and legalized.¹ Rather, the legality of such techniques seems to be taken for granted and the emphasis placed on legislation clarifying and adopting already existing standards of practice,² or on leaving such standards to be determined by

¹ A notable exception is the recent Ontario Law Reform Commission Report which states in recommendation 1: "[a]rtificial conception technologies, that is, artificial insemination, *in vitro* fertilization, and *in vivo* fertilization followed by lavage, should continue to be available and accepted as legitimate techniques to be used. . . ." Ontario Law Reform Commission, *Report on Human Artificial Reproduction and Related Matters*, vol. 2 (Toronto: Queen's Printer, 1985) at 275 (Chair: D. Mendes da Costa) [hereinafter OLRC Report]; see also Ethics Committee of the American Fertility Society, *Ethical Considerations of the New Reproductive Technologies* (1986) 46 FERTIL. & STERIL. 89S: "[i]n Vitro fertilization for infertility not solvable by other means is considered ethical." [hereinafter *Ethical Considerations*].

² Canada: see recommendations 6, 8, 9, 16, 17, 18, 22, 23, 24, 29, 31, 33, 34, OLRC Report, *ibid.* at 275-80; see also section 25 of the proposed *Human Artificial Insemination Act*, Saskatchewan Law Reform Commission, *Tentative Proposals for a Human Artificial Insemination Act* (Saskatoon, November 1981) at xv (Chair: R. Cuming) [hereinafter *Sask. Proposals*]; recommendations 2 and 3, Health and Welfare Canada, *Report of the Advisory Committee on the Storage and Utilization of Human Sperm* (April 1981) [hereinafter *HW Can. Report*]. Australia: recommendation I, paragraph 4.6, New South Wales Law Reform Commission, *Artificial Conception: Human Artificial Insemination* (Report No. 1) (June 1986) [hereinafter *NSWLRC Report*]; *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163 (assented to 20 November 1984; however, only sections 1-3, 6(1)-6(4), 6(6)-6(8), 7-9, 24-33 are in force as of 10 August 1986). Great Britain: see Royal College of Obstetricians and Gynecologists, *Report of the Royal College of Obstetricians and Gynecologist Ethics Committee on In Vitro Fertilisation and Embryo Replacement or Transfer* (March 1985) [hereinafter *RCOG Report*] which states at recommendation 14.3(1):

The Committee recognises that to recommend the establishment of legislation designed to supervise the performance of IVF [*in vitro* fertilization] and ER [embryo replacement] may be viewed as an undesirable intrusion into the field of clinical practice. It is also very much aware of the dynamic state of the work and does not wish limitations to be placed on its proper development. Nevertheless it feels that this is a highly sensitive area where human life is being created under artificial circumstances and where there is scope for commercial exploitation of those who are longing for a child. It therefore recommends that legislation should be enacted which will give Secretaries of

professional norms.³ Most studies assume that the therapeutic nature of such procedures are subject to standard medical, ethical norms and would leave them within health plan cost structures. Interestingly, although the studies do not recommend that reproductive technology be legitimized and legalized, they all either provide for extensive regulation, or they recommend guidelines for artificial conception practices while limiting them to licensed institutions.⁴

State powers of supervision. It is possible that these powers would never be invoked but the Committee takes the view that carefully framed legislation now would be better than hastily drawn up laws at a later date.

United States: *see Ethical Considerations, supra*, note 1 at 10S-11S; *Alternative Reproduction Act*, H.R. 4554 (Mich. 1985); *Surrogate Parenting Act*, H.R. 4555 (Mich. 1985) (Michigan House Bills introduced 16 April 1985 by Rep. Richard Fitzpatrick); American Fertility Society, *Report of the Ad Hoc Committee on Artificial Insemination*, Model Legislation (November 1980) [hereinafter *Am. Fert. Soc. Report*]; *Sperm Bank Licensure and Regulation Act 1984*, Bill 5-359 (D.C.) (introduced by District of Columbia Council Member Ray on 24 January 1984). France: *see Proposition de loi tendant à faire de l'insémination artificielle un moyen de procréation*, 47 Sénat, 1re sess., 1978-79, art. 1. Council of Europe: Comité ad hoc d'experts sur les progrès des sciences biomédicales (CAHBI), *Principes provisoires sur les techniques de procréation artificielle humaine et sur certains procédés appliqués aux embryons en liaison avec ces techniques*, Annexe I, principe 6 (Strasbourg) (10 mars 1986) (Document de travail) [hereinafter *CAHBI 1986*]. This working document contains various principles reflecting different positions. They are therefore not to be taken as reflecting the official position of the Council. The Council did reach a consensus on some issues as found in its Recommendation 1046, *infra*, note 13.

³ If leaving such standards up to the profession allows for more flexibility, one can question the ability of the professional corporations to adequately sanction breaches of those standards. Canada: *see* recommendation 2, British Columbia, Royal Commission on Family and Children's Law, *Artificial Insemination*, report No. 9 (Vancouver, May 1975) [hereinafter *BCRC Report*]. Australia: *see* recommendation 2, paragraph 4.7, recommendation 4, paragraph 5.12, recommendation 18, paragraph 9.11, *NSWLRC Report, supra* note 2; recommendation 4 of South Australia Health Commission, *Report of the Working Party on In Vitro Fertilization and Artificial Insemination by Donor* (January 1984) [hereinafter *S. Austl. Report*]. Britain: *see* paragraph 2.17, Department of Health and Social Security, *Report of the Committee of Inquiry Into Human Fertilization and Embryology* (London: Her Majesty's Stationery Office, July 1984) at 14 (Chair: M. Warnock) [hereinafter *Warnock Report*]; paragraph 8.6, U.K., Council for Science and Society, *Human Procreation: Ethical Aspects of the New Techniques* (Report of a Working Party) (Oxford: Oxford University Press, 1984) at 84 (Chair: G. Dunstan) (hereinafter *Dunstan Report*). United States: *see Ethical Considerations, supra*, note 1 at 10S-11S; Conclusion No. 2(A)(1) of U.S., Department of Health, Education, and Welfare, *Report and Conclusions: Health, Education, and Welfare Support of Research Involving Human In Vitro Fertilization and Embryo Transfer* (4 May 1979) [hereinafter *HEW Report*].

⁴ Canada: *see* recommendation 3, *OLRC Report, supra*, note 1 at 275, which recommends that "artificial conception procedures . . . constitute the 'practice of medicine' and hence would be subject to standards set under the *Health Disciplines Act*, R.S.O. 1980, c. 196. However, recommendation 4 at 275 stipulates that "[p]hysicians should not be required to obtain a special licence or [sic] to practise in a specially licensed health facility in order to perform artificial conception procedures". Nevertheless, recommendation 17(1) at 277 states that sperm banks must be licensed; *see also* section 3, *Sask. Proposals, supra*, note 2 at vi, which would only allow artificial insemination to be practised by a "physician or medical personnel acting under the direct control of a

Some reports expressed the need for the establishment of a statutory body to advise the government generally on matters relating to reproductive technology.⁵ Others have recommended the establishment of statutory

physician"; recommendation 1, BCRC Report, *supra*, note 3 (no specific reference to licensing is made, but it does infer that such practices should be done by "physicians" and hence would be subject to licensing requirements for physicians.); Health and Welfare Canada makes general recommendations for the regulation of artificial insemination practices and, although not referring specifically to the necessity of licensing, does state in recommendation 2.5 "no new human sperm bank should be allowed to operate outside the jurisdiction of a university or other publicly owned agency", HW Can. Report, *supra*, note 1. Australia: see NSWLRC Report, *supra*, note 2, recommendations 1 and 2, paragraphs 4.6 and 4.7. This Report states that artificial insemination as a *practice*, as opposed to acts on an individual basis, should be restricted to the medical profession; however, the Report stipulates clearly that the "restriction would not prevent the administration of AI by recognised institutions such as family planning centres and skilled persons such as qualified nurses, provided that professional medical control or supervision is present"; Infertility (Medical Procedures) Act 1984 (Victoria), No. 10163, s. 7 (assented to 20 November 1984) (hospitals must be approved by the Minister); recommendation 6.3 (hospitals must be pre-approved) and paragraph 2.2 of Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising From In Vitro Fertilization, Report on the Disposition of Embryos Produced by In Vitro Fertilization (August 1984) [hereinafter Victoria Report]; Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising From In Vitro Fertilization, Report on Donor Gametes in IV Fertilization (August 1983) [hereinafter Waller Report], which sets out general regulations throughout the report; but specifically see section 3.4 with respect to qualified counsellors and section 6.27 which refers to authorized hospitals; paragraph B.1(iii), Queensland, Report of the Special Committee Appointed by the Queensland Government to Enquire Into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters, vol. 1 (March 1984) [hereinafter Queensland Report]; recommendation 7, S. Austl. Report, *supra*, note 3, which states that *in vitro* fertilization "should take place only in recognised hospitals approved specifically for this purpose by the South Australian Health Commission". Britain: see paragraph 13.7, Warnock Report, *supra*, note 3 at 77, which recommends the licensing of practitioners, and paragraph 11.18 at 64, which recommends licensing for those doing research on human embryos *in vitro*; paragraph 4.7, Dunstan Report, *supra*, note 3 at 41, which suggests that sperm and embryo banks should be subject to licensing and paragraph 4.9 at 42, which suggests licensing of AID and IVF clinics; recommendation 14.3, RCOG Report, *supra*, note 2, which recommends "[r]egistration of Persons Carrying out IVF and ER and Licensing of Premises where it is Performed". United States: see Ethical Considerations, *supra*, note 1 at 69S, which suggests that specific training and "continuing assessment of practitioner's skills" should be developed (licensing is not specifically mentioned); Sperm Bank Licensure and Regulation Act 1984, Bill 5-359, s. 3 (D.C.) (introduced by District of Columbia Council Member Ray on 24 January 1984). Council of Europe: see Annexe I, principe 6, CAHBI 1986, *supra*, note 2.

⁵ Australia: see Infertility (Medical Procedures) Act 1984 (Victoria), No. 10163, s. 29, which creates a Standing Review and Advisory Committee whose role is "to advise the Minister in relation to infertility and procedures for alleviating infertility", to approve experimental procedures and "any matters relating to infertility and procedures for alleviating infertility" (s. 29.6) (assented to 20 November 1984); recommendation 5.4, Victoria Report, *supra*, note 4, which advocates the creation of a Standing Review and Advisory Body on Fertilization, Reproduction and Related Matters "to examine and report on all matters in the field of the scientific and medical management of infertility, and related issues"; paragraphs 15.1, 15.2, 15.6, NSWLRC Report, *supra*, note 2, which defers the creation of an Advisory Committee whose function would be to collect accurate

licensing bodies to regulate and monitor such practices⁶ (these bodies could also have an advisory or an executive function). Some would go so far as to set up local ethics committees for the purposes of screening applicants or research projects within each institution offering infertility treatment.⁷ If instituted, this latter recommendation would subject applicants seeking access to reproductive technologies to a form of "strict scrutiny" not imposed on the general population seeking to procreate.

(ii) *Banking*

In Canada, the 1975 British Columbia Royal Commission on Family and Children's Law was the precursor in advocating a federal regulatory and supervisory role over banking facilities.⁸ A subsequent report in Canada recommended that only approved public institutions acquire and

information and "maintain an overview of all aspects of artificial conception" until completion of the reports on IVF and surrogate motherhood; *see also* Queensland Report, *supra*, note 4, which supports the creation of the Queensland Bioethics Advisory Committee whose primary role would be to "advise the Queensland Government through the Minister for Health, on ethical guidelines which should be observed by those undertaking research into human reproduction and human fetal development". The Report continues that "the need for a general supervisory and advisory body arises in part from the need to ensure that all persons involved in research into human reproduction and fetal development and in experimental clinical treatment of infertility are subject to the same ethical guidelines". Finally, the Council of Europe, in its Parliamentary Assembly [*Recommendation 1046 (1986)(1) on the use of human embryos and fetuses for diagnostic, therapeutic, scientific, industrial and commercial purposes* (26 September 1986)], recommended that the Committee Ministers "call on the governments of the member states . . . to facilitate and encourage the creation of national multidisciplinary committees or commissions on artificial human reproduction" (recommendation 14(A)(vii)) [hereinafter, Council of Europe, *Rec. 1046*].

⁶ See note 4 and accompanying text, *supra*.

⁷ Australia: *see* paragraph 6.2.1, National Health and Medical Research Council, *First Report by NHMRC Working Party on Ethics in Medical Research: Research on Humans* (August 1982) [hereinafter *NHMRC Report*], which recommended to the Ministers of Health of the States and Territories that it be mandatory for every institution in which medical research is undertaken to maintain an institutional ethics committee; Queensland Report, *supra*, note 4 at 46, which supports the NHMRC position, but states that "[a]t the same time, it considers that the range and complexity of the issues of an ethical character which have been or are likely to be thrown up by changes in medical technology, and the public policy implications of these issues are such that it would be insufficient to entrust their resolution to the ethics committee of particular organizations or institutions". The report then recommends the establishment of a Queensland Bioethics Advisory Committee (*see* Queensland Report, note 5 and accompanying text, *supra*). United States: *see Ethical Considerations*, *supra*, note 1 at 87S paragraph 1, which states: "[e]very group initiating a program of *in vitro* fertilization should have all aspects of the program approved by a properly constituted Institutional Review Committee." France: *see Proposition de loi relative au statut de l'enfant conçu ainsi qu'aux expérimentations et recherches concernant la création de la vie humaine*, Ass. nat. no. 2158, 2e sess., 1983-84, art. 7.

⁸ Canada: recommendation 21, BCRC Report, *supra*, note 3. United States: *see* recommendation 2, HEW Report, *supra*, note 3, which supported the same idea; it is worthy to note that no such recommendation was included in *Ethical Considerations*, *supra*, note 1.

store human gametes or embryos for certain periods of time.⁹ A decade later, the Ontario Law Reform Commission went further in recommending commercial banking, subject again to strict regulation and uniform standards of importation and exportation.¹⁰ The only other recommendation of like nature is that of the 1984 Warnock *Report* in England.¹¹

The Law Reform Commission of Ontario suggested that in the case of the death of a donor, or disagreement between a couple concerning the use or disposition of a fertilized ovum, legal control should "pass to the physician, clinic, gamete bank, or other authority that has actual possession of the ovum",¹² thereby extending the watchdog role of the government. Indeed, according to the Commission, approved institutions or licensed physicians would be free to dispose of such fertilized ova.¹³ "Orphaned" or "contentious" embryos would then be in the possession of the physician or bank and would become available for export or research donation, subject to regulation.¹⁴ Thus, the potential for a market economy of stored human embryos in the hands of individual physicians, clinics or banks could become a reality. This is supported by the fact that only a minority of the reports would prohibit the storage or freezing of embryos altogether.¹⁵

⁹ Recommendation 2.5, HW Can. *Report*, *supra*, note 2; *see also* paragraph VI, *Ethical Considerations*, *supra*, note 1 at 89S.

¹⁰ Recommendation 18, OLRC *Report*, *supra*, note 1 at 277.

¹¹ Warnock *Report*, *supra*, note 3.

¹² Recommendation 27(1)(c), OLRC *Report*, *supra*, note 1 at 280.

¹³ *Ibid.*; *but see* Council of Europe, *Rec. 1046*, *supra*, note 5, in its *Appendix, Rules governing the use of human embryos or fetuses and the removal of their tissues for diagnostic and therapeutic purposes*, recommendation B(d) suggests that "embryos and fetuses may not be used without the consent of the parents or gamete donors where the latter's identity is known".

¹⁴ *See* notes 1, 2, 3 and 4, and accompanying text, *supra*, concerning the subject of regulation. *See also* Council of Europe, *Rec. 1046*, *supra*, note 5, in its *Appendix*, which makes no mention of the export or import of embryos. *But see* notes 162-4, *infra*.

¹⁵ Australia: Under the *Infertility (Medical Procedures) Act* (Victoria), No. 10163, s. 6(6), there is a penalty of 100 penalty units or four years imprisonment for carrying out a "procedure that involves freezing an embryo". However, this provision does not apply to embryos frozen in an approved hospital with the intention of implanting them in a woman at a later date (section 6(7)); France: *see Proposition de loi relative au statut de l'enfant conçu ainsi qu'aux expérimentations et recherches concernant la création de la vie humaine*, Ass. nat. no. 2158, 2e sess., 1983-84, art. 4, which creates a total prohibition except where it is done in the interest of the child or mother; *see also* Comité consultatif national d'éthique pour les sciences de la vie et de la santé: *Avis sur les prélèvements à des fins thérapeutiques, diagnostiques et scientifiques de tissus d'embryons ou de fœtus humains morts*, (Paris) (avril 1984) 82; Comité consultatif national d'éthique pour les sciences de la vie et de la santé; *Avis sur les problèmes éthiques nés des techniques de reproduction artificielle*, (Paris) (23 octobre 1984) 81 at 84; Council of Europe, *Rec. 1046*, *supra*, note 5, recommendation 14(a)(iv) does not prohibit freezing and, indeed, it implicitly recognizes the legitimacy when it forbids the maintenance of *in vitro* embryos beyond the fourteenth day after fertilization "having deducted any time necessary for freezing".

(b) *Regulation of Practice*

Mention has already been made of the governmental supervisory role regarding the banking of genetic material, but it is important to note the proposed limitations which would determine where infertility treatment could be offered and by whom.

