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## CHAPTER FOUR

### Recommendations

We have already concluded that leaving the application of medically assisted procreation technologies to individual initiative entails too many risks and that the alternatives cannot ensure adequate control of the various aspects of assisted procreation.<sup>579</sup> We must therefore consider the appropriateness of legislative intervention.

Ensuring respect for the fundamental values of society,<sup>580</sup> protecting the public against risks that they cannot protect themselves against, and drafting statutes and principles of law that are capable of resolving potential disputes are, in our opinion, the main considerations that should inform legislative intervention.

The Commission is aware that provincial law has a very important role to play in medically assisted procreation. However, we feel it is essential to deal with the issue on a national scale and to take a comprehensive approach. The recommendations we present in this chapter reflect this view. Since medically assisted procreation raises issues of principle and practice that are of national interest, consistency in the policies adopted is very important. We will also have to consider the appropriateness of and need for a central agency to implement and ensure compliance with these policies throughout the country.

Before dealing with specific issues, we should point out that there are fundamental objections to the use of any or all medically assisted procreation technologies. Some hold that the technologies dehumanize procreation, go against nature and pose a threat to maternity and paternity, which, in this view, cannot be separated from the procreative aspect of sexuality.<sup>581</sup> Further, the use of third-party donations raises concerns about the

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579. See chap. 3.

580. *Crimes against the Foetus*, *supra*, note 7 at 32. *Ibid.* at 31:

As observed earlier, such principles cannot be found simply by reliance on market research or religious doctrine. In our view, they can only be discovered by reference to our fundamental social values. Such values, we contended in *Our Criminal Law*, are of two kinds. Some are essential to the very existence of society, some to the existence of our own particular society in its present shape and form.

Included in the first category of values are respect for life and the inviolability of the person; included in the second are justice, equality, dignity and individual freedom. See LRC, *Our Criminal Law*, Report 3 (Ottawa: Supply and Services Canada, 1976) at 20-21.

581. See Pope Pius XII, *Discourse to Those Taking Part in the 26th Congress of the Italian Society of Urology*, 8 October 1953: AAS 45(1953) 678; and, more recently, Congregation for the Doctrine of the Faith, *supra*, note 490.

adverse psychological impact on the child and the infertile partner that may result from involving a third person in the make-up of a family unit.<sup>582</sup> As noted earlier,<sup>583</sup> the legitimacy of gamete donation also raises a number of questions. Does it not constitute a [TRANSLATION] “shift in the order of family relationships”?<sup>584</sup> Finally, there are those who maintain that the human embryo must be treated with the same respect and afforded the same protection as the person. They believe it should be forbidden to freeze, destroy<sup>585</sup> or experiment on embryos. Does this not mean that one might go so far as to oppose the creation of surplus embryos?

Still, there is no denying that these medical technologies do exist and that, in cases where natural procreation is impossible or undesirable, there may be moral grounds to justify the development and use of technologies to remedy infertility problems.

It is nevertheless essential that our society continue to question how human embryos and gametes should be treated and what value should be placed on them. In the field of medically assisted procreation, the issues must be weighed within the context of current medical knowledge so that the implications of a decision may be considered. Prohibiting the creation of surplus embryos, for example, would affect the safety of women participating in IVF programs. With each new cycle, these women would have to face the risks and inconvenience of superovulation and egg retrieval, and would have to agree to the transfer of a large number of embryos and accept the accompanying risks.<sup>586</sup>

The issues must also be considered as part of an ongoing debate because the development of a policy on these important matters calls for education and discussion on a suitably advanced level. We therefore cannot claim to offer in this paper a definitive answer to this social dilemma. Our objectives are to contribute to the debate and to take the current situation into account in an effort to solve urgent problems. The Commission set out on this path by publishing the working papers *Crimes against the Foetus*<sup>587</sup> and *Biomedical Experimentation Involving Human Subjects*.<sup>588</sup>

On the strength of their potential for life and genotype, the Commission has already recognized gametes and embryos as having some moral value. First, it has argued that gametes and embryos should be distinguished from other human cells and tissues: “The first [gametes] are the virtual sources of new human life; the second [embryos] already

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582. The strongest objection to this procedure comes from the Vatican, which holds that recourse to the gametes of a third person “constitutes a violation of the reciprocal commitment of the spouses and a grave lack in regard to that essential property of marriage which is its unity.” See Congregation for the Doctrine of the Faith, *supra*, note 490 at 24.

583. See *supra* at 46ff.

584. See Hermite, *supra*, note 207 at 337.

585. One of the Vatican’s objections to in vitro fertilization is based on the fact that it may involve the destruction of some embryos. Congregation for the Doctrine of the Faith, *supra*, note 490 at 18.

586. Especially since the technologies using the natural cycle are still in the experimental stage. See *supra* at 22.

587. *Supra*, note 7.

588. *Supra*, note 7.

have life.”<sup>589</sup> Further, in the principles it stated and the limits it recommended in its working paper on experimentation, the Commission accorded the embryo intrinsic value.<sup>590</sup> For example, the Commission proposed that the creation of embryos solely for the purpose of scientific research be prohibited;<sup>591</sup> that the law never treat embryos as mere objects (indeed, the commercialization of embryos would be strictly forbidden); that experimentation be prohibited after the fourteenth day of embryo development; and that experimentation be authorized by a multidisciplinary ethics committee. The Commission also holds the view that the most appropriate way to dispose of surplus embryos resulting from in vitro fertilization is not to destroy them but to donate them to infertile couples or, failing that option, to use them for experimentation to advance knowledge.<sup>592</sup>

The protection afforded embryos is not, therefore, at odds with the creation, freezing or donation of surplus embryos. In fact, one of our recommendations specifically allowed for the freezing of embryos for a period of five years.<sup>593</sup> At this stage in our research, we believe that it is appropriate to reaffirm this position. We do not confirm their legitimacy, but we have no objection to the creation of surplus embryos or to the donation or freezing of gametes and embryos.

## I. General Principles

Individual freedom, equality and human dignity<sup>594</sup> are some of the principles and values challenged and sometimes placed in conflict by the various issues associated with medically assisted procreation. Among these issues are access to technologies; the risks of a shift toward eugenic practices; the post mortem commercialization and use of gametes and embryos; and the phenomenon of surrogate motherhood. Meanwhile, the parentage of children born as a result of medically assisted procreation and control over gametes and embryos also raise problems in terms of the possible application by the courts of existing legislation and principles of law. Which values should prevail? What social choices should guide lawmakers? Are there acceptable compromises for Canadian society? What can be done to resolve disputes caused by these technologies? These are some of the questions that will be broached in this chapter.

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589. *Ibid.* at 53.

590. For the various legal conditions imposed on the validity of experimentation and the mechanisms proposed to ensure compliance with these principles, see *ibid.*, rec. 6 at 51.

591. The prohibition led to the recommendation of a criminal sanction: *ibid.*, rec. 7(1) at 52.

592. *Ibid.* at 51: “