(i) *Licensing of Institution*

There is some agreement on the need to limit the practice of artificial conception to specially licensed health facilities.¹⁶ Again, the Law Reform

¹⁶ Canada: recommendation I(3), *Sask. Proposals, supra*, note 2 at 1-12, which suggests that artificial insemination by donor be carried out by a licensed physician "or by medical personnel acting under the direct control of a physician." (Note: this document refers only to AID), *see supra* note 4 and Australia: *see Infertility (Medical Procedures) Act 1984* (Victoria) No. 10163, s. 7(1), which would require "application to the Minister for approval of the hospital as a place at which relevant procedures of the class specified in the application may be carried out". Also, the following procedures must be carried out in an approved institution: *in vitro* fertilization of ovum produced by patient with semen produced by her husband (s. 10(2)), *in vitro* fertilization of ovum produced by patient with semen produced by a donor (s. 11(2)), *in vitro* fertilization of ovum produced by a donor with semen of the patient's husband (s. 12(2)), *in vitro* fertilization of ovum produced by a donor with semen of a donor (s. 13(2)). Furthermore, "[a] person who is not a medical practitioner shall not carry out a procedure of artificial insemination" (s. 17(1)) unless the procedure is carried out in an "approved hospital" (s. 17(2)); recommendation 3, *Victoria Report, supra*, note 4, paragraph 2.2, which states: "Freezing and storage of embryos shall only be undertaken in a hospital already approved to conduct an IVF programme, which is specially authorised by the Minister of Health to conduct such activities"; recommendation 6.27, *Waller Report, supra*, note 4, which advocates that "[h]ospitals should be specifically authorised to use donor gametes in IVF programmes"; recommendation B1(iii), *Queensland Report, supra*, note 4, which would allow "IVF and ET services only at centres licensed for that purpose by the Director-General of Health and Medical Services," and further recommends (B1(iv)) that the "number of centres established to provide this service be strictly limited"; recommendation 7, *S. Austl. Report, supra*, note 3 at 14, which states "IVF should only take place . . . in recognised hospitals approved for that purpose by the South Australian Health Commission"; Supp. Note 4, (1), *NHMRC Report, supra*, note 7, which states: "[e]very centre or institution offering an IVF and ET program should have all aspects of the program approved by an institutional ethics committee". Britain: *see* paragraph 13.7, *Warnock Report, supra*, note 3 at 77, which states: "[w]e recommend that all practitioners offering the services that we have recommended should only be provided under licence, and all premises used as part of any such provision, including the provision of fresh semen and banks for the storage of frozen human eggs, semen and embryos should be licensed by the licensing body"; paragraphs 4.7 and 4.9, *Dunstan Report, supra*, note 3 at 41 and 42 (respectively), which recommends that sperm and embryo banks, AID and IVF clinics, should be subject to licensing; paragraph 14.3(3), *RCOG Report, supra*, note 2, which postulates that: "[l]egislation should be enacted to register directors of institutions where IVF and ER is being carried out and also to license the premises." France: *see Proposition de loi tendant à faire de l'insémination artificielle un moyen de procréation*, 47 Sénat, 1re sess., 1978-79, art. 1; Comité consultatif national d'éthique pour les sciences de la vie et de la santé, *Avis relatif aux recherches sur les embryons humains in vitro et à leur utilisation à des fins médicales et scientifiques* (Paris) (15 décembre 1986) at 21-2 [hereinafter *Avis du Comité d'éthique*]; *see also* Council of Europe: Annexe I, principe 6, *CAHBI 1986, supra*, note 2: "[t]out acte

Commission of Ontario,¹⁷ along with one Australian State,¹⁸ take exception to this general rule, maintaining that artificial conception procedures constitute the practice of medicine. The Commission denied that “a further overlay of licensing, involving a new or expanded bureaucratic involvement in health care, is required to protect the community or its constituents”.¹⁹ Thus, while subjecting artificial conception to the monitoring of medical practice generally, private practitioners would be free to offer artificial conception services in private offices without a special licence.²⁰

The positive impact of this would be that most physicians in private offices would have to link up their services to licensed gamete banks or facilities. This would effectively decentralize the services and make such treatment available to a broader public. Those seeking access would not be forced to travel and incur increased costs, as is presently the case. The negative impact would be a greater chance of error, loss of samples and damage to genetic material in transit, not to mention loss of effective quality control.

(ii) *Licensing of Physicians*

Other studies not only limit the practice to certain licensed facilities, but also to licensed physicians.²¹ The underlying rationale for restricting artificial conception to licensed physicians is summarized by the Law Reform Commission of Ontario:

[W]hile, for example, the physical application of donated sperm is a relatively simple matter, the range of counselling, donor selection, and instruction of patients that should precede the procedure, and the subsequent follow-up care

requis par les techniques de procréation artificielle et les procédés appliqués aux embryons qui y sont liés doivent être faits sous la responsabilité d'un médecin et dans le cadre d'établissements agréés par une autorité compétente de l'État ou par une autorité créée par l'État à cet effet.” Recommendation 14(A)(vi), Council of Europe, *Rec. 1046, supra*, note 5 “call[s] on the governments of member states . . . to create national registers of accredited medical centres authorised to carry out such techniques and to make use of them for scientific purposes”. Furthermore, its *Appendix, supra*, note 13, maintains that “any use of the embryo or foetus must be undertaken by highly qualified teams in approved hospitals of scientific centres approved by the public authorities” (B(b))

¹⁷ Recommendation 4, OLRC Report, *supra*, note 1 at 275.

¹⁸ Recommendation 1, paragraph 4.6, NSWLRC Report, *supra*, note 2 states: “[w]e . . . recommend that legal regulation of AI should apply when it is *practised* publicly or for reward or by a person who holds himself or herself as prepared to perform it”; recommendation 2, paragraph 4.7 states: “[w]e further recommend that the practice of AI be restricted to the medical practitioners. Such a restriction would not prevent the administration of AI by recognised institutions such as family planning institutions and skilled persons such as qualified nurses, provided that professional medical control or supervision is present.” This would mean then that AI as an individual *act* would not be restricted while as a *practice* it would be.

¹⁹ OLRC Report, *supra*, note 1 at 153.

²⁰ *Ibid.*

²¹ See notes 4 and 16 and accompanying text, *supra*.

to ascertain its effectiveness, depend upon medical knowledge and skills. And where donated ova are required, the case for medical management of the procedure is obviously much more clear and convincing.²²

One Australian report²³ suggests that the restrictions imposed on the practice of artificial insemination would not prevent the administration of artificial insemination by recognized institutions such as family planning centres and skilled persons such as qualified nurses, provided that professional medical control or supervision is present. Nevertheless, unless a special case were made for self-administered artificial insemination, all of the other techniques of assisted conception require medical intervention. Presuming that the majority of these techniques will come under some medical supervision and control in order to protect the genetic material, the question as to what criteria would govern the eligibility of candidates remains a crucial one.

3. *Criteria for Participation*

Generally, the selection of participants for infertility treatment goes beyond medical indications and includes questions of marital status or psycho-social criteria. It is self-evident that this system of triage imposed on prospective patients (to say nothing of the lack of effective recourse in the case of refusal²⁴) constitutes a form of discriminatory selection not imposed on other members of the population when they decide to have a child.

(a) *Medical Criteria*

Medical admissibility criteria under most reforms would be either proven infertility or genetic contra-indications or age.

²² OLRC Report, *supra*, note 1 at 151.

²³ Paragraph 4.7, NSWLRC Report, *supra*, note 2.

²⁴ Canada: *see* recommendation 7, OLRC Report, *supra*, note 1 at 275, which states: "[g]iven the present variety of means by which grievances may be redressed, no additional or different means of challenge or appeal should be made available to a person who is denied access to artificial conception services"; *but see* recommendation 5, BCRC Report, *supra*, note 3, which states: "[i]f an applicant fails to receive acceptance as a recipient for artificial insemination, she should have the option to appeal to a tribunal constituted especially for this purpose. The tribunal should be representative of medicine, social sciences and appropriate agencies of government." Britain: *see* paragraph 2.13, Warnock Report, *supra*, note 3 at 12, which states: "[w]e recognise however that individual practitioners are on occasions going to decline to treat a particular patient and we recommend that in cases where consultants decline to provide treatment they should always give the patient a full explanation of the reasons. This would at least ensure that patients were not kept in ignorance of the reason for refusal, and would be able to exercise their right to seek a second opinion."

(i) *Infertility or Genetic Indications*

Proven infertility or sterility is a common medical requirement for admissibility for infertility treatment.²⁵ Most studies would also make such technologies available to those seeking to avoid the transmission of genetic disorders.²⁶ This implicit recognition of a genetic rationale under-

²⁵ Canada: see recommendation 1, OLRC Report, *supra*, note 1 at 275, which states: "[a]rtificial conception technologies, that is, artificial insemination, *in vitro* fertilization, and *in vivo* fertilization followed by lavage, should continue to be available and accepted as legitimate techniques to be used (except where a fertile and genetically healthy single woman receives treatment: see Recommendation 5) where medically necessary to circumvent the effects of infertility and genetic impairment."; recommendation 3, BCRC Report, *supra*, note 1, which states: "[i]n principle, eligibility for artificial insemination using an anonymous donor should be the same as for adoption." However, the Report mentions nothing with respect to medical need. Australia: see *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, ss. 10(3)(c), 11(3)(c), 12(3)(c), 13(3)(c) (these provisions were not in force as of 10 August 1986), which each require not less than twelve months of "examination or treatment by a medical practitioner (other than the medical practitioner by whom the procedure is to be carried out) as might reasonably be expected to establish whether or not a procedure other than a fertilization procedure might cause the woman to become pregnant"; paragraph 3.6, Waller Report, *supra*, note 4, which provides for admission only after "all other appropriate medical procedures, during a period in excess of 12 months" have been undertaken (see also paragraph 5.6); paragraph B.2(i) and B.2(ii), Queensland Report, *supra*, note 4, which states that the "couple should have sought alternative treatment for a period of at least two years"; recommendation 4, referring to Draft Guidelines AID No. 2, S. Austl. Report, *supra*, note 3 at 43, which states: "[t]he husband should have a thorough examination by a specialist experienced in male infertility and should have had at least three semen samples analysed."; recommendation 8, referring to Draft Guidelines in IVF No. 3 (at 50) states: "[p]articipants should have intractable or otherwise untreatable infertility, relatively long term infertility or infertility which has failed to respond to appropriate treatment." Britain: see also paragraph 2.4, Warnock Report, *supra*, note 3 at 9; paragraphs 3.2 and 3.3 RCOG Report, *supra*, note 2. United States: see paragraph I, *Ethical Considerations*, *supra*, note 1 at 89S. France: see *Avis du comité d'éthique*, *supra*, note 16 at 7; *Proposition de loi tendant à faire de l'insémination artificielle un moyen de procréation*, 47 Sénat, 1re sess., 1978-79, art. 5; *Proposition de loi relative au statut de l'enfant conçu ainsi qu'aux expérimentations et recherches concernant la création de la vie humaine*, Ass. nat., no 2158, 2e Sess., 1983-84, art. 3; Council of Europe: CAHBI 1986, *supra*, note 2, Annexe 1, principe 3(1)(a).

²⁶ Canada: see OLRC Report, *supra*, note 1 at 141-2, which states that "[t]o suggest that childlessness or dysgenic reproduction must simply be accepted as a necessary, albeit unfortunate, physical evil, and accordingly to prohibit treatment by means of artificial conception, would, in one sense, place infertility in a rather special category of affliction. It would do so because, under such a regime, it would be a disease for which treatment is possible, relatively safe, and often uncomplicated, but simply not permissible." Australia: see recommendation 7, paragraph 6.14, NSWLRC Report, *supra*, note 2; *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, ss. 11(3)(d)(ii) and 12(3)(d)(ii) (these provisions were not in force as of 10 August 1986); paragraph 5.6 Waller Report, *supra* note 4, which states that "it shall be unlawful for donor embryos to be used in IVF except in the case of couples whose infertility can not [*sic*] be overcome by other means, or where the couple may transmit undesirable hereditary disorders"; recommendation B.2(ii), Queensland Report, *supra*, note 4, which provides that an exception to the two-year treatment period mentioned at note 25 above would arise where "there was a known risk of a severe genetic disease or an obvious and otherwise irremedial bar to fertility";

scores the prediction that increasingly large numbers of the population (infertile or not), will be turning to artificial conception to attempt to ensure the genetic health of their future offspring. Moreover, since diagnostic services not readily available in the public health care system would be offered to those involved in treatment, couples or individuals seeking to have children at these centres would be advantaged in terms of pre-conceptual and prenatal diagnosis, surveillance and monitoring. The exact medical standards governing such indications would, for the most part, be left to be determined by the medical profession.²⁷

(ii) Age

With regard to an age criteria, the Report of the Law Reform Commission of Ontario is one of the few reports to endorse the possibility of using minors as sperm donors.²⁸ It would, however, prohibit minors from "undergoing any procedure undertaken deliberately to donate ova" except where obtained indirectly.²⁹ Only in the case of surrogacy would there be a requirement that women reach the age of majority.³⁰

Other reports do not discuss the question of age at all. They rely instead on the criteria of marital status as perhaps an implicit indication of legal age. These criteria fail to recognize or to condemn the current practice of refusing access to infertility programs to women who, due to advanced maternal age, would be at risk for foetal malformation or anomalies. Presently, this practice is justified on the basis of risk (to whom?) or on the basis of a scarce resource argument of respecting personal choice.

Draft Guidelines on AID No. 5, S. Austl. *Report, supra*, note 3 at 43, which states "[e]xpert genetic counselling should precede any decision to provide AID when the indication is one of genetic abnormality rather than infertility" (see also Draft Guidelines on IVF No. 7 at 50). Britain: see paragraph 9.3, Warnock *Report, supra*, note 3 at 48; paragraph 5.2, Dunstan *Report, supra*, note 3 at 47. Council of Europe: Annexe I, principe 3(1)(b), CAHBI 1986, *supra*, note 2.

²⁷ Canada: see recommendation 14, BCRC *Report, supra*, note 3. Australia: see paragraph 6.18, NSWLRC *Report, supra*, note 2; *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, which generally leaves standards up to doctors to determine, for example, paragraph 11(3)(d) states "as a result of that examination or treatment, a medical practitioner (other than the medical practitioner by whom the procedure is to be carried out) is satisfied that it is reasonably established" (only sections 1-3, 6(1)-6(4), 6(6)-6(8), 7-9, 24-33 of the Act are in force as of 10 August 1986); paragraph 3.6, Waller *Report, supra*, note 4; recommendation B(2)(v), Queensland *Report, supra*, note 4. Britain: see generally Warnock *Report, supra*, note 3, chapter 9 at 48-52; paragraph 5.2, Dunstan *Report, supra*, note 3 at 47.

²⁸ Recommendation 10, OLCRC. *Report, supra*, note 1 at 276; see *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, s. 25(1), which permits the use of gametes produced by children. Child is defined as a person not having attained eighteen years or not being married (s. 25(2)); paragraph 3.12, Waller *Report, supra*, note 4, which states that donations of gametes from children should be prohibited.

²⁹ *Ibid.*, recommendation 11 at 276.

³⁰ *Ibid.*, recommendation 41 at 282.

(b) *Marital Status and Social Criteria*

The "threshold issue"³¹ of marital status was debated before the various Commissions on two fronts. The first argument was based on the idea that the couple or family is the foundation of society or are necessary for the best interests of the child. The second argument, while not advocating an unfettered right to artificial conception, would condemn or condone the eligibility of single women.

(i) *Two Parent Norm*

The recommendations in the Australian and the English reports would require that any legislation specify that services be made available both to married couples and to those living in long term *de facto* relationships.³² The question of spousal consent or notification is also addressed, and most reports³³ and legislators³⁴ favour the requirement of obtaining such consent. Some would not legislate on the question at all but would leave the question to the physician who would be governed by "ethical guidelines".³⁵ Presumably, the profession itself would set such guidelines. Proposed legislation in France would go so far as to put all such decisions of admissibility before a local bioethics committee.³⁶

³¹ OLRC Report, *supra*, note 1 at 153.

³² Australia: see paragraphs 4.7 and 4.8, Waller Report, *supra*, note 4, stating that "[p]riority should be given to married couples, although couples living in a stable de facto relationship will not be excluded. Institutions licensed to provide an IVF service should be free to restrict it to married couples."; No. 3(a), NHMRC Report, *supra*, note 7 at 26-7, which requires "an accepted family relationship". Britain: see paragraph 2.6, Warnock Report, *supra*, note 3 at 10, which defines a "couple" as a "heterosexual couple living together in a stable relationship, whether married or not"; paragraph 5.1, Dunstan Report, *supra*, note 3 at 45-6; paragraph 3.1, RCOG Report, *supra*, note 2, which defines marriage as a "hetero-sexual couple cohabiting on a stable basis, whether or not legally married".

³³ Australia: see paragraph 3.5, Waller Report, *supra*, note 4; paragraph B.2(vii), Queensland Report, *supra*, note 4, which requires informed consent from both spouses to be recorded; recommendation 17, S. Austl. Report, *supra*, note 3 at 52, which adopts consent forms which clearly stipulate the need for the signature of both spouses, which must be witnessed. Britain: paragraph 3.5, Warnock Report, *supra*, note 3 at 16, which states that the consent of both partners is a "matter of good practice". United States: see paragraph II, *Ethical Considerations*, *supra*, note 1 at 89S, which speaks of a "couple" and of consent form to the "couple". But see paragraph 7.5, NSWLRC, Report, *supra*, note 2, which states that the husband's consent as a general requirement should not be prescribed. Canada: recommendation I(2), Sask. Proposals, *supra*, note 2 at 1-5, which states: "[t]he consent of an applicant's husband should not be a statutory prerequisite to her eligibility for artificial insemination."

³⁴ See *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, ss. 10(3)(b), 11(3)(b), 12(3)(b), 13(3)(b) (these provisions were not in force as of 10 August 1986), which all require consent of the donors in writing; *Artificial Conception Amendment Act 1986* (New South Wales), arts. 5(2)(b) and 5(4), which create an irrebuttable presumption of paternity where there is consent. This is also the case in the Province of Quebec by virtue of art. 586 C.C.Q., see note 94 *infra*. These provisions would seem to imply the necessity of obtaining the written consent of the husband in order to ensure the filiation of the child.

³⁵ Paragraph 7.5, NSWLRC Report, *supra*, note 2; see also Queensland Report, *supra*, note 4 at 108-9 and 145.

³⁶ *Proposition de loi relative au statut de l'enfant conçu ainsi qu'aux expérimentations et recherches concernant la création de la vie humaine*, Ass. nat. no 2158, 2e sess., 1983-84, art. 7.

Considering both the criteria for adoption currently in force and the human rights legislation of most countries, there is no doubt that any criteria based on marital status would be open to question on the grounds of discrimination.³⁷ Furthermore, the acceptance of the two parent norm as the ideal belies the social reality of non-exclusive parenthood.³⁸ It could also be asked whether the acceptance of *bona fide* common law relationships, in the absence of specific reference to male and female, would leave open the possibility of homosexual couples being granted access.

In 1981, the Law Reform Commission of Saskatchewan was alone in recommending that there be no legislative prohibition against offering artificial insemination by donor to the single woman.³⁹ In a similar vein, but with greater specificity, two Australian committees would leave the question of marital status to the medical ethics of the treating physician.⁴⁰ Nevertheless, neither failing to prohibit such discrimination, nor leaving the question to the prerogative of medical ethics answers the problem, since social biases and prejudices will undoubtedly interfere. These social biases are particularly evident in the criteria to be applied in the best interests of the child, that is, limiting access to couples or individuals on the basis of the quality of their relationship or the characteristics of their personality.

(ii) *Best Interests of the Child*

Perhaps most Committees hope that through the use of reproductive technologies parenthood could be resuscitated, for no thread is more common to the studies than the search for "accepted family relationships" or for "the stable" individual. Indeed, all the studies would recommend some form of psychological testing and counselling of participants.⁴¹

³⁷ See *Charter of Human Rights and Freedoms*, R.S.Q. 1977, c. C-12, s. 10; see generally B. Knoppers, *Modern Birth Technology and Human Rights* (1985) 33 AM. J. COMP. L. 1.

³⁸ See K.T. Bartlett, *Rethinking Parenthood as an Exclusive Status: The Need for Legal Alternatives When the Premise of the Nuclear Family Has Failed* (1984) 70 VA. L. REV. 879.

³⁹ Sask. *Proposals*, *supra*, note 2 at 1-2 to 1-5; see *The Saskatchewan Human Rights Code*, S.S. 1979, c. S-24.1, s. 12, which prohibits discrimination against any person or class of persons on the basis of marital status with respect to services which are offered to the public. See also *Ethical Considerations*, *supra*, note 1 at 22S, which has adopted an equivocal position: "[o]ther things being equal, the Committee regards the setting of heterosexual marriage as the most appropriate context for the rearing of children. But because other factors are often not equal, the Committee is unwilling to view non-marriage as a general constraint on the liberty right to reproduce."

⁴⁰ Paragraph 6.13, NSWLRC *Report*, *supra*, note 2 and paragraph C(5)(i), Queensland *Report*, *supra*, note 4.

⁴¹ Canada: see OLRC *Report*, *supra*, note 1 at 155; recommendation 3, BCRC *Report*, *supra*, note 3. Australia: see *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, ss. 10(3)(e), 11(3)(e), 12(3)(e), 13(3)(e) (these provisions were not in force as of 10 August 1986); recommendation 5, paragraphs 2.4 and 2.5, Victoria *Report*, *supra*, note 4; paragraphs 3.3, 3.4 and 3.6, Waller *Report*, *supra*, note 4; paragraph 7.10, NSWLRC

In that vein, the Law Reform Commission of Ontario would not acclaim "an unrestricted acceptance of the right of *all* infertile or genetically impaired persons to participate in an artificial conception programme".⁴² The reason for this is that "[i]t is at this initial juncture that the state is able to intervene in a manner that will ensure, as much as possible, that the future child will be born into, and reared in, a satisfactory home environment".⁴³ Accordingly, where the marital or non-marital union is a stable one, the couple would be eligible.⁴⁴ Suitability for parenthood, then, like most other studies promoting "accepted family relationships",⁴⁵ or advocating the two parent family in the best interests of the child,⁴⁶ would be based on the ability to offer a proper home environment for the child.⁴⁷ Yet, according to the Ontario Commission, even though the welfare of children would be better served by the two parent family, the Commission did not preclude access by "stable" single individuals.

(iii) *Single Parents*

We have already seen the obvious contradictions created by a total interdiction of single parents in both human rights legislation and adoption legislation (not to mention the possibility that single persons may make suitable parents). Moreover, in line with the preference of the Law Reform Commission of Ontario towards "stable" couples, the same criteria is applied to singles.⁴⁸ The Report of the British Columbia Commission would have made the test, whether applied to couples or individuals, one of an "ability to nurture".⁴⁹ Other studies avoid psycho-social criteria as applied to single individuals altogether, simply remarking that children born to unmarried couples or single individuals would be illegitimate⁵⁰

Report, supra, note 2; *Queensland Report, supra*, note 4 at 125-9; recommendations 12 and 13, *S. Austl. Report, supra*, note 3 at 16. Britain: paragraph 5.5, *Dunstan Report, supra*, note 3 at 49; paragraph 3.5, *RCOG Report, supra*, note 2.

⁴² *OLRC Report, supra*, note 1 at 154.

⁴³ *Ibid.*

⁴⁴ Recommendation 5, *OLRC Report, supra*, note 1 at 275. Furthermore, the Commission concludes (*ibid.* at 157) that "while participation in an artificial conception programme should not be a right given to every infertile or genetically diseased person or couple wishing to have a child, eligibility for participation should not be restricted to married couples or, indeed, even to couples."

⁴⁵ See paragraph 4.7, *Waller Report, supra*, note 4; Supp. Note 4, s. 3(a), *NHMRC Report, supra*, note 7.

⁴⁶ See paragraph 2.11, *Warnock Report, supra*, note 3 at 11-2; see generally *Dunstan Report, supra*, note 3 at 46.

⁴⁷ See *OLRC Report, supra*, note 1 at 154.

⁴⁸ Recommendation 5, *OLRC Report, supra*, note 1 at 275.

⁴⁹ Recommendation 3, *BCRC Report, supra*, note 3.

⁵⁰ See paragraph 7.3.1, *Dunstan Report, supra*, note 3 at 63. France: *Proposition de loi tendant à faire de l'insémination artificielle un moyen de procréation*, 47 Sénat, Ire sess., 1978-79, art 9. The artificial insemination of single women was a possibility under the original bill before the French National Assembly, but due to much opposition the proposal was dropped before the Senate hearing (see Sénat, Séance du 5 juillet 1980 at 2397). Council of Europe: Annexe 1, principe 3(1), *CAHBI 1986, supra*, note 2.

(presuming that such a fate in itself would obviously not be wished upon any child by a stable individual). While the concerns are most laudable and perhaps necessary, it is axiomatic that *divorced*, single women with children constitute the largest group living below the poverty line in Canada.⁵¹ Perhaps the legislative emphasis should lie on taking care of those children already born to formerly "stable" couples, rather than taking the form of legislated social triage via reproductive technologies.

C. Donation and Records

1. Introduction

Much of the consensus surrounding the need for greater regulation and the establishment of eligibility criteria dissipates in the discussion surrounding the donation of gametes. While admitting the variety, to say nothing of the laxity, of current practices, issues of genetic screening and frequency of use are often subsumed by the "moral" issue of payment for gametes. By concentrating on the "moral" question of "how much" and its qualification as remuneration or payment, some studies skirt the "moral" issues of individual autonomy over one's body and personal privacy. Obviously, the availability and cost of these techniques are dependant on the resolution of these questions. Where payment or remuneration is prohibited altogether, the number of donations could well be affected.

In addition, the possible liability of the donor and the physician or other health professionals will become increasingly relevant. Public paranoia on the issue of the transmission of AIDS or genetic disorders will add new dimensions to potential physician liability. It may also increase the possible liability of donors. The necessary regulation of gamete choice is, however, more than an issue of avoiding the transmission of deleterious genes or diseases or of legal liability. It is at this juncture that the question of "normalcy" and acceptance of differences in a given society becomes acute, for the values to be espoused cannot be separated from those governing the fertile members of that same society. The implementation and availability of testing procedures and the regulation of gamete choice discussed below may one day be applied to or demanded by the general population.

Linkage and tracing through complete and long-term record keeping are necessary to effectively regulate and evaluate the choice of gametes. However, from the donors' perspective, anonymity is essential. The viability of an infertility programme hinges on the maintenance of confidentiality. The issue becomes one of balancing these two seemingly

⁵¹ Eighty-five percent of single parent families are headed by women and of these, forty-seven percent are living below the poverty line: Statistics Canada, *Income Distribution by Size in Canada, 1982* (Ottawa: Supply and Services Canada, May 1984) table 19 at 67 and table 86 at 167 [as cited in E. Sloss, ed., *Family Law in Canada: New Directions* (Ottawa: Canadian Advisory Council on the Status of Women, 1985) at 2].

irreconcilable norms. Obviously, genetic information can be separated from nominative personal information and all records can be coded to protect privacy. However, when third parties act not only as donors but also as recipients, or where the genetic sources are different from the gestational or social sources, record keeping is not such a simple issue. Furthermore, as we will also see below, the resulting child may have an interest in such information.

2. Regulation of Gamete Choice

As mentioned, the future regulation of gamete choice centers around the issues of selection and the possible legal liability for that selection. Like the choice of eligible participants, such regulation has grave social implications. If the same logic justifying government intervention in the choice of participants is to prevail, regulation of gamete choice in the name of the "best interest" of the future child could also be justified.

(a) Selection

The selection of gametes is based on the results of testing and screening; but the variety and quality may also be dependent on whether the physician or clinic has access to a greater number of gametes. This raises the issue of payment as well as the issue of the frequency of use of the gametes of any one donor.

(i) Screening

Once the administrative formalities of donor selection have been fulfilled, there is the requirement, common to all proposals, of some form of genetic screening of the donor.⁵² This screening to eliminate genetic disability may be seen as a form of eugenics or as simply a way to avoid malformations and the human hardship they involve.

Generally, genetic screening of donors involves obtaining information directly from the donor with regard to his or her genetic history. As the science of genetics advances, the degree of information sought will vary and therefore screening requirements will not necessarily remain constant.

⁵² Canada: see recommendations 8, 9 OLRC Report, *supra*, note 1 at 275-6, and recommendation I(4), Sask. *Proposals*, *supra*, note 2 at 1-12; see also recommendations 2.1 and 2.2, HW Can. Report, *supra*, note 2 (this document also sets out extensive criteria to be used in the screening process. See p. 7 *et seq.*). Australia: see paragraph 5.15, NSWLRC Report, *supra*, note 2, and Queensland Report, *supra*, note 4 at 111; see also recommendation 4, S. Austl. Report, *supra*, note 3 with reference to *Standards for Artificial Insemination by Donor Services, Draft Guidelines for South Australia* (1982) at 44. Britain: see paragraph 4.18, Warnock Report, *supra*, note 3 at 24 and paragraph 4.5, Dunstan Report, *supra*, note 3 at 40. United States: see *Ethical Considerations*, *supra*, note 1 at 83S; The American Fertility Society, *Report of the Ad Hoc Committee on Artificial Insemination* (1981) at 4, 5, 6, 8 [hereinafter *Report on Artificial Insemination*]; District of Columbia, Bill 5-359, s. 4(a)(2); Michigan HB 4114, ss. 5(d) and 6(2).

In response to this, several reports recommend leaving screening standards up to the medical profession.⁵³ One report would require legislation to establish minimum guidelines and would leave any excess requirements up to the profession.⁵⁴

No explicit rationale for these recommendations is given beyond the fact that this latter approach would ensure some uniformity of basic standards of screening and selection. Presumably, the establishment of minimum guidelines would, to some degree, avoid forum shopping between centers based on the degree of screening and matching. More importantly, it would provide minimum safeguards for all parties concerned, including the child.

Once the sperm has been donated it can be used right away, or it can be frozen for later use. Ova donation is still relatively rare. The advantage of frozen sperm is that more extensive tests can be conducted on it to determine the presence of sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), hepatitis and other diseases. While the recommendations of most studies group the initial genetic screening of donors and gamete testing together, some make specific reference to the need for the testing of the gametes for infectious diseases immediately prior to use.⁵⁵ It is likely that in the wake of the AIDS scare and the recent cases of transmission, such "pre-use" verification will become a standard and obligatory requirement since the donor may have contracted a disease after initial testing.⁵⁶

(ii) *Payment*

The issue of payment to donors has until recently been dealt with by existing practices. Sperm donors have received from twenty to seventy dollars for each donation. Payment has been deemed compensation for lost time, transportation, costs and inconvenience. It has not been seen as a direct payment for the gametes.⁵⁷ In this way, the moral issue of payment for human genetic material has been avoided by the compensatory rationale for the payment. Determination of the amount of each payment is

⁵³ Canada: see recommendation 8, OLRC Report, *supra*, note 1 at 275. Australia: see recommendation 18, paragraph 9.11, NSWLRC Report, *supra*, note 2. Britain: see paragraph 4.5, Dunstan Report, *supra*, note 3 at 40.

⁵⁴ See recommendation I(4), Sask. Proposals, *supra*, note 2 at 1-12; minimum federal regulation is supported by recommendation 2, HW Can. Report, *supra*, note 2.

⁵⁵ Canada: see recommendation 11, BCRC Report, *supra*, note 3; see also recommendation 2.1, HW Can. Report, *supra*, note 2, and see generally pp. 10-1; Australia: S. Austl. Report, *supra*, note 3 at 44.

⁵⁶ "Four Women Get AIDS After Sperm Bank Visit", [Montreal]Gazette (25 July 1985) A1. See the propositions in 1986. Australia: paragraphs 5.16-5.18, NSWLRC Report, *supra*, note 2. United States: Ethical Considerations, *supra*, note 1 at 86S notes that effective screening for AIDS or other infectious diseases requires screening again at least three months later (since AIDS can be transmitted in the sperm before the antibodies show up in the donor's sperm) and then releasing the frozen sperm for use.

⁵⁷ Compare: District of Columbia, Bill 5-359.

therefore premised on balancing the need to entice donors against the necessity of ensuring that payment is not so enticing as to encourage donors to conceal relevant information.

The issue of payment is dealt with in all of the studies discussing the use of donated genetic material. The principles enunciated above relating to present rationale are repeated in each of them: expenses should be reimbursed;⁵⁸ such payment should not be seen as payment for the gametes;⁵⁹ payment should not constitute a "financial incentive";⁶⁰ and payment should not be enough to encourage non-disclosure by the donor.⁶¹ The District of Columbia⁶² in the United States has stated that there should be no payment of any kind for such donations — not even compensation for expenses. This has long been the practice in France.⁶³ Interestingly, the Law Reform Commission of Ontario foresees greater payment to ova donors than to sperm donors since the donation of ova involves a more invasive and time consuming procedure.⁶⁴ No other study has drawn such an explicit distinction.

⁵⁸ Canada: see recommendation 15(1), OLRC Report, *supra*, note 1 at 276. Australia: see *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, ss. 11(6)(a), (b), 12(6)(a), (b), 13(6)(a), (b) (these provisions were not in force as of 10 August 1986); paragraphs 3.10 and 3.11, Waller Report, *supra*, note 4; see also recommendation 24, paragraph 10.9, NSWLRC Report, *supra*, note 2; paragraph C(5)(vi), Queensland Report, *supra*, note 4. Britain: see paragraphs 4.27 and 6.6, Warnock Report, *supra*, note 3 at 27-8 and 36-7; paragraph 4.5, Dunstan Report, *supra*, note 3 at 40, which states "small payment . . . for the inconvenience"; see also paragraph 14.4, RCOG Report, *supra*, note 2. United States: see recommendation 12, *Ethical Considerations*, *supra*, note 1 at 37S. France: see generally Actes du Colloque, *Génétique, Procréation et droit*, Paris, Actes Sud, 1985; Council of Europe: Annexe I, principe 11(1), CAHBI 1986, *supra*, note 2.

⁵⁹ See paragraphs 3.10 and 3.11, Waller Report, *supra*, note 4; paragraph B.3(ii), Queensland Report, *supra*, note 4.

⁶⁰ This point was mentioned in paragraph 7.11 of New South Wales Law Reform Commission, *Artificial Conception: Human Artificial Insemination* (Discussion Paper No. 1). This point was *not* repeated in the NSWLRC Report, *supra*, note 2; see paragraphs 10.4 and 10.5.

⁶¹ See paragraphs 4.27 and 6.6, Warnock Report, *supra*, note 3 at 27-8 and 36-7.

⁶² District of Columbia, Bill 5-359, s. 6.

⁶³ See *Proposition de loi tendant à faire de l'insémination artificielle un moyen de procréation*, 47 Sénat, Ire sess., 1978-79, art. 2 and *Proposition de loi relative au statut de l'enfant conçu ainsi qu'aux expérimentations concernant la création de la vie humaine*, Ass. nat. no 2158, 2e sess., 1983-84, art. 2. The C.E.C.O.S. in France have long operated under this principle. See generally Actes du Colloque, *Génétique Procréation et droit*, Actes Sud, 1985. But see Council of Europe, Annexe I, principe 11(1), CAHBI 1986, *supra*, note 2, which states that reasonable expenses such as loss of salary and travel could be paid; however, gametes and embryos shall not be the object of commercialisation according to recommendation 3; *Avis du Comité d'éthique*, *supra*, note 16 at 6; and Council of Europe, *Rec. 1046*, in its Appendix B(vi)(e) *supra*, note 13, maintains that "the use of embryos, foetuses or their tissues for profit or remuneration shall not be allowed".

⁶⁴ See recommendation 15(2), OLRC Report, *supra*, note 1 at 276.

Generally, there is no support for clear commercialization and the establishment of a "market value" for gamete donations in any of the studies. However, the Law Reform Commission of Ontario report is in favour of commercial gamete banks that import and export and "buy and sell sperm, ova and embryos".⁶⁵ Moreover, while such banks should be allowed to operate only under licence and should be subject to stringent regulation, they should be allowed to earn a "reasonable profit".⁶⁶ This raises the question of who will finally profit and what the meaning of "reasonable" is. Another very important question to address is whether there will eventually be differential fees for different quality gametes.

(iii) *Frequency of Use*

Due to the techniques of freezing and storing sperm and ova,⁶⁷ it is conceivable that any number of children could potentially be the product of one donor. In order to avoid problems of either consanguinity prohibitions or the later discovery of genetic disorders or other conditions related to that donor, most law reform proposals recommend a restriction on the number of times the gametes of each donor is used. The recommendations vary. The attitude taken by the Law Reform Commission of Ontario leaves the numbers to be determined by the medical profession.⁶⁸ Other proposals would limit the pregnancies to a specific number. For example, in 1986 the American Fertility Society set the limit at fifteen,⁶⁹ while Health and Welfare Canada⁷⁰ and the British Columbia Royal Commission on Family and Children's Law would set the number at approximately six.⁷¹ Only the District of Columbia states that no more than one recipient may be inseminated by a particular donor (although that recipient may be inseminated a number of times).⁷²

(b) *Liability*

The responsibility for the health of the donated gametes rests on the practitioner in so far as he or she must take steps to screen and test the donation and on the donor in so far as he or she must disclose any relevant information.

⁶⁵ See recommendation 17(1), *ibid.* at 277.

⁶⁶ OLRC Report, *ibid.*

⁶⁷ There is increasing experience in the freezing of ova, especially in Australia and France. Embryos have also been frozen and following thawing have resulted in live births. However, these techniques remain experimental; see *Ethical Considerations*, *supra*, note 1 at 52S and 55S.

⁶⁸ See recommendation 16, OLRC Report, *supra*, note 1. See also recommendation 20, paragraph 9.15, NSWLRC Report, *supra*, note 2 also recommends that the actual number should be left to the practising organization.

⁶⁹ See *Ethical Considerations*, *supra*, note 1 at 37S (originally, in 1981, the report of the Ad Hoc Committee on Artificial Insemination set the number at fifteen).

⁷⁰ See recommendation 2.4, HW Can. Report, *supra*, note 2 at 15.

⁷¹ See recommendation 12, BCRC Report, *supra*, note 3.

⁷² District of Columbia, Bill 5-359, ss. 9(a), (b).

(i) *Physicians*

Where reproductive technologies are considered the "practice of medicine", the legal responsibility of practitioners would most frequently fall within the purview of the civil law of negligence and contract relating to physician liability. The screening and testing requirements, whether legislated or set by professional standards, would outline the practitioner's obligations with respect to the procedures of assisted conception as with other medical interventions.

For the above reason, the reports which discuss the issue of legal liability of the physician advise against a statutory provision imposing a higher standard on a practitioner of the reproductive technologies than the normal standards established for the practice of medicine.⁷³ To ensure that this standard is met, the New South Wales Law Reform Commission Report recommends "that no action be taken to enact legislation to confer exemption from liability upon medical personnel who act in good faith and without negligence when performing an act or duty imposed by legislation in relation to AI and AID".⁷⁴

This "status quo" aspect of the law reform proposals results from the fear of the potential increase in litigation based on notions of "wrongful birth" and "wrongful life" which is in part due to the increased medicalization of conception and pregnancy. As physicians have access to more information and more facilities for testing, the standards imposed on the medical profession will rise with respect to genetic and foetal health. Where there is an actual medical intervention in conception and when there is an active and at least a somewhat educated choice of gametes, any time a child is born with a defect which may, under optimal conditions, have been avoided, the potential for liability increases substantially.

⁷³ On physician liability *see generally*, B. M. Knoppers, *CONCEPTION ARTIFICIELLE ET RESPONSABILITÉ MÉDICALE: UNE ÉTUDE DE DROIT COMPARÉ* (Cowansville: Ed. Yvon Blais, 1986). Canada: *see* OLRC Report, *supra*, note 1 at 153; recommendation 14, *Sask. Proposals*, *supra*, note 2, which states: "[a] new statute should impose a negligence standard on the doctor, and expressly exclude any concepts of implied warranties. However, if the doctor's consent form and counselling did not include a *full disclosure* of the risks involved, this omission should be seen as contributing negligence *per se* in the event of any problems caused by the procedure which are experienced by the baby or the recipient"; *see also* HW Can. Report, *supra*, note 2 at 31, which states "legal duty of care the same as other medical procedures". Australia: *see* paragraphs 6.14 and 9.11, recommendation 8, NSWLRC Report, *supra*, note 2. Britain: *see* paragraph 13.1, Warnock Report, *supra*, note 3 at 75; paragraph 7.8.4, Dunstan Report, *supra*, note 3 at 74; *see also* paragraph 10.7, RCOG Report, *supra*, note 2. United States: *see* HEW Report, *supra*, note 3 at 71ff.

⁷⁴ Australia: *see* paragraph 14.11, NSWLRC Report, *supra*, note 2. United States: *see* Am. Fert. Soc. Report, *supra*, note 2 which provides that "[i]f the practitioner has complied with the provisions of this statute and has carried out a standard level of practice in the selection of donor or sperm bank, and in the processing and administration of the semen, the practitioner shall not be liable to the donor, recipient, her spouse or any resultant child."

For that reason, the OLRC *Report* suggests that claims for "wrongful life", "wrongful birth" and the like be the subject of another study.⁷⁵ In England, where physician liability is already limited by legislation,⁷⁶ a recent report held that there is no "case for suggesting that the general law relating to compensation for handicap or injury should be any different in connexion with 'artificially assisted births'".⁷⁷

A few reports⁷⁸ would, nevertheless, specifically incorporate into legislation the right of the born child to sue for negligently caused prenatal injuries. Since a suit could then be brought irrespective of the time at which the negligence occurred, the plaintiff would no longer be faced with the issue of demonstrating legal personality or viability at the time of injury.⁷⁹ Some reports would go still further and hold the physician to either a strict liability standard⁸⁰ or make the physician the guardian of the embryo.⁸¹

As we have seen, the proposals generally suggest leaving the question of liability within the generally accepted law relating to medical liability leaving the physician without any direction. Thus, while general guidelines for practice are encouraged, no heavier burden is put on the practitioner of the reproductive technologies than in any other aspect of the

⁷⁵ See recommendation 25, OLRC *Report*, *supra*, note 1 at 279-80.

⁷⁶ Britain: see *The Congenital Disabilities (Civil Liability) Act 1976*, (U.K.), 1981, c. 28, which provides that a child born disabled in consequence of the fault of another may have a remedy; however, the Act provides in subsection 1(5) that a doctor "is not answerable to the child, for anything he did or omitted to do when responsible in a professional capacity for treating or advising the parent, if he took reasonable care, having due regard to then received professional opinion applicable to the particular class of case; but this does not mean that he is answerable only because he departed from received opinion."

⁷⁷ See paragraph 7.8.4, Dunstan *Report*, *supra*, note 3 at 74.

⁷⁸ Canada: see recommendation II(6), *Sask. Proposals*, *supra*, note 2 at 2-16, which states: "[a] person born as a result of artificial insemination with [donor semen] . . . should have a cause of action based on the tort of negligence under which he would be able to recover pecuniary and non-pecuniary damages for losses to which he has been subjected or will, in the future be subjected as a result of the fact that he was born with abnormalities which an AID child would not have if the negligence has not occurred." Furthermore, under recommendation II(9), an "action in damages for personal injuries [can be] brought by a person artificially inseminated . . . a) [where] he [the physician] has artificially inseminated a woman and did not ensure that the necessary investigation and screening was conducted". Australia: see paragraph 3.4.1, Victoria, *Interim Report of the IVF Committee* (August 1984), which states: "[t]he law of Victoria now provides that a child born alive has a right of action for pre-birth injuries. The Committee considers that this encompasses injuries which are traceable to the use of donated gametes, or to the fertilization and embryo transfer." Britain: see paragraph 7.6.5, Dunstan *Report*, *supra*, note 3 at 72, which would provide an action against a donor where the donor deliberately withheld information or gave false information.

⁷⁹ B. Knoppers, *supra*, note 37 at 16-21 and note 73.

⁸⁰ See M. Cohen, *Fashioning Remedies for the Victim of In Vitro Fertilization* (1980) 4 AM. J. LAW MED. 320; see also M. Shaw, *Conditional Prospective Rights of the Fetus* (1984) 5 J. LEG. MED. 63.

⁸¹ *Human Embryos*, LSA Rev. Stat., c. 3 (1986), §126; *Abortion Law*, 1975 Ill. Rev. Stat., c. 38, *am.* 1981.

practice of medicine. Irrespective of the approach adopted, problems of proof for the parents would be insurmountable in all but the obvious cases, which underscores the necessity for a more global solution in the case of disability.⁸²

(ii) *Donors*

All studies formulate a duty to be imposed on the donor not to conceal relevant information and not to give false information.⁸³ Several would impose a civil sanction for breach of this duty.⁸⁴ The New South Wales Law Reform Commission⁸⁵ suggests the adoption of a provision similar to the *Victoria Infertility (Medical Procedures) Act 1984*.⁸⁶ It recommends the creation of a specific statutory offence for the supply by a semen donor of false or misleading personal information when providing medical or other personal particulars. This is similar to the solution of the Victoria legislation. One report imposes a duty on the donor to sign a consent form requiring him to notify the physician upon contracting any contagious or venereal disease and to then refrain from further donation.⁸⁷ Liability would have to be extended to ova and embryo donors and would in this way counterbalance physician liability for proper screening.

In conclusion, it should be mentioned that, with respect to liability in general, there is also the possibility that the courts will apply the law relating to the sale of goods to the donation or sale of gametes.⁸⁸ Should the

⁸² B. Knoppers, *Alternatives to Tort Liability in Other Countries*, in L.B. Andrews, ed., *LEGAL LIABILITY AND QUALITY ASSURANCE IN NEWBORN SCREENING* (Chicago: American Bar Foundation, 1985) at 222-39.

⁸³ Canada: see recommendation 23, *OLRC Report, supra*, note 1 at 279; recommendation III(8), *Sask. Proposals, supra*, note 2 at 3-16; see also *HW Can. Report, supra*, note 2 at 21, which states that "[t]he donor has no legal responsibility to anyone arising from the sperm donation if he has given full and accurate answers, to the best of his knowledge and belief, to the questions asked of him by the physician involved, concerning his genetic background and medical history". Australia: see *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, s. 27(1); recommendation 5, paragraph 5.18, *NSWLRC Report, supra*, note 2. United States: see *Ethical Considerations, supra*, note 1 at 22S.

⁸⁴ See, e.g., Canada: recommendation 23, *OLRC Report, supra*, note 1 at 279, which states that a breach of duty "should be made a provincial offence". See also Australia: *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, s. 27(1); recommendation 6, paragraph 5.18, *NSWLRC Report, supra*, note 2.

⁸⁵ See paragraph 5.18, *NSWLRC Report, supra*, note 2.

⁸⁶ (Victoria), No. 10163, s. 27(1).

⁸⁷ See *Am. Fert. Soc. Report, supra*, note 2 at 16-7. The model legislation would require the donor's signature on a consent form to this effect. This form may be found in the Appendix entitled "Statement of Understanding". More recently, the Ethics Committee has recommended the implementation of a screening procedure of sperm donors, without mention of the consent form. See *Ethical Considerations, supra*, note 1 at 85S-86S.

⁸⁸ See discussion in the *OLRC Report, supra*, note 1 at 192 and recommendation III(9), *Sask. Proposals, supra*, note 2 at 3-16. It is important to note that the way in which the transaction is actually classified will to a large extent define the applicability of sale of goods legislation and the consequent application of the "fitness for purpose" and "warranty" provisions. Where the transaction is clearly not defined in terms of "sale", then this legislation is of limited applicability.

transaction be considered synonymous with a sale of goods transaction, the principles of implied warranties of merchantable quality and fitness for purpose would apply. For that reason, the Law Reform Commission of Ontario Report recommends "the enactment of legislation that would provide that principles of strict liability, and particularly the implied warranties of merchantable quality and fitness for purpose . . . should not be applied to the direct or indirect donation or supply of gametes or embryos; rather, recovery in such a transaction should be dependent upon general principles of the law or negligence".⁸⁹

Considering that the Law Reform Commission of Ontario would permit the exportation and importation of human genetic material,⁹⁰ it is difficult to see how "sale of goods" treatment is to be avoided. Indeed, where national or provincial regulation is not sufficient, it may be necessary to impose standards outside of their respective jurisdictions.⁹¹ In any event, while the civil liability of the physician for screening and the liability of the donor for the honest communication of information serves as some measure of protection, it is doubtful that the general principles of civil negligence are sufficient to regulate trade with those jurisdictions applying different standards.

(iii) *Renunciation of Parentage*

All law reform proposals, without exception, would require a donor to renounce all of his or her parental rights in the gametes.⁹² The opportunity to revoke such a renunciation exists only until the gametes are fertilized. The only exception to this is in the case of surrogate motherhood arrangements.⁹³ The obligatory renunciation of parenthood is necessary in the context of gamete donations in view of the legal presumptions of paternity and possible maternity⁹⁴ which grant the parents at birth certain

⁸⁹ See OLRC Report, *supra*, note 1 at 194.

⁹⁰ See recommendation 18, *ibid.* at 277; see also recommendation 13.13, Warnock Report, *supra*, note 3.

⁹¹ See recommendation 18(2), OLRC Report, *supra*, note 1 at 277. See also Council of Europe, *Rec. 1046*, *supra*, note 5, which states that "any exclusively national regulation of the question runs the risk of being ineffective as any activity in this field could be transferred to another country which did not enforce the same regulations". See also B. Knoppers, *International Protection and Regulation of Human Genetic Material*, (1987) 32 McGill L. J.

⁹² Canada: see recommendation 19.2, OLRC Report, *supra*, note 1 at 277; see also recommendation III(4) and subsection 19(a) of the proposed *The Human Artificial Insemination Act*, *Sask. Proposals*, *supra*, note 2 at 3-14 and xxxix; recommendation 1, BCRC Report, *supra*, note 3. Australia: see paragraph 3.14, Waller Report, *supra*, note 4; S. Austl. Report, *supra*, note 3 at 24. Britain: paragraph 4.22, Warnock Report, *supra*, note 3; paragraphs 5.3 and 14.14(1), RCOG Report, *supra*, note 2. United States: see Michigan HB 4114, s. 6(1); District of Columbia, Bill 5-359, s. 8(c).

⁹³ See Part III, C, 3, (b)(ii) of this paper on the right of repudiation of the gestational mother in a surrogate arrangement, *infra*.

⁹⁴ Canada: see recommendation 19(1), OLRC Report, *supra*, note 1 at 277, stating that the child born is presumed to be the legal child of the woman who bears the child and

rights and obligations. Beyond the issue of renunciation, the legislation seems to be moving toward a definition of the family which is not necessarily related to genetic ancestry. What is needed, however, is more study and analyses of the legal validity of such anticipatory renunciation of parental legal obligations, for the duty to maintain one's children is a duty of public order. Surrendering rights may not necessarily be considered synonymous with avoidance of one's obligation.

Finally, it is interesting to note that the donor is not obliged to surrender all control over the gametes donated. Like other reports,⁹⁵ the Law Reform Commission of Ontario Report would leave the donor certain rights including the right to restrict the use of his or her genetic material for specific purposes⁹⁶ and the right to withdraw consent and require that the donation be wasted⁹⁷ or returned to him or her.⁹⁸

her husband or male partner who gives consent; *see also* recommendation III(1) and section 19(b) of the proposed *The Human Artificial Insemination Act, Sask. Proposals*, *supra*, note 2 at 3-8 and xiii, both of which state that the child is deemed legitimate where the husband consented to the insemination; *see also* recommendation 17, BCRC Report, *supra*, note 3; art. 586 C.C.Q.: [w]hen a child has been conceived through artificial insemination, either by the father or with the consent of the spouses, by a third person, no action for disavowal or contestation of paternity is admissible"; *Children's Act*, S.Y.T. 1984, c. 2, ss. 14(3), (5); recommendation 1.1, HW Can. Report, advises that provincial legislation be passed making AID children legitimate. Australia: *see* paragraph 4.6, Waller Report, *supra*, note 4; *see also* the draft *Artificial Conception Bill* at 34, s. 4(2)(a); paragraphs 7.6-7.8, NSWLRC Report, *supra*, note 2; New South Wales, *Artificial Conception Act, 1984*, s. 5(2); paragraphs C.1(i) and D.2, Queensland Report, *supra*, note 4, which creates an irrebuttable presumption that a woman giving birth is the child's mother; South Australia, *Family Relationships Act Amendment Act, 1984*, ss. 10(c), (d)(1). Britain: *see* paragraphs 4.17, 6.8 and 7.6, Warnock Report, *supra*, note 3 at 23-4, 37-8 and 40-1; paragraph 4.3, Dunstan Report, *supra*, note 3 at 37-8; *see also* paragraph 14.2, RCOG Report, *supra*, note 2, *AID Children (Legal Status) Act 1977 (Bill)* (28 June 1977) s. 1; United States: *see* Am. Fert. Soc. Report, *supra*, note 2 at 18 no. 2, Michigan H.B. 4114, s. 5; District of Columbia Bill 5-359, s. 8.

⁹⁵ Australia: under the New South Wales *Artificial Conception Act, 1984*, the donor has no rights once the gametes are donated; *but see* paragraph 10.18, NSWLRC Report, *supra*, note 2, which makes it clear that a donor should have the right to restrict the use of his gametes, that is, he may donate for "a special purpose" set out in an agreement with the AI clinic, but in the view of the Commission, "legislation [should] be enacted to the effect that the AI clinic should have the power to determine the use, storage and disposal of semen donated to it for AID". *See also* paragraphs B.3(vii) and B.6(i), Queensland Report, *supra*, note 4, which states that "[t]he wishes of the donors regarding the use, storage and ultimate disposal of sperm, ova and resultant embryos should be ascertained prior to the collection of the gametes"; Supplementary Note 4, Art. (6), NHMRC Report, *supra*, note 7, which states that "[t]he wishes of the donors regarding the use, storage and ultimate disposal of the sperm, ova and resultant embryos should be ascertained and as far as possible respected by the institution"; S. Austl. Report, *supra*, note 3 at 25, which states that there is no right of revocation after donation. Britain: *see* paragraph 10.11, Warnock Report, *supra*, note 3 at 56, stating "the couple who have stored an embryo for their use should be recognized as having the rights to the use and disposal of the embryo, although these rights ought to be subject to limitation."

⁹⁶ *See* recommendation 13, OLRC Report, *supra*, note 1 at 276.

⁹⁷ *See* recommendation 14, *ibid.*

⁹⁸ *Ibid.*

3. Record Keeping

As statutory or regulatory controls are placed on artificial conception techniques, questions arise as to whether records should be kept, and if they are kept, whether it is possible or even desirable to preserve and protect the parties' anonymity.

(a) Maintenance

There are two predominant issues related to the issue of record keeping: the first is the purpose of keeping records and the second is the manner in which the records should be kept and for how long.

(i) Rationale

The maintenance of records may be seen as having several purposes, the most important being that such records facilitate linkage. Linkage is predominantly supported for medical purposes. Where a child conceived of donated genetic material is born with some genetically inherited disability, the identity of the donor(s) must be determined. This is to ensure not only that the donor's genetic material is not used again, but also to alert the donor of the problem and to enable him or her to take an educated approach to his or her own family.

Only the OLRC *Report* would impose a duty on a doctor who becomes aware of a "genetic or transmissible defect or disease in a donor or a donor's child . . . to make all reasonable efforts to report all relevant information to any person whose health and welfare the doctor reasonably believes may be affected by it".⁹⁹ This is a far-reaching recommendation with important implications. Not only is terminology such as "reasonable" or "relevant" vague considering that the physician would be subject to civil liability for failure to meet the duty, but it fails to recognize the volatile value of such genetic information and the impact of such knowledge on concerned parties. It also fails to acknowledge the various parties' right to privacy. As genetic brokers, physicians would have an enormous responsibility. While it is obvious that some parties would want to know the information, the risks of such a loosely defined duty are too great and warrant further study.

Another reason for the maintenance of such records is the regulation of the number of times gametes from one donor may be used.¹⁰⁰ As well, it is feasible that the use of these techniques may bring to light new information regarding procreation which may be useful for epidemiological rea-

⁹⁹ Recommendation 22(5)(a), *ibid.* See also *Ethical Considerations, supra*, note 1 at 10S, which maintains that "if future evidence reveals that a child created with the aid of a particular reproductive technology is more likely to suffer from a genetic or chromosomal defect, that information should be revealed as well [to the couple]".

¹⁰⁰ See the discussion on the frequency of the use of donor gametes in Part C.2.(a)(iii), *supra*.

sons. For these reasons most reports recommend the establishment of a linkage system.¹⁰¹

(ii) *Form*

There are a variety of ways in which records may be kept on the various parties involved in artificial conception. There may be national banking of relevant information or private files kept by the physicians or clinics involved. The information may be coded and kept at two different levels, for example: non-identifying material maintained in a central registry with physicians records holding full information. The manner in which such records are kept depends on their purpose.

The OLRC *Report* makes it clear that since artificial conception techniques fall within the practice of medicine, gamete donors are patients for the purpose of keeping records.¹⁰² Records would therefore be maintained by virtue of the statutory, regulatory and ethical duty imposed on physicians.¹⁰³ These records would thereby benefit from the same level of confidentiality accorded any medical record. Since the Commission considers the donors as patients, there is then no necessity for special values with regard to record keeping.¹⁰⁴

The report of the British Columbia Royal Commission on Children and Family Law approved of record storage in either the doctor's confidential files or in the confidential files of fertility clinics.¹⁰⁵ The New South Wales Law Reform Commission takes the same position and further stipulates that the records should contain both identifying and non-identifying information.¹⁰⁶

In contrast to recommending that such records be maintained by the clinic or physician immediately involved, some studies recommend the creation of a central registry, either national or state-wide, to which all these records must be forwarded.¹⁰⁷ Record keeping need not stop,

¹⁰¹ In particular, see recommendation 22(2) and (3), OLRC *Report*, *supra*, note 1.

¹⁰² OLRC *Report*, *ibid.* at 149.

¹⁰³ See B. Knoppers, *Confidentiality and Accessibility of Medical Information: A Comparative Analysis* (1982) 12 R.D.U.S. 395.

¹⁰⁴ OLRC *Report*, *supra*, note 1 at 185 which states that "[i]n order to ensure that the legislation and other guidelines respecting medical records are as comprehensive as possible, we recommend that the relevant statutes, regulations, and professional rules be amended to make it clear that gamete donors are patients for the purposes of record keeping."

¹⁰⁵ Recommendation 18, BCRC *Report*, *supra*, note 3.

¹⁰⁶ Paragraph 13.18, NSWLRC *Report*, *supra*, note 2. See also *Ethical Considerations*, *supra*, note 1 at 37S, where the same proposition is made.

¹⁰⁷ Australia: *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, sections 19, 21 and 22 would require the recording of extensive detail regarding the artificial conception in a government register (these provisions were not in force as of 10 August 1986); paragraph 3.32, Waller *Report*, *supra*, note 4 recommends the establishment of a registry controlled by the Health Commission; Queensland *Report*, *supra*, note 4 at 108 advocates that AID practitioners be required to keep a history of the donor and send a copy to the Department of Health. Britain: paragraph 4.26, Warnock *Report*, *supra*, note 3

however, upon successful initiation of a pregnancy or the use of a gamete or embryo. The Report of Health and Welfare Canada on artificial insemination recommends that the records contain not only information about the genetic history of the donor but also all follow-up data on the child.¹⁰⁸ An Australian report also recommends that comprehensive details on all donors, all AID pregnancies and all abnormalities in the children be included in a government register.¹⁰⁹ The *OLRC Report* would not impose a positive duty of follow-up on the physician, but it did contemplate the possibility of such a requirement in the future.¹¹⁰ Keeping in mind the recommendation of that report already noted, to the effect that where the physician becomes aware¹¹¹ of a genetic or transmissible defect he would have to make reasonable efforts to contact third parties or the participants themselves, the further imposition of a duty to follow-up would place the physician in an almost intolerable position. Indeed, should both duties come into existence, the new role of the physician as genetic broker and geneologist could well be in conflict with the interests and freedoms of those persons who wish to conceive or continue bearing less-than-perfect children and do not wish to have their personal privacy or family life interfered with.

(b) Confidentiality

The issue of record keeping is complicated by the right of the gamete donor to anonymity and by the question of who should have access to the records that are kept.

(i) Anonymity

The valid medical reasons for maintaining records on participants in artificial conception techniques is counterbalanced by the parties' right to anonymity. This right is supported, to varying degrees, by all of the

recommends the creation of a "centrally maintained list of NHS numbers of existing donors" to ensure that the limit of ten children per donor is maintained. The report further recommends in paragraph 4.21 that upon reaching the age of eighteen, the child should have a right of access to genetic information regarding the donor, hence one can assume that records of a fairly extensive nature are proposed; paragraph 8.4, *RCOG Report, supra*, note 2 goes so far as to recommend that "[t]he College should consider the feasibility of setting up an international register", as well, paragraph 8.2 suggests that every institution should keep extensive records. United States: Michigan HB 4114, s. 5.8(2) states the practitioner must keep records which must be sent to the state registrar pursuant to subsection 8(3); District of Columbia, Bill 5-359 in section 7: (a) sperm banks are to devise and maintain their own record keeping system; (b) "with a code used for identifier information" and (c) "[s]canitized copies of files on each donor and recipient shall be sent to the District of Columbia Bureau of Vital Statistics where they shall be maintained in confidence for a period of 50 years."

¹⁰⁸ HW Can. Report, *supra*, note 2 at 23-4.

¹⁰⁹ Paragraph 3.32, Waller Report, *supra*, note 4.

¹¹⁰ OLRC Report, *supra*, note 1 at 187.

¹¹¹ Recommendation 22(5)(a), *ibid.*

recommendations.¹¹² Nevertheless, it is difficult to guarantee the right to remain anonymous when records are kept. For this reason, the New South Wales Law Reform Commission is against comprehensive records being kept by the government since such centralization in a public body increases the potential for jeopardizing this right.¹¹³

Several studies simply state that while records will be kept, anonymity will be protected. They do not give any specific formulation as to how this will be achieved.¹¹⁴ Many would protect the identifying information kept on record, but would allow either the parents¹¹⁵ or the child (at a certain age)¹¹⁶ access to information regarding the donor's genetic or even social background.¹¹⁷

¹¹² Canada: recommendations 22(4) and 22(7)(b), OLRC Report, *supra*, note 1; recommendation II(12), Sask. Proposals, *supra*, note 2 where recommendation 12(c) would grant a right of action against anyone disclosing a name, and 12(d) states that records should not be admissible in court; recommendations 1 and 9, BCRC Report, *supra*, note 3; HW Can. Report, *supra*, note 2 at 19. Australia: paragraphs 3.36 and 3.14, Waller Report, *supra* note 4 (would give no guarantee of permanent anonymity); paragraph 13.28, NSWLRC Report, *supra*, note 2, which states that clinical records kept by practitioner or clinic should be subject to confidentiality and anonymity according to "good medical practice". Legislation "should not be prescribed"; paragraph B.3(xiii), Queensland Report, *supra*, note 4; S. Austl. Report, *supra*, note 3 (Draft Guidelines) at 44, which states that anonymity should be a possible condition of donation. Britain: paragraph 3.2, Warnock Report, *supra*, note 3; paragraph 14.4(1), RCOG Report, *supra*, note 2. United States: *Ethical Considerations*, *supra*, note 1 at 34S; District of Columbia, Bill 5-359, ss. 4(a), 2(g). France: *Proposition de loi tendant à faire de l'insémination artificielle un moyen de procréation*, 47 Sénat, 1re sess., 1978-79, art. 4; Council of Europe: Annexe I, principe 9, CAHBI 1986, *supra*, note 2.

¹¹³ Recommendation 37, paragraph 13.30, NSWLRC Report, *supra*, note 2, states: "[a]s far as New South Wales is concerned, we see no case for the establishment of a central register of AID information. . . . A central register would, in our view, be a duplication of record keeping that will already have been done as a statutory obligation."

¹¹⁴ See, e.g., OLRC Report, *supra*, note 1 at 189-90, which would leave such protection up to the medical profession.

¹¹⁵ *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, s. 19(1) (this provision was not in force as of 10 August 1986); recommendation 6.20, paragraph 3.26, Waller Report, *supra*, note 4 paragraph B.3(x), Queensland Report, *supra*, note 4.

¹¹⁶ Paragraph 4.21, Warnock Report, *supra*, note 3; paragraph 14.4(11), RCOG Report, *supra*, note 2.

¹¹⁷ Australia: *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, s. 19(1) states that "[b]efore a relevant procedure is carried out in relation to a married woman, the designated officer of the approved hospital in which the procedure is to be carried out shall give in writing to the married woman particulars of each person (other than particulars by which that person may be identified) who gives gametes that may be used in the procedure" (this provision was not in force as of 10 August 1986); recommendation 6.20, paragraph 3.26, Waller Report, *supra*, note 4, states that "[t]he hospital should offer non-identifying information about the sperm or ovum donor to the recipient"; Queensland Report, *supra*, note 4, refers to the *Declaration of the Rights of the Child* and concludes at page 56 that "provision be made for the keeping of sufficient medical and social information about the donor of sperm used to allow the child to have access to a reliable medical and social history." The same report also states in recommendation B.3(x): "[n]on-identifying information about the sperm or ovum donor may be made available to the recipients if they request it". Britain: paragraph 4.21, Warnock Report,

The OLRC *Report* recommends that disclosure of any information in the records be kept to the discretion of individual members of the medical profession, but stipulates that "under no circumstances should any doctor or other person disclose information that could in any way identify the parties".¹¹⁸

The Queensland *Report*, which advocates the creation of a central registry, recommends that the donor's identity be kept in a sealed envelope in the Office of the Registrar-General.¹¹⁹ Another study recommends that identifying information "should be kept in a separate register under lock and key".¹²⁰ The records themselves would therefore only contain codified, non-identifying information.

While the Queensland *Report* would allow the donor's identity to be disclosed upon an order made by a court,¹²¹ other studies recommend that anonymity should be available as a condition of donation,¹²² that records kept should not be admissible in court,¹²³ that the information in a donor registry be exempt from any freedom of information legislation,¹²⁴ or that a permanent record be designed to preserve anonymity and confidentiality.¹²⁵

Obviously, where records are kept, unless there is a clear statutory protection of anonymity, the right to confidentiality, if only nominally protected, will have no guarantees.¹²⁶

(ii) Access

Once information regarding a donor is registered (for whatever purposes), the question becomes what information will be available and to whom?

As already noted, the general trend is to separate the recorded information into that which identifies the parties and that which does not. The former can be set aside by saying that at present, the general policy of the law reform proposals is that such nominative, personal information should not be available to other participants or to any third parties. There are, however, exceptions to this. For example, the Victoria report did not come to any conclusion with respect to the availability of identifying informa-

¹¹⁸ Recommendation 22(7)(b), OLRC *Report*, *supra*, note 1; *see also* the discussion in the same report at 189.

¹¹⁹ Paragraph C.3(iii), Queensland *Report*, *supra*, note 4.

¹²⁰ Paragraph 4.6, Dunstan *Report*, *supra*, note 3.

¹²¹ Paragraph C.3(iii), Queensland *Report*, *supra*, note 4.

¹²² S. Austl. *Report*, *supra*, note 3 at 44.

¹²³ Recommendation 12(d), Sask. *Proposals*, *supra*, note 2.

¹²⁴ Paragraph 3.36, Waller *Report*, *supra*, note 4.

¹²⁵ *Ethical Considerations*, *supra*, note 1 at 37S.

¹²⁶ Paragraph 3.14, Waller *Report*, *supra*, note 4. However, recommendation 36, paragraph 13.28, NSWLRC, *Report*, *supra*, note 2, recommends that no legislation be enacted concerning the preservation of confidentiality and anonymity of records.

tion,¹²⁷ while the Queensland report states that the child's right of access to identifying information should be decided in the future.¹²⁸

With respect to non-nominative information, some studies say that such information should be available to the child or to the child's legally recognized parents.¹²⁹ In fact, it is interesting that the Queensland report substantiates its conclusions by reference to the United Nations *Declaration of the Rights of the Child* of November 1959. By reference to principles 2 and 4 of the Declaration, the Queensland report says children need access to a reliable medical (genetic) history,¹³⁰ and recommends that provision should "be made for the keeping of sufficient medical and social information about the donor of sperm used to allow the child to have access to a reliable medical and social history".¹³¹

In contrast, Canada's Health and Welfare report states that anonymity outweighs the need for information on the child's biological descent.¹³² Finally, the New South Wales report concludes that "insufficient reason exists for creating legal rights in favour of any person for access to recorded identifying information about semen donors or any other party to AID".¹³³ Only Sweden has specifically legislated the right of the child to information as to its genetic origins.¹³⁴

The above issue is a difficult one, for anonymity of donors is generally considered essential to the maintenance of an infertility program. Moreover, no law presently forces "natural" parents to reveal hidden truths as to the genetic origins of their children. Parallels can, of course, be drawn to adoption law, but in most cases of assisted conception one of the parents will be a donor (genetic, uterine or both). Perhaps if the notion of "parent" were to be legally redefined as intentional, consensual and social, exceptions to the necessary blanket protection of confidentiality could be examined on a case by case basis by the courts without legislative intervention. Any redefinition of the notion of "parent", however, must take into account the protection to be afforded the child from conception onwards throughout the pregnancy under the proposals for reform.

III. REPRODUCTIVE TECHNOLOGY AND THE JUDICIALIZATION OF PREGNANCY

A. Introduction

The institutionalization of reproductive technology also requires some regulation of the human genetic material, the individual gametes, or

¹²⁷ Paragraph 3.34, *Waller Report*, *supra*, note 4.

¹²⁸ *Queensland Report*, *supra*, note 4 at 108.

¹²⁹ *See* note 117, *supra*.

¹³⁰ *Queensland Report*, *supra*, note 4 at 55.

¹³¹ *Ibid.* at 56.

¹³² *HW Can. Report*, *supra*, note 2 at 19.

¹³³ Paragraph 13.23, *NSWLRC Report*, *supra*, note 2.

¹³⁴ L. Hamberger, *Artificial Insemination by Donor (A.I.D.) in Sweden* (1985) HUMAN REPRODUCTION (News and Views).

the embryo. Needless to say, the ultimate goal is to achieve the birth of a child. The extensive medicalization of conception and pregnancy has proportionately increased the control that can be exercised before and after a pregnancy. The first question to be discussed is: How is the genetic material to be qualified or protected under law? In other words, with whom does legal control lie — the donor, the “father”, the “mother” or the recipient?

The freedoms to be exercised or limited are directly related to the possible commercialization of child bearing, particularly in the case of surrogate motherhood. The legislator, while protecting the child-to-be, could also regulate access to parenting through the prohibition or control of surrogacy.

This further legitimization of the role of the State, the legislator and the courts over pregnancy is reflected in the degree of control to be exercised over human genetic material. Whereas physicians and pregnant women are increasingly subject to legal liability for the “quality” of a child once born, legal control is currently moving into the gestational period and with the advent of reproductive technologies, even prior to implantation. The final step in the process of the judicialization of pregnancy has arrived.

B. *The Child*

1. *Introduction*

The question of whether the individual gamete or embryo is a person or property, of whether it can be owned or passed on to one's heirs, of whether it can be stored indefinitely, donated to others, or experimented upon, concern the actual degree of legal status or protection afforded human life *in vitro* prior to implantation.

Furthermore, the use of donated genetic material, or the use of another woman's womb, undermines all existing notions of legally presumed or proven filiation. Due to the uncertainty that has always surrounded it, paternity has legally been presumed within the marital context. Now the only remaining certainty is the identity of the woman giving birth — a woman who may or may not have contributed genetically to the child. For these and other reasons, the proposed reforms seek to extend legal presumptions of paternal filiation to maternal filiation of the child as well.

2. *Status and Protection of Human Life*

Before any decision can be made with regard to the uses of human genetic material, all of the commissions have had to decide upon its qualification as person or property. Moreover, irrespective of the ultimate qualification, there is no agreement as to what may be done to such human genetic material prior to implantation.

(a) *Person or Property*

While there is some consensus on the issue of qualification, there is no unanimity as to the protection to be afforded this "human life" or the degree of control to be exercised prior to implantation.

(i) *Potential Personhood*

No report has recognized the legal status of personhood in either the *in vitro* embryo or the *in utero* foetus prior to live birth.¹³⁵ While none would leave such human genetic material without any protection, all reports seek to distinguish it from the general rules governing human tissue or organ transplants, experimentation, and from the donation of hair, blood and other regenerable body parts. This is achieved by treating the embryo as a "potential human person"¹³⁶ or as human life worthy of protection.

¹³⁵ The following discussion on the status and protection of human genetic material is reproduced to some extent in Knoppers, *supra*, note 91. Canada: see OLRC Report, *supra*, note 1 at vol. 1, c. 3, s. 7; see also the recent discussion draft of the Medical Research Council of Canada, *Revised Guidelines on Research Involving Human Subjects* (October 1986) [hereinafter MRC Revised Guidelines] at 27, which states: "[a]t this time, the legal status of embryos and fetuses is inchoate. . . . The human embryo is no less a unique human life form than a foetus and warrants a high order of respect." Australia: section 2.1.3, Appendix III, NHMRC Report, *supra*, note 7, states: "[e]mbryos derived from human sperm and ova should be treated with respect, but that need not encompass the full rights attributed to persons." Britain: paragraph 11.6, Warnock Report, *supra*, note 3, states that the human embryo has no legal status *per se*; paragraph 5.7, Dunstan Report, *supra*, note 3 at 54, gives a very good discussion of the difficulty of determining when to accord what rights to the human foetus acknowledging that "[t]he embryo's 'right' not to suffer pain is, of course, the same right as we extend to any other creatures which possess 'awareness' in this rudimentary sense. In the case of humans the scientific evidence is clear: pain cannot be experienced at the embryonic stage but only after the fetus has developed a nervous system, six weeks after pregnancy being the earliest"; paragraph 13.6, RCOG Report, *supra*, note 2, states that while there is no clear rule, it depends on the neural development of the foetus, and in essence it is an ethical decision. United States: HEW Report, *supra*, note 3 at 101, states "the Board is in agreement that the human embryo is entitled to profound respect; but this respect does not necessarily encompass the full legal and moral rights attributed to persons"; *Ethical Considerations*, *supra*, note 1 at 77S would refer to the embryo prior to fourteen days as a pre-embryo, the term "embryo" itself being reserved for "the rudiment of the whole person that first appears in the second week after fertilization and continues to develop". France: *Avis du Comité d'éthique*, *supra*, note 16: "[l]'embryon humain doit être reconnu comme une personne potentielle et que cette qualification constitue le fondement du respect qui lui est dû." Paragraph 14(A)(iv), Council of Europe, *Rec. 1046*, *supra*, note 5, states no maintenance of embryos *in vitro* beyond the fourteenth day after fertilization (having deducted any time necessary for freezing), as well, paragraph 6 states "a definition of the biological status of an embryo . . . is necessary", paragraph 7: "[t]he legal status of the embryo and foetus [is] particularly precarious, and this status is at present not defined by law", paragraph 10: "[h]uman embryos and fetuses must be treated in all circumstances with the respect due to human dignity".

¹³⁶ France: see *Avis du Comité d'éthique*, *ibid.* at 3. United States: see *Ethical Considerations*, *supra*, note 1 at 77S, which states: "[t]he Committee finds that the human embryo is not a person but is entitled to respect because it has the potential to become a person."

Yet despite a general prohibition of extreme forms of experimentation,¹³⁷ a closer examination of the issue of donor control reveals a hybrid person-property approach to the question of the legal status of the embryo.

(ii) Donor Control

Few reports have gone so far as to openly advocate a right of ownership of the donors of sperm, ova and embryos in such "property".¹³⁸ Suggested and actual *in vitro* time prior to implantation stands at fourteen days, a point coinciding with implantation and "with the legal distinction between contraception and abortion".¹³⁹ Even while the "potential human person" approach advocates that the life of such a potential person be respected, the degree of control to be given to donors closely resembles ownership. Indeed, even in the absence of declared real property rights, donors would generally maintain full control over the uses to which their material is put;¹⁴⁰ over the length of storage;¹⁴¹ and over the

¹³⁷ See notes 160-4, *infra*.

¹³⁸ Australia: paragraphs 10.10-10.13 and 10.18, NSWLRC Report, *supra*, note 2; Supplementary Note 4, recommendation (6), NHMRC Report, *supra*, note 7, which states: "[s]perm and ova produced for IVF should be considered to belong to the respective donors." Britain: recommendation 10.11, Warnock Report, *supra*, note 3, which states: "[w]e recommend that legislation be enacted to ensure there is no right of ownership in a human embryo. Nevertheless, the couple who have stored an embryo for their use should be recognised as having rights to the use and disposal of the embryo, although these rights ought to be subject to limitation"; paragraph 14.4(3), RCOG Report, *supra*, note 2, states that the semen is owned by the donor until destruction is requested. Upon death of the donor the semen passes as chattel. This is the same with respect to embryos; see paragraph 14.4(4). United States: paragraph II, *Ethical Considerations*, *supra*, note 1 at 89S, which states "gametes and concepti are the property of the donors."

¹³⁹ See MRC, *Revised Guidelines*, *supra*, note 135. See also note 165, *infra*.

¹⁴⁰ Canada: recommendation 14(1), OLRC Report, *supra*, note 1 at 165, would agree with this except where the donated gametes are fertilized with gametes donated by someone else, in which case control would not be granted (see recommendation 27(2)(a)). Australia: paragraph 3.17, Waller Report, *supra*, note 4, which would allow the donor to withdraw consent; paragraph 2.8, Victoria Report, *supra*, note 4, which states:

The Committee does not regard the couple whose embryo is stored as owning or having dominion over that embryo . . . the Committee nevertheless does consider the couple whose gametes are used to form the embryo in the context of an IVF programme should be recognized as having rights which are in some ways analogous to those recognized in parents of a child after its birth.

As well, paragraph 2.9 states "the couple shall be required to make their decision about the disposition of the embryo which is to be stored before that procedure is initiated"; and paragraph 2.17 would require donors to prescribe the destiny of the embryo in light of possible events such as the donors' death; see also paragraph 10.18, NSWLRC Report; recommendation (6), NHMRC Report, *supra*, note 7; S. Austl. Report, *supra*, note 3 at 25, no revocation after donation. Britain: paragraph 11.24 Warnock Report, *supra*, note 3; paragraph 7.10, Dunstan Report, *supra*, note 3. United States: paragraph II, *Ethical Considerations*, *supra*, note 1 at 89S.

¹⁴¹ Australia: paragraph 2.13, Victoria Report, *supra*, note 4, which states, "where a couple consents to long term storage, the consent shall be reviewed after 5 years, and then may be renewed"; Supplementary Note 4, recommendation (7), NHMRC Report,

possible future destruction of their genetic material.¹⁴²

Like most studies, the OLRC *Report* would give donors control over the destiny of their gametes.¹⁴³ Thus, where there is a "fertilized ovum outside the body, produced with the gametes of the intended recipient and her husband or partner, [it] should be under the joint legal control of the man and woman".¹⁴⁴ Moreover, in the case of death of one of the donors, there would also be a right of legal control in the survivor.¹⁴⁵ As already mentioned, and in contrast to other studies, in cases of dispute or death of both donors, "control should pass to the physician, clinic, gamete bank, or other authority that has actual possession of the ovum".¹⁴⁶ Considering that the Commission would permit gamete banks to operate on a commercial basis, these banks would be the residual beneficiary.

Equally controversial is the suggestion of one Australian report that questions or disputes regarding the destiny of an embryo proceed before the courts as in a custody or adoption case.¹⁴⁷ The 1983 report of the English Royal College of Obstetricians and Gynaecologists went even further in advocating that in the absence of specific instructions by the donor (owner), sperm, ova or embryos pass as chattel to the estate upon death.¹⁴⁸ Finally, considering that recommended storage time of gametes or embryos ranges from twelve months,¹⁴⁹ or the reproductive life of the donor,¹⁵⁰ to two,¹⁵¹ five¹⁵² or ten year¹⁵³ statutory limits prior to destruction, the lip-service paid to the "potential person" qualification is self-evident. This becomes more apparent when one examines the recommendations concerning the uses of human genetic material.

supra, note 7. Britain: paragraph 10.10, Warnock *Report*, *supra*, note 3, which states: "[w]e recommend a maximum of ten years for storage of embryos after which time the right to use or disposal should pass to the storage authority." United States: paragraph VI, *Ethical Considerations*, *supra*, note 1 at 89S states: "[t]he concepti should not be retained in the cryopreserved state for longer than the reproductive life of the female donor."

¹⁴² Recommendation 14(1), OLRC *Report*, *supra*, note 1; *see also* paragraphs 2.11 and 2.17, Victoria *Report*, *supra*, note 4; paragraph 10.18, NSWLRC *Report*, *supra*, note 2.

¹⁴³ Recommendation 14, OLRC *Report*, *supra*, note 1. Note, however, that where donated gametes are fertilized, such exclusive control is lost (recommendation 27(2)(a)).

¹⁴⁴ Recommendation 27(1)(a), *ibid*.

¹⁴⁵ Recommendation 27(1)(b), *ibid*.

¹⁴⁶ Recommendation 27(1)(c), *ibid*.

¹⁴⁷ Paragraph B.6(ii), Queensland *Report*, *supra*, note 4.

¹⁴⁸ Paragraph 14(4)(3), RCOG *Report*, *supra*, note 2.

¹⁴⁹ Appendix VI: *Interim Report on Human In Vitro Fertilization and Embryo Replacement and Transfer*, in BR. MED. J.; vol. 286, 1594 (14 May 1983).

¹⁵⁰ Supplementary Note 4, recommendation (7), NHMRC *Report*, *supra*, note 7; paragraph VI, *Ethical Considerations*, *supra*, note 4 at 8.

¹⁵¹ Paragraph B.4(iii), Queensland *Report*, *supra*, note 4.

¹⁵² Waller *Report*, *supra*, note 4 at 89S.

¹⁵³ Recommendation 32, OLRC *Report*, *supra*, note 1; recommendation 20(d), S. Austl. *Report*, *supra*, note 3; Supplementary Note 4, recommendation (7), NHMRC *Report*, *supra*, note 7.

(b) *Uses of Human Genetic Material*

There is some consensus as to the time limit prior to transfer, but none whatsoever concerning donation. However, the freedom of the donor to consent to experimentation would be restricted in all jurisdictions.

(i) *Donation of Embryos*

The OLRC *Report* allows for embryo donation and, presumably,¹⁵⁴ the gamete banks as ultimate residual beneficiaries could do likewise, even on a commercial basis. One British report, however, considered the donation of embryos to be "unethical" based on the possibility of siblings being unknown to each other.¹⁵⁵ Some commissions would permit donation where both donors consent,¹⁵⁶ while a few would prohibit it altogether.¹⁵⁷ The American Fertility and Sterility Society would only permit such donation when the donors had satisfied their own infertility problem.¹⁵⁸ One Australian report, however, recommended legislation to the effect that gamete donors could specify in the consent form the eventual disposition of the embryo.¹⁵⁹

(ii) *Experimentation*

No report has gone so far as to advocate permitting experimentation on *in vitro* embryos, either within or outside of currently existing practices. The Law Reform Commission of Ontario would permit experimentation on a fertilized ovum in research centres approved by the Ministry of Health¹⁶⁰ if such experimentation were subject to internal screening by an ethics review committee.¹⁶¹ Other reports are more stringent in terms of either prohibiting experimentation or certain types of experimentation,¹⁶²

¹⁵⁴ Recommendation 27(1), OLRC *Report*, *supra*, note 1. See also page 203 of the text of the *Report*.

¹⁵⁵ Paragraph 11.4, RCOG *Report*, *supra*, note 2. This Report would, however, allow embryo donation if the possibility of unknown siblings could be avoided.

¹⁵⁶ Australia: *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, ss. 13(5)(a) and 13(6)(a) (these provisions were not in force as of 10 August 1986); recommendation 6.8, Waller *Report*, *supra*, note 4; paragraph B.3(xix), Queensland *Report*, *supra*, note 4. Britain: paragraph 5.7, Dunstan *Report*, *supra*, note 3. United States: paragraph VII, *Ethical Considerations*, *supra*, note 1 at 89S.

¹⁵⁷ Recommendation 21, S. Austl. *Report*, *supra*, note 3; paragraph 11.4, RCOG *Report*, *supra*, note 2. They prohibit it for fear of siblings being known to each other.

¹⁵⁸ Paragraph VII, *Ethical Considerations*, *supra*, note 1 at 89S.

¹⁵⁹ Recommendation 2.17, Victoria *Report*, *supra*, note 4.

¹⁶⁰ Recommendation 29(2), OLRC *Report*, *supra*, note 1.

¹⁶¹ Recommendation 29(3), *ibid.* See also MRC *Revised Guidelines*, *supra*, note 135 at 28-9, which states that "the Committee sees a broad prohibition of all research on embryos as neither justified nor wise . . . regional proposals involving embryos will vary with regional and individual differences, and thus the local REB is an appropriate forum in which to assess each protocol. In reaching its decision, an REB must take into account the embryo as human life at an early stage of the life cycle and the purpose for which the research is proposed."

¹⁶² Australia: *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, section 6(2) defines "prohibited procedure" as "(a) cloning; or (b) a procedure under

or in terms of the sanctions to be applied.¹⁶³ Some would prohibit experimentation all together.¹⁶⁴ All reports are unanimous in prohibiting the

which the gametes of a man or a woman are fertilized by the gametes of an animal" and section 6(3) states: "[a] person shall not carry out an experimental procedure other than an experimental procedure approved by the Standing Review and Advisory Committee"; paragraph 3.29, *Victoria Report, supra*, note 4, which states that "the use of any embryo for research shall be immediate, and in an approved and current project"; paragraph B.3(xx), *Queensland Report, supra*, note 4: "[a]n embryo should not be created for the purposes of experimentation"; recommendation 18, *S. Austl. Report, supra*, note 3, which states that "fertilized gamete(s) should never be used for scientific or genetic experimentation"; paragraph 5.5.8, *NHMRC Report, supra*, note 7, which states that "uninhibited research on gametes and fertilized ova is not acceptable". As well, Supplementary Note 4, paragraph 5.5.11, recommendation 5 states: "Research with sperm, ova or fertilized ova has been and remains inseparable from the development of safe and effective IVF and ET; as part of this research other important scientific information concerning human reproductive biology may emerge." Britain: paragraph 11.18, *Warnock Report, supra*, note 3, states that "research conducted on human *in vitro* embryos and the handling of such embryos should be permitted only under licence" and paragraph 11.24 states that "as a matter of good practice no research should be carried out on a spare embryo without the informed consent of the couple from whom that embryo was generated, whenever this is possible"; paragraph 8.3, *Dunstan Report, supra*, note 3 at 81, states that the Council is "not averse to the use of 'spare' embryos in research so long as certain conditions are satisfied: (a) The research use of such embryos must always be with the fully informed consent of the parents; it is their feelings which matter and should be respected. (b) Embryos which have been experimented on (as distinct from their therapeutic treatment) should never be implanted in a mother"; paragraph 13.8, *RCOG Report, supra*, note 2, supports the MRC (Medical Research Council of Britain) in that "scientifically sound research on the processes and products of *in vitro* fertilisation between human gametes is ethically acceptable and should be allowed to proceed on condition both that there is no intention to transfer to the uterus any embryo resulting from or used in such experiments and also that the aim of the research is clearly defined and directly relevant to clinical problems such as contraception or the differential diagnosis and treatment of infertility and inherited diseases". This would be subject to the informed consent of the donors. United States: paragraph IV, *Ethical Considerations, supra*, note 1 at 89S, states that "it is considered ethically acceptable to scientifically examine any conceptus donated for this purpose, provided such examination is carried out prior to the time development has reached the stage when implantation would normally occur. For the purpose of this paragraph 14 days after insemination is considered to be the limit"; conclusion (2), *HEW Report, supra*, note 3, states that it is "acceptable from an ethical standpoint to undertake research involving human *in vitro* fertilization and embryo transfer provided that: "A. . . . 1. The research complies . . . with regulations governing research with human subjects . . . ; 2. The research is designed primarily: (A) To establish the safety and efficacy of embryo transfer and (B) To obtain important scientific information toward that end not reasonably attainable by other means." There must also be full and informed consent with respect to "the nature and purpose of the research in which such materials will be used and have specifically consented to such use" France: *Avis du Comité d'éthique, supra* note 16 at 14-5.

¹⁶³ Australia: *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, ss. 6(1), (3), (5) and (6), which would set it at one hundred penalty units or imprisonment for four years (these provisions were not all in force as of 10 August 1986). Britain: paragraph 11.18, *Warnock Report, supra*, note 3, which states that "any unauthorised use of an *in vitro* embryo would in itself constitute a criminal offence".

¹⁶⁴ Australia: recommendation 18, *S. Austl. Report, supra*, note 3. France: *Proposition de loi relative au statut de l'enfant conçu ainsi qu'aux expérimentations et*

implantation in a woman of an embryo subjected to non-therapeutic experimentation. There is also a general consensus (for the time being) as to the fourteen-day limit on the development of the embryo *in vitro*.¹⁶⁵

Even though every Commission recognizes that the embryo *in vitro* constitutes human life worthy of protection (via medical or statutory regulation), it is obvious that the degree of recognition varies greatly. This is indicative of the difficult political and social problems underlying the question and of whether such infertility treatment constitutes medical "therapy". While the range of options represents the particular compromises various jurisdictions were willing to make, if recommendations are implemented in their present garden-variety, they could also lead to forum-shopping by participants and scientists alike. Indeed, if we are to distinguish between human genetic material as property, as a simple product of conception or as a person, there is *no* area where the need for some national and international uniformity is more imperative. The one area where there has been legislative reaction, however, is that of filiation. The need for certainty in the legal status of the child once born is self-evident.

3. Filiation

In contrast to the questionable protection of *in vitro* human genetic materials, nowhere is the common tendency towards state protection of the child more evident than in the legislation seeking to establish the filiation of the artificially conceived child after birth. In those states, countries or provinces maintaining the distinction between illegitimate and legitimate children, some earlier effort was made to prevent the illegitimacy of the child, or to prevent the possibility of disavowal of paternity by the husband of the woman giving birth after artificial insemination by a donor.

recherches concernant la création de la vie humaine, Ass. nat. no. 2158, 2e sess., 1983-84, art. 5; *Comité consultatif d'éthique*, *supra*, note 16 at 14-9 (prohibited if meant to determine genetic characteristics, such as predictions of sex or defect, and a general ban of three years on research for preimplantation genetic diagnosis). Council of Europe: paragraph 14(A)(iv), Council of Europe, *Rec. 1046*, *supra*, note 5; Annexe I, principe 17, *CAHBI 1986*, *supra*, note 2.

¹⁶⁵ Canada: recommendation 31, *OLRC Report*, *supra*, note 1; *MRC Revised Guidelines*, *supra*, note 135 at 28-9 (14-17 days). Australia: Supplementary Note 4, recommendation 5, *NHMRC Report*, *supra*, note 7. Britain: paragraph 11.22, *Warnock Report*, *supra*, note 3; paragraph 13.8, *RCOG Report*, *supra*, note 2 (17 days). United States: Conclusion (2)A.4, *HEW Report*, *supra*, note 3; paragraphs IV and V, *Ethical Considerations*, *supra*, note 1 at 89S, which states: "[n]on-transferred concepti should not be allowed to develop in the laboratory more than 14 days and may be disposed of without scientific examination." France: *Comité consultatif d'éthique*, *supra*, note 16 at 16-7 (7 days on surplus embryo). See also Council of Europe, Annexe I, principe 18, *CAHBI 1986*, *supra*, note 2, art. 1(d), which states that research would be permitted on embryos not implanted after 14 days development *in vitro*. However, this was superseded by paragraph 14(a)(iv), Council of Europe, *Rec. 1046*, *supra*, note 5, which limited *in vitro* development to fourteen days.

More recent reforms seeking to address the filiation of the child in a more comprehensive fashion (irrespective of the source of genetic material) would go even further by adding legal presumptions of maternity.

(a) *Paternity and Artificial Insemination by Donor*

Most of the proposed reforms are concerned with either the possible illegitimacy (in those jurisdictions where such a distinction still exists) of the child or with the question of the consent of the recipient's partner. Linked to a constantly evolving family law (usually of provincial or state jurisdiction), it is an added problem that the earlier reports or reforms dealt only with artificial insemination by donor and thereby implemented changes with untoward legal implications for other forms of reproductive technology.

(i) *Presumed Paternity*

In Canada, only four provinces have abolished illegitimacy.¹⁶⁶ Only Quebec¹⁶⁷ and the Yukon¹⁶⁸ have passed legislation specifically excluding the possibility of a denial of paternity where the husband has consented to the artificial insemination of his wife. Most of the Australian or American states legislating in this area have passed similar statutes which are concerned with establishing the legitimacy of the child and establishing uncontestable or irrebuttable paternity.¹⁶⁹

The legislation of both Quebec and the Yukon, limited as it is to artificial insemination by donor, reflects the dangers of adopting a piecemeal legislative approach to each technique of artificial conception. This is particularly evident in the fact that the irrebuttable presumptions of paternity following the husband's consent to artificial insemination have made it impossible for the biological father to claim his child if he has contracted with a married surrogate whose consenting husband is irrefutably the legally presumed father.

The requirement of spousal consent may itself be in conflict with already existing legislation on medical treatment, to say nothing of the question of the autonomy of the individual in matters concerning his or her health or body.

¹⁶⁶ These provinces are Quebec, New Brunswick, Manitoba and Ontario.

¹⁶⁷ Art. 586 C.C.Q.

¹⁶⁸ *Children's Act*, S.Y.T. 1984, c. 2, s. 14(3).

¹⁶⁹ Victoria: *Status of Children (Amendment) Act, 1984* (Principal Act No. 8602 as amended by No. 9863), ss. 10C(2)(a), 10C(3)(a), 10D(2)(a) and 10D(3)(a). New South Wales: *Artificial Conception Act, 1984*, ss. 5(2), (3). South Australia: *Family Relationships Act Amendment Act, 1984*, s. 10(d). United States: see L.B. Andrews, *NEW CONCEPTIONS* (New York: St. Martin's Press, 1984); see also *Ethical Considerations*, *supra*, note 1 at 12S, where discussion of existing legislation took place but no position was taken by the society on the issue of filiation.

(ii) *Spousal Consent*

The majority of studies, and even current legislation, concerning artificial insemination require spousal consent prior to artificial insemination by donor.¹⁷⁰ Few studies specify whether it should be written consent, nor do they specify what sanctions would follow an omission to obtain such consent.¹⁷¹ Some studies would go so far as to create a rebuttable presumption of spousal consent.¹⁷² This proposal may be considered disrespectful of individual autonomy, as is the initial requirement of spousal consent for artificial insemination.¹⁷³ Furthermore, the requirement of spousal consent is contrary to other legislation specifying that spousal consent is not necessary for medical treatment.¹⁷⁴ It demonstrates the failure to separate the issue of a spouse or partner voluntarily seeking to assume parental obligations from the question of the necessity of obtaining spousal consent in order for the treatment to be given. It also incorporates current existing presumptions of paternity in the marital context.

¹⁷⁰ Canada: recommendation 1, BCRC Report, *supra*, note 3. Australia: *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, ss. 10(3)(b), 11(3)(b) and 12(3)(b) (these provisions were not in force as of 10 August 1986); paragraph 3.5, Waller Report, *supra*, note 4; paragraph C.1, Queensland Report, *supra*, note 4; recommendation 8, S. Austl. Report, *supra*, note 3 at 50 no. 2 (Draft Guidelines). Britain: paragraph 3.5, Warnock Report, *supra*, note 3. France: *Proposition de loi tendant à faire de l'insémination artificielle un moyen de procréation*, 47 Sénat, 1re sess., 1978-79, art. 6. Council of Europe: Annexe I, principe 6, CAHBI 1986, *supra*, note 2.

¹⁷¹ Canada: recommendation 1, BCRC Report, *supra*, note 3. Australia: *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, ss. 10(3)(b), 11(3)(b) and 12(3)(b) (these provisions were not in force as of 10 August 1986); paragraph 3.5, Waller Report, *supra*, note 4; paragraph B.2(vii), Queensland Report, *supra*, note 4. Britain: paragraph 3.5, Warnock Report, *supra*, note 3. France: *Proposition de loi tendant à faire de l'insémination artificielle un moyen de procréation*, 47 Sénat, 1re sess., 1978-79, art. 6. Council of Europe: Annexe I, principe 6, CAHBI 1986, *supra*, note 2.

¹⁷² See OLRC Report, *supra*, note 1 at 177-8, which explains the presumption of spousal consent in the following way: "[w]e cannot think of a more unpalatable regime than one in which the child's legal status is made dependent upon some affirmative, mandatory manifestation of consent by one's mother's spouse or partner, and particularly upon a formal, written consent procedure, prior to the commencement of treatment. Accordingly, we recommend that the consent of the husband or partner should be presumed as a matter of law. However, this presumption should be rebuttable at his instance or at the instance of another person with a legitimate interest." See also paragraph 4.6, Waller Report, *supra*, note 4; paragraph 4.24, Warnock Report, *supra*, note 3.

¹⁷³ It goes without saying that if individual women should be free to decide whether, how and when they wish to exercise reproductive choice, no man involved as a partner (through marriage or a *de facto* relationship) should be subject to legally enforced paternity where he did not so consent.

¹⁷⁴ Take for example Quebec's law: *An Act Respecting Health Services and Social Services*, R.S.Q. 1977, c S-5, s. 156: "[t]he consent of a consort shall not be required for the furnishing of services in an establishment." In spite of this clear statement under Quebec's health and social services legislation, articles 586 and 588 of the *Civil Code of Quebec* mention spousal consent as a bar to the disavowal of the paternity of a child following the consent of a husband to the artificial insemination by donor of his wife. These articles on filiation have been taken to mean that the physician requires the consent of a spouse before offering access to artificial insemination by donor to a married woman.

The need for a more extensive reordering of filiation, taking into account the consequences of all types of artificial conception, was foreseen in other studies dealing with paternal *and* maternal filiation as well as the filiation of the societal parents in the case of surrogacy.

(b) *Maternity and Reproductive Technologies*

Since time immemorial, maternity has been certain while paternity was presumed by law so as to safeguard the legitimacy of the child as well as the genealogical heritage. New problems emerge with the possibility of egg and embryo donation. Like sperm donation, however, the fact of donation is secondary to the question of who will actually bear and give birth to the child. Maternal filiation thus remains linked to these functions.

In the case of surrogacy the notion of a social mother has emerged. Limiting ourselves to social parentage as recognized in the studies, it is evident that such a concept undermines whatever (presumed or imposed) "legitimacy" remains of traditional notions of filiation.

(i) *Maternal Filiation*

The Law Reform Commission of Ontario,¹⁷⁵ like some of their Australian¹⁷⁶ and British counterparts,¹⁷⁷ has recommended that, irrespective of the source of genetic material, the woman who bears the child and her husband or partner should be deemed under law to be the parents. While the husband or partner could rebut this presumption, no mention is made of rebuttable maternity. As with sperm donation, ova donation would not grant the donor any "parental" rights. Thus, in the case of embryo donation, the ultimate "bearer" or "carrier" would presumably be considered the mother under law by virtue of giving birth.

This position of the OLRC *Report* is consistent with its view that maternal filiation for surrogacy be treated separately.¹⁷⁸ Indeed, in contrast to the respect given to the gestational mother under such an explicit legislative recognition of maternity, in the surrogacy context, the woman bearing the child would be forced to give it up at birth in favour of the social parents.¹⁷⁹

¹⁷⁵ Recommendation 19(1), OLRC *Report*, *supra*, note 1.

¹⁷⁶ See Victoria: *Status of Children (Amendment) Act, 1984*, (Principal Act No. 8602 as amended by No. 9863), ss. 10E(2)(a) and (3)(a); paragraph D.2, Queensland *Report*, *supra*, note 4; South Australia: *Family Relations Act Amendment Act, 1984*, s. 10C.

¹⁷⁷ Paragraph 7.3.22, Dunstan *Report*, *supra*, note 3, poses the question but comes to no definite conclusion.

¹⁷⁸ Recommendation 52, OLRC *Report*, *supra*, note 1, which states that "upon the birth of a child pursuant to an approved surrogate motherhood arrangement, the social parents will be the parents of the child for all legal purposes."

¹⁷⁹ Recommendation 49, OLRC *Report*, *supra*, note 1. This is the only report that supports such a position. Indeed, a breach of an agreement to surrender the child could in fact be sanctioned by damages and custody decided by the courts.

(ii) *Social Parentage*

In the case of surrogacy, some proposals¹⁸⁰ like the Ontario one,¹⁸¹ would deem the societal parents receiving the child at birth to be the legal parents. In any event, the attempt in the studies to partially restructure legal filiation so as to incorporate different genetic, biological or social notions of legally defined "parenting" or filiation is still based on legal presumptions within the marital context.

The above measures are based on an antiquated system of presumptions of spousal consent as well as *ex post facto* presumptions of paternity and maternity. Such legal fictions can no longer accommodate the fallout of reproductive technology — nor indeed of family relationships generally. Instead, filiation, the establishment of a parent-child relationship as recognized under law, could in *all* births be voluntary, intentional and consensual and legally sanctioned rather than legally imposed or presumed. Parents could then, in the context of reproductive technologies, be those individuals who together or singly choose to contribute gametes for the creation of an embryo so as to conceive and raise a child.

Following this reasoning, in the case of a married or cohabiting couple where *both* parties have contributed gametes for the creation of an embryo, the consent of both must be obtained prior to implantation, but it would be as participating donors, not due to the fact of marriage. When only one party has contributed gametes or wishes to become a parent under law, the consent of the other should not be necessary nor be presumed. Legal responsibility would then flow from a deliberate choice to become a parent. Perhaps the arrival of reproductive technology will force this larger reform.

C. *Surrogate Motherhood*1. *Introduction*

Surrogate motherhood does not itself constitute one of the technologies of reproduction. It does, however, add a very important dimension to them. Surrogate motherhood is an arrangement whereby a woman agrees to be artificially inseminated, to carry the child to term and to surrender all of her parental rights to that child at birth in favour of the person or persons with whom she made the pre-conception agreement. The legal problems of these arrangements focus on the legality and regulation of the contractual relationship between the parties and, where

¹⁸⁰ Britain: *Surrogacy Arrangements Act 1985* (U.K.), 1985, c. 49, s. 1(8), which defines payment as "payment in money or money's worth" and which could be broadly interpreted to mean any form of consideration passing from the societal parents to the gestational mother; subsection 1(9) states: "[t]his Act applies to arrangements whether or not they are enforceable by or against any of the persons making them." See also Comité consultatif national d'éthique pour les sciences de la vie et de la santé, Document de travail sur les problèmes éthiques posés par les recours aux "mères de substitution" (le 25 octobre 1984) [unpublished] [hereinafter *Document sur les problèmes éthiques*].

¹⁸¹ Recommendation 52, OLRC Report, *supra*, note 1.

they are deemed legal, the respective obligations of both parties in terms of fulfillment of the contract.

2. *Validity and Enforceability*

The primary concern voiced by legal policy-makers initially focussed on the legality of the surrogate motherhood contract, particularly in terms of its enforceability in court. Those studies which recommend the legal recognition of these contracts also established basic guidelines for their regulation.

(a) *Legality*

The scarcity of detailed analysis of surrogacy arrangements is due to the fact that most studies simply dismiss them outright as contrary to public policy. A few notable exceptions argue for the legal recognition of such contracts.

(i) *Illegality*

Surrogate motherhood contracts are expressly prohibited in England and in the State of Victoria in Australia.¹⁸² Such contracts, even if undertaken in those countries where there is no *specific prohibition*, rely totally on the good faith of the parties. If challenged, it seems clear that they would be unenforceable in the courts as contrary to public policy.¹⁸³ The moral, ethical and social implications of surrogacy have led most of the legal policy-makers to recommend that these contracts simply remain unenforceable.¹⁸⁴ This leaves parties the freedom to enter such contracts,

¹⁸² The United Kingdom has enacted legislation expressly prohibiting the negotiating of surrogacy arrangements on a commercial basis. See *Surrogacy Arrangements Act 1985* (U.K.), 1985, c. 49, s. 2. Payment is interpreted as payment in money or money's worth (s. 1(8)) (*Quaere* whether "money's worth" would include an altruistic arrangement providing for food, medicine and lodging only). For the United States, see Andrews, *supra*, note 169 at 226ff. Under the adoption laws of most countries, the prohibition against the exchange of money also serves as a means of outlawing surrogacy. See also *Ethical Considerations*, *supra*, note 1 at 77S: "[t]he Committee opposes the use of surrogate gestational mothers for nonmedical reasons. . . ." See also pages 615 and 67S. However, the Committee believes that there may be medical reasons to justify individual decisions and sees no adequate reasons to recommend legal prohibition of surrogate motherhood.

¹⁸³ Canada: See *OLRC Report*, *supra*, note 1 at 220, where it states: "[a]lthough not otherwise prohibited, it would appear that such arrangements are illegal and unenforceable at common law." Australia: see *Queensland Report*, *supra*, note 4 at 115 and S. Austl. *Report*, *supra*, note 3 at 29; France: see *Document sur les problèmes éthiques*, *supra*, note 180 at 23.

¹⁸⁴ Australia: see *Queensland Report*, *supra*, note 4 at 117. Britain: see paragraph 8.19, *Warnock Report*, *supra*, note 3 at 47 and paragraph 5.6, *Dunstan Report*, *supra*, note 3 at 51, where it is also suggested that medical codes may deem surrogate motherhood permissible under very special circumstances. Some reports, while not mentioning unenforceability, do consider such contracts as being unethical. See, e.g., paragraph 7.6, *RCOG Report*, *supra*, note 2. United States: see *Ethical Considerations*, *supra*, note 1 at 77S, which states that "the Committee has serious ethical reservations about surrogacy".

but provides them with no judicial remedies or protections.

The Queensland *Report* recommends that such contracts remain unenforceable but suggests that ethical guidelines be established for practising physicians.¹⁸⁵ The South Australian *Report* has gone further, recommending that "a policy should be formally adopted by the government in relation to the *Adoption of Children Act* to prevent surrogacy from being practiced in South Australia".¹⁸⁶ These recommendations are based on the negative psychological and emotional implications for the gestational mother on having to give up a child she carried to term,¹⁸⁷ the repugnance of contracting to surrender parental rights,¹⁸⁸ and the potential of commercial exploitation of such arrangements¹⁸⁹ (which one British report has equated with prostitution).¹⁹⁰

(ii) *Validity*

In contrast, the OLRC *Report* (with one dissent) has recommended that contracts for surrogate motherhood be recognized by the courts¹⁹¹ and has formulated basic regulations for such contracts. In the United States, where it appears that such contracts are being undertaken more and more frequently, at least four states have proposed legislation for their regulation and enforcement.¹⁹²

The common underlying rationale for the legitimacy of such contracts is the acknowledgment of the reality that they do exist and will continue to be undertaken.

The preliminary requirements for the legality of a surrogate mother contract would be that the gestational mother has attained majority¹⁹³ and that the social parents have proof that there is "a medical need that is not amenable to alleviation by other available means".¹⁹⁴ While the Tennessee

¹⁸⁵ See paragraph D.3, Queensland *Report*, *supra*, note 4.

¹⁸⁶ *Supra*, note 3.

¹⁸⁷ Canada: See generally OLRC *Report*, *supra*, note 1 at 230. Australia: see paragraph 4.4, Victoria *Report*, *supra*, note 4; Queensland *Report*, *supra*, note 4 at 115. Britain: see paragraphs 8.10 and 8.11, Warnock *Report*, *supra*, note 3 at 44-5. See also paragraph 5.6(a), Dunstan *Report*, *supra*, note 3 at 50; RCOG *Report*, *supra*, note 2 at 7.

¹⁸⁸ Canada: see OLRC *Report*, *supra*, note 1 at 230. Australia: see Queensland *Report*, *supra*, note 4 at 115. Britain: see RCOG *Report*, *supra*, note 2 at 7.

¹⁸⁹ Australia: see paragraph 4.11, Victoria *Report*, *supra*, note 4; Queensland *Report*, *supra*, note 4 at 115. Britain: see paragraph 8.17, Warnock *Report*, *supra*, note 3 at 46; subsection 5.6(b), Dunstan *Report*, *supra*, note 3 at 50.

¹⁹⁰ See subsection 5.6(b), Dunstan *Report*, *supra*, note 3 at 50.

¹⁹¹ See recommendations 34 to 66, OLRC *Report*, *supra*, note 1 at 281-5.

¹⁹² See Michigan: *The Surrogate Parenting Act*, H.B. 4555 (introduced 16 April 1985); Tennessee: *The Tennessee Surrogate Motherhood Regulation Act of 1982* (the status of this proposed legislation is uncertain. A copy of the draft legislation is on file at the Ottawa Law Review) [hereinafter *Tennessee Proposals*]; California: *Surrogate Parenting Act*, project 3771; New Jersey: *The Surrogate Parenting Act*, SB 3608.

¹⁹³ Recommendation 41, OLRC *Report*, *supra*, note 1 at 282. See also Tennessee: *Tennessee Proposals*, *ibid.*, cl. 106.

¹⁹⁴ Recommendation 38, OLRC *Report*, *supra*, note 1 at 281-2. See also Michigan: *The Surrogate Parenting Act*, H.B. 4555 (introduced 16 April 1985), s. 4(e).

Proposals make no reference to this latter requirement, the Warnock *Report* and the Dunstan *Report* make it very clear that such arrangements are unequivocally unacceptable where a gestational mother is used for the convenience of the prospective social parents alone.¹⁹⁵

While the Law Reform Commission of Ontario recommends that the marital requirements of the social parents be left up to the courts' consideration,¹⁹⁶ proposed legislation in Tennessee and Michigan appear to presume there will be two prospective nurturing parents,¹⁹⁷ although actual marriage requirements are not explicit.

(b) *Regulation*

The studies that favour surrogacy arrangements (or at least recognize that they won't go away) recommend detailed proposals for judicial review, statutory regulation, counselling and medical surveillance.

(i) *Judicial Review*

The OLRC *Report* recommends that all surrogate motherhood contracts be subject to the approval of the court before they be considered valid.¹⁹⁸ In recommending review by the courts of all surrogate motherhood arrangements, the Commission would also give the court jurisdiction to review the actual terms of each contract.¹⁹⁹ Any unduly onerous clauses should be excluded prior to the contract taking effect. Obviously, such proposals leave the family court judges with an enormous amount of discretion.

This system of pre-contractual court authorization raises fairly strong presumptions in favour of the contractual stipulations once the contract has been approved by the court, thereby placing a heavy burden on a party who wishes to challenge the effect of any of its terms at a later time. While it is readily acknowledged that there is no standard formula for surrogate motherhood contracts (the situation of the parties being different in each case), this solution for *ad hoc* review does not lend any standardized protection to any of the parties. Such protection may be necessary since each arrangement provokes different fundamental moral, ethical and emotional responses, and the court must be respectful of the individual. Furthermore, these arrangements may acquire legal certainty over time. Nevertheless, detailed statutory regulation may be a more legally efficient route and provide greater protection for all the parties than would judicial review.

¹⁹⁵ See paragraph 8.17, Warnock *Report*, *supra*, note 3 at 46. See also paragraph 5.6, Dunstan *Report*, *supra*, note 3 at 51, which clearly states: "[n]ever for the purposes of convenience".

¹⁹⁶ See recommendation 39, OLRC *Report*, *supra*, note 1 at 282.

¹⁹⁷ Michigan: *The Surrogate Parenting Act*, H.B. 4555 (introduced 16 April 1985), s. 4(1); Tennessee: *Tennessee Proposals*, cl. 211(1)(b).

¹⁹⁸ See recommendation 35, OLRC *Report*, *supra*, note 1 at 281.

¹⁹⁹ See recommendation 36, OLRC *Report*, *supra*, note 1 at 281.

(ii) *Statutory Regulation*

Where surrogate motherhood legislation has been proposed, such as those in both Tennessee²⁰⁰ and Michigan,²⁰¹ judicial review is not required. The contract will be governed directly by the legislation. In Tennessee, any surrogate motherhood arrangements are deemed to fall within the purview of the legislation,²⁰² whereas Michigan provides sanctions for any person who contracts contrary to the provisions in the Act.²⁰³

Under these statutes, surrogate motherhood contracts must be in writing²⁰⁴ and must bear the signatures of at least the social parent(s) and the gestational mother. The Tennessee Act would further require the signature of the gestational mother's husband where she is living with her spouse.²⁰⁵ The Act then takes this requirement of spousal consent further by stating that even where the gestational mother and her husband are no longer living together, her husband must be given notice of the proposed contract.²⁰⁶ He then has thirty days to obtain judicial relief enjoining his spouse from entering the contract.²⁰⁷ Considering that, in contrast to artificial insemination of a married woman intending to keep the child, the woman who acts as a gestational woman will be giving up the child, this provision for spousal consent (like those requiring spousal consent for any assisted conception, or presuming it after the fact for husbands of married women) is indicative of the perpetuation of some form of "property" right between the spouses over each other.

(iii) *Counselling*

Parties to the prospective surrogate motherhood contract, whether subject to judicial review or statutory regulation, must undergo some form of counselling to determine their suitability. The OLRC *Report* recommends that the court be responsible for determining the suitability of the prospective parents²⁰⁸ and the gestational mother.²⁰⁹ Michigan would require a signed acknowledgment from a person qualified under the Act to the effect that the gestational mother is capable of consenting to the surrender of her parental rights and has been adequately counselled.²¹⁰ The prospective societal parents must also have received counselling and

²⁰⁰ *Tennessee Proposals*, *supra*, note 192.

²⁰¹ *The Surrogate Parenting Act*, H.B. 4555 (introduced 16 April 1985).

²⁰² *Tennessee Proposals*, *supra*, note 192, cl. 102.

²⁰³ *The Surrogate Parenting Act*, H.B. 4555 (introduced 16 April 1985), s. 3(2).

²⁰⁴ See recommendation 36, OLRC *Report*, *supra*, note 1 at 281. See also Michigan: *The Surrogate Parenting Act*, H.B. 4555 (introduced 16 April 1985), s. 7(1); Tennessee: *Tennessee Proposals*, *supra*, note 192, cl. 211.

²⁰⁵ *Ibid.*, cl. 211(3).

²⁰⁶ *Ibid.*

²⁰⁷ *Ibid.*

²⁰⁸ See recommendation 39, OLRC *Report*, *supra*, note 1 at 282.

²⁰⁹ See recommendation 42, OLRC *Report*, *supra*, note 1 at 282.

surrender of her parental rights and has been adequately counselled.²¹⁰ The prospective societal parents must also have received counselling and must understand the consequences of the arrangement.²¹¹ One British report, despite its reluctance to approve of surrogate motherhood contracts, does state that where such a contract is undertaken all parties should receive "impartial and disinterested counselling".²¹² There is no doubt that counselling as to the legal and social void surrounding such techniques is necessary, but what is worrisome is the fact that this counselling could easily be used as a form of discrimination.

(iv) *Medical Surveillance*

In most surrogacy cases the gestational mother is artificially inseminated with the sperm of the prospective social father. She therefore contributes fifty percent of the child's genetic make-up. It is to be expected that the gestational mother will be subject to standards of screening similar to those discussed with respect to gamete donors.²¹³ Obviously, under the judicial review approach of the *OLRC Report*, the court could examine any contractual terms relating to medical surveillance subject to the general recommendations of the report.

The *Tennessee Proposals* is the only document on surrogacy which specifically stipulates that all parties have a positive obligation to fully disclose "any condition, including relevant genetic history" that would have an effect on the pregnancy, the health of the child, the fertility of the gestational mother or anything which "may affect the physical and mental well-being of the surrogate mother".²¹⁴ This obligation is imposed on "[a]ll parties to a contract under this act"²¹⁵ and does not therefore apply only to the gamete donor (that is, the gestational mother) but also to the social parents, particularly where the social father is also the biological father. This seems to be an added dimension to the screening requirements already discussed with respect to individuals participating in other forms of assisted reproduction. It is not clearly stipulated in any of the studies reviewed that a woman artificially inseminated with donor sperm would have an affirmative duty of disclosure, whereas such a duty would often be imposed on sperm donors.²¹⁶

²¹⁰ *The Surrogate Parenting Act*, H.B. 4555 (introduced 16 April 1985), s. 4(1)(f).

²¹¹ *The Surrogate Parenting Act*, H.B. 4555 (introduced 16 April 1985), s. 4(1)(c).

²¹² See paragraph 8.5, *Dunstan Report*, *supra*, note 3 at 51.

²¹³ Canada: see recommendations 15 and 23, *OLRC Report*, *supra*, note 1 at 276 and 279; see also recommendation 8, *BCRC Report*, *supra*, note 3; section 4 of the model legislation in *Sask. Proposals*, *supra*, note 2 at XIX. Australia: see *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, s. 37 (this provision was not in force as of 10 August 1986); see also paragraph 5.15, *NSWLRC Report*, *supra*, note 2; paragraph B.3(iv), *Queensland Report*, *supra*, note 4; recommendation 4, *S. Austl. Report*, *supra*, note 3. Britain: see section 4.5, *Dunstan Report*, *supra*, note 3 at 40.

²¹⁴ *Supra*, note 192, cl.214.

²¹⁵ *Ibid.*

²¹⁶ See note 213, *supra*.

Both the Michigan and the Tennessee proposals have clauses relating to medical supervision of the gestational mother during the pregnancy.²¹⁷ Because the development of the child is dependent on the health of the gestational mother, contractual conditions relating to her conduct during the pregnancy are to be expected; however, there must be some assurance that such clauses are not too onerous. To ensure this, both Michigan and Tennessee qualify medical surveillance clauses by stating that such clauses must be "reasonable". Michigan states that the gestational mother must agree to "any *reasonable* request by the societal father for a medical, psychiatric, or psychological examination or a genetic screening".²¹⁸ Tennessee stipulates that the gestational mother must comply with the advice given by the doctor chosen by the social parents where that advice is "reasonable".²¹⁹

While the qualification of reasonableness may be expected to limit the enforceability of terms relating to medical surveillance which are clearly too onerous (for example, where too physically intrusive or where the non-compliance with the medical advice would, by virtue of the contract, allow the prospective parents to rescind), in cases of dispute, standards of reasonableness would be left for the judiciary to determine. Whether or not this is an appropriate solution for the problem is questionable; however, it does appear to be clear that some form of protection must be given to the gestational mother against onerous contractual stipulations. At this time, the test of "reasonableness" would seem to be the least contentious solution. Paradoxically, while it would appear that the pre-approval by the court of the terms of the contract in Ontario provides adequate protection from "unreasonable" clauses for the parties, such court approval may, in fact, seriously increase the onus on the party contesting the clause or seeking to change it at a later date and so restrict flexibility.

More promising than the above is the stipulation under the *Tennessee Proposals* that the gestational mother is *presumed* to have agreed not to do "any act which may tend to endanger the child".²²⁰ More specific regulation of her diet or her lifestyle is within the power of the contracting parties to stipulate.²²¹ The Ontario report makes a similar recommendation.²²² This presumption appears to be more respectful of the moral and individual responsibility of the gestational mother.

²¹⁷ Michigan: *The Surrogate Parenting Act*, H.B. 4555 (introduced 16 April 1985), s. 7(1)(a); Tennessee: *Tennessee Proposals*, *supra*, note 192, cl. 215.

²¹⁸ *The Surrogate Parenting Act*, H.B. 4555 (introduced 16 April 1985), s. 7(1)(a) (emphasis added).

²¹⁹ *Tennessee Proposals*, *supra*, note 192, cl. 225.

²²⁰ *Ibid.*, cl. 226.

²²¹ *Ibid.* See also cl. 202, which grants the parties the freedom to "agree to whatever terms they desire within the bounds of the law".

²²² See recommendation 55(1)(f), *OLRC Report*, *supra*, note 1 at 284.

Finally, it is only the OLRC *Report* which clearly recommends that the gestational mother should receive separate legal representation.²²³ This is an important stipulation when examining the power balance between the gestational mother and the prospective parents.

3. *Fulfillment of the Contract*

Once past the preliminary issues of the prohibition and enforceability of surrogate motherhood contracts, the most contentious issue for the few reports envisaging its regulation remains the question of payment. Moreover, because of the very particular nature of these contracts, any law regulating their use must also deal with remedies for breach in the case of repudiation.

(a) *Payment*

The motive of the prospective social parents in a surrogate motherhood contract is clearly the custody and legal parentage of the child born to the gestational mother. The gestational mother's motives are not so clear. In certain cases a woman may become a gestational mother for altruistic reasons, in others it may be for economic consideration, and often it is likely a combination of both.

The studies are clearly divided on the issue of payment. Those that recommend the prohibition of surrogacy do so mainly on the basis of a repugnancy of the commercialization of motherhood, while those that accept surrogacy maintain that payment should and can be regulated.

(i) *Prohibition*

The issue of payment formed the basis of the general condemnation of surrogacy contracts.²²⁴ The Warnock *Report* considered it "inconsistent with human dignity that a woman should use her uterus for financial profit and treat it as an incubator for someone else's child".²²⁵ The Dunstan *Report* concluded that "it may be said that the less the profit motive enters into any aspect of human reproduction, the more likely it is that having children will retain the qualities of love and dignity".²²⁶ Similar motives are expressed in other reports.

²²³ See recommendation 36, OLRC *Report*, *supra*, note 1. But see *The Surrogate Parenting Act*, H.B. 4555 (introduced 16 April 1985), s. 10, which does provide some protection for the parties by stipulating: "[a]n attorney who represents a societal father and a societal mother, or any other attorney with whom that attorney is associated, shall not represent simultaneously a female who is or proposes to be a surrogate mother or a surrogate carrier in any matter relating to a surrogate agreement with that societal father and societal mother."

²²⁴ See *Infertility (Medical Procedures) Act 1984* (Victoria), No. 10163, ss. 30(2)(b) and 30(2)(c). See also paragraph 4.11, Victoria *Report*, *supra*, note 4.

²²⁵ Paragraph 8.10, Warnock *Report*, *supra*, note 3 at 47.

²²⁶ Paragraph 8.5, Dunstan *Report*, *supra*, note 3 at 84.

(ii) *Regulation*

Despite the distaste that is voiced when the issue of payment comes up, it is clear that the trend seems to be toward approval for the payment of reasonable expenses. The notion of baby-buying is circumvented once again by describing the financial terms of the surrogate contract as remuneration as opposed to profit.²²⁷

It seems, therefore, that where surrogate motherhood contracts are approved by legislation, the tendency is to ensure that any agency involvement in the arrangements between the gestational mother and the prospective social parents must be done on a non-profit basis and should be subject to some form of scrutiny or control.²²⁸ The economic issues relating to the surrogate motherhood contract are complicated by the prospect of third parties or agencies being used to facilitate contracting. When a third party organization becomes involved in the contract, the potential for commercial exploitation rises significantly.

The OLRC *Report* describes four different types of payment: payment 1) for profit; 2) to cover expenses; 3) to cover lost income and lost earning opportunities; and 4) as compensation for pain and suffering.²²⁹ Generally, the issue of payment is discussed in the studies as either profit or remuneration for expenses. There is a strong tendency to disallow payment for profit.²³⁰

After having broken payment down into these four categories, the Ontario report does not make a firm statement with respect to which should be authorized. Instead, the Commission once again refers the question of payment to the judiciary who is to decide whether or not to approve the amount agreed upon by the contracting parties.²³¹

In contrast, the *Tennessee Proposals* stipulate that payment will be \$10,000 upon completion of the pregnancy, not including expenses, unless otherwise agreed. The commentary accompanying this provision states that "generally, the amount of compensation is left to the market to determine".²³² It is interesting to note that although the amount contemplated is exclusive of expenses, the term "compensation" is used to

²²⁷ *The OLRC Report, supra*, note 1 at 261, expressed concern that surrogacy arrangements "not be tainted by an offensive commercialism" and has therefore recommended that all surrogate motherhood agencies be permitted to operate solely under the supervision of the Ministry of Community and Social Services (recommendation 60 at 284).

²²⁸ *Ibid.*

²²⁹ *See OLRC Report, supra*, note 1 at 254.

²³⁰ *Supra*, note 224; *see also* paragraph B.3(ii), *Queensland Report, supra*, note 4 and paragraphs 3.10 and 3.11, *Waller Report, supra*, note 3.

²³¹ *See* recommendation 51, *OLRC Report, supra*, note 1 at 283.

²³² *Supra*, note 192, cl. 222 and commentary. This Act goes on to state that express related payments are severable and should be "computed on an increasing sum of the weeks' digits basis over a forty-week period commencing with fertilization", unless otherwise agreed (s. 223(1)). "[n]on-expense related payments . . . are to be paid into an escrow account . . . prior to attempted fertilization and disbursed upon termination of the contract (s. 223(2)).

describe the payment. The Michigan Act does not state a specific amount but implies that payment is to be agreed upon by the parties.²³³

In jurisdictions seeking to avoid exploitation by agencies via the above form of regulation, it will be interesting to see whether the monetary value placed on childbearing will spill over into other areas, such as damages, or if it will generally affect societal recognition of such "work". Still, payment, while ostensibly controllable, has as its counterpart the possibility of payment by the defaulting party or parties in case of a breach of the contract. Perhaps even more controversial, it may allow questionable remedies such as forcing the surrogate to give up the child to be enforced.

(b) *Remedies*

It goes without saying that where a contract of surrogate motherhood is unenforceable as contrary to public policy, the court will not recognize a suit for breach of contract and hence no judicial remedies are available. If the gestational mother refused to surrender custody the law would presume her right to the child as its gestational mother subject to later proof of paternity. If the child was actually the result of *in vitro* fertilization utilizing the sperm and ovum of the social parents, the societal parents would have recourse against her only in so far as they could prove their genetic link to the child. Presumptions of paternity which were discussed above with respect to children born of artificial insemination would work against any biological father where the gestational mother was married or cohabiting with a man. In those jurisdictions aiming to prohibit or regulate surrogacy, remedies for both the refusal of the surrogate to hand over the child, as well as the refusal of the social parents to accept the child must be envisaged.

(i) *Repudiation by Gestational Mother*

Unquestionably, the most important issue in discussing the remedies of the breach of a surrogate motherhood contract arises in the case where a gestational mother refuses to give the child up at birth. The Ontario study is the only one to have recommended that in such cases the court can order specific performance.²³⁴ The study goes so far as to recommend anticipatory orders in those cases where the court "is satisfied that the surrogate mother intends to refuse to surrender the child upon birth". Accordingly, "it should be empowered, prior to the birth of the child, to make an order

²³³ *The Surrogate Parenting Act*, H.B. 4555 (introduced 16 April 1985), s. 7(3). Subsection 7(4) also provides that at the time the contract is filed the prospective social father must file a surety bond to "indemnify this state for any cost up to \$100,000 incurred by the state for the care of a child born to a surrogate or to pay for the costs described in subsection 4(3) (*i.e.*, the costs incurred in putting the child up for adoption in cases where both societal parents die).

²³⁴ See recommendation 49, *OLRC Report*, *supra*, note 1 at 283.

for transfer of custody upon birth.”²³⁵ This is a highly contentious recommendation since it seems to equate a surrogate motherhood contract with ownership passing under a sale of goods contract. Moreover, it refuses to recognize the parenthood of the surrogate in any way.

In other studies, specific performance is ruled out as a remedy;²³⁶ although in some, the best interests of the child are given priority and hence the court could consider such an order.²³⁷ This latter approach would be preferable since it recognizes the rights of all parties.

According to the OLRC *Report*, the only circumstance under which the surrogate mother would be given the right to retain custody of her child is where there has been a “change in circumstances, or new information has become available, indicating that the approved social parents are unsuitable to receive the child”.²³⁸ In those cases, the surrogate mother or the Children’s Aid Society would be permitted to have the agreement reviewed and the judge would be given the power to rescind the agreement.²³⁹

In Michigan, the gestational mother has a statutory right to revoke her consent in which case custody *will be determined* within twenty days of birth.²⁴⁰ In Tennessee, were the gestational mother to revoke her consent, the societal parents have only a right to damages.²⁴¹ The legislation provides that “[t]he child shall not be involuntarily taken from the surrogate mother, whether or not she is the biological parent”.²⁴² Such an approach is consistent with adoption law generally in that the natural mother usually has a limited right of revocation of consent.

(ii) *Repudiation by Social Parents*

Where the prospective social parents refuse to take the child at birth, it is fairly evident that the courts will not force them to; however, alternative mechanisms are proposed to ensure the child is cared for. In Ontario, where specific performance vis-a-vis the gestational mother is enforced, the societal parents are recognized as the child’s legal parents upon birth and are therefore responsible for that child as any parents are responsible for their offspring.²⁴³

Michigan guarantees the financial protection of the child until the issue of legal parentage is settled by requiring the social parents to post a

²³⁵ *Ibid.*

²³⁶ See paragraph 8.12, Warnock *Report*, *supra*, note 3 at 47 and paragraph 5.6, Dunstan *Report*, *supra*, note 3 at 51. See also *Tennessee Proposals*, *supra*, note 192, cl. 204(1).

²³⁷ See recommendation 50, OLRC *Report*, *supra*, note 1 at 283.

²³⁸ *Ibid.*

²³⁹ *Ibid.*

²⁴⁰ *The Surrogate Parenting Act*, H.B. 4555 (introduced 16 April 1985), s. 6(3).

²⁴¹ *Tennessee Proposals*, *supra*, note 192, cl. 204(3).

²⁴² *Ibid.*, cl. 204(3).

²⁴³ See recommendation 46, OLRC *Report*, *supra*, note 1 at 284.

bond to be held in escrow.²⁴⁴ In Tennessee, a surrogate mother can claim "damages for obligations due under the contract" and incidental and consequential damages which are limited to indemnification of costs for putting the child up for adoption "whether or not the surrogate mother keeps the child".²⁴⁵

In conclusion, surrogacy is a particularly difficult situation to evaluate from a legal standpoint and especially a feminist one. While it does reinforce the notion of woman as a breeder, it is perhaps the ultimate test of the principle of reproductive freedom of choice, that is, of the belief in women as responsible decision-makers. Furthermore, it is important to separate the natural and valid repugnancy towards agencies and other profiteers in the surrogate business from that of the act itself. A legislative approach obviates judicial discretion and the need for outside third parties, limiting the ambit of monetary and medical surveillance clauses. Certainly some minimum age requirement would be necessary to safeguard against exploitation of minors, but marital status should be irrelevant. While it is difficult to go as far as the OLRC *Report* in recommending anticipatory court orders forcing the surrogate to hand over the child, it is respectful of the dignity of human life to ban all private agencies set up for profit-making purposes,²⁴⁶ to create minimum legislative safeguards, and to leave further disputes to the courts. Surrogacy is the final recourse of desperate couples and inevitably invites further tragedies which cannot always be foreseen even by legislation, but surrogacy should certainly not be ignored nor totally prohibited in the hopes that it will go away.

IV. CONCLUSION

There is no doubt that reproductive technology will become big business: big business for those perfecting genetic diagnosis and manipulation techniques that could be applied to the general population as well as big business for those involved in banking or storage techniques and, furthermore, big business for those doing research on human genetic material in the absence of the implementation of some of the proposed reforms outlined in this paper. As evidenced by the multiplicity, variety and complexity of the reforms, lawmakers, philosophers, scientists, ethicists and others are also hard at work in the "business" of resolving the resulting legal and ethical imbroglio.

²⁴⁴ *The Surrogate Parenting Act*, H.B. 4555 (introduced 16 April 1985), s. 7(4).

²⁴⁵ *Tennessee Proposals*, cl. 204(2).

²⁴⁶ Canada: recommendation 60 of the OLRC *Report*, *supra*, note 1 at 284 does not explicitly rule out private agencies, but would subject all agencies to regulation by the Ministry of Community and Social Services. Australia: both subsection 30(2)(a) of the *Infertility (Medical Procedures Act) 1984* (Victoria), No. 10163 and recommendation D.1 of the *Queensland Report*, *supra*, note 4, suggest a prohibition on advertising. Britain: under the *Surrogacy Arrangements Act 1985* (U.K.), 1985, c. 49, "[b]ody of persons means a body of persons corporate and unincorporate" (subsection 1(7)) and thus includes agencies of any sort. As well, advertising to recruit is an offence (section 3).

What underlies the often pragmatic character of these reforms is the controversy that would arise if some of the contentious issues surrounding these techniques were to be debated in a more public forum than commission reports, private member bills or governmental advisory boards or committees. Issues such as abortion, contraception, contragestation, eugenics, child welfare and freedom of choice as to what to do with one's body, its component parts, or indeed, one's life, exist apart from reproductive technologies, but are latent in the nature of the reforms proposed. They are inseparably linked to the basic moral and religious values underlying Western culture and civilization.

It is axiomatic, however, that so much stress is put on the issues of reproductive technologies as affecting the protection of human life in its most vulnerable form, when in fact so little attention is paid to that life once born. To speak of the best interests or welfare of the "child" *in vitro* or *in utero* and yet ignore the economic, social and environmental conditions confronting those already born, attests to the fact that what *is* at issue here is the political question of freedom, of self-determination of moral and legal responsibility. This freedom and responsibility, particularly in the medical domain, is receiving increasing recognition in the form of living wills, in the respect for the decision-making of the capable adult to refuse treatment, in the decriminalization of suicide, or in the freedom to donate a kidney, skin or bone marrow while alive (to take but a few examples). Where, however, a technique could relieve infertility, or change the concept of maternity and filiation, individual self-determination and responsibility is being second-guessed by the legal policy-makers.

Until reproductive freedom of choice is established for those who seek it in order to conceive, or not to conceive, until access to reproductive technologies becomes available without discriminatory distinction and parenthood becomes voluntary and intentional, the *necessary* regulation and protection of human life as more than a genetic byproduct serves as a cover-up for a larger political reality and for the avoidance of a more public debate.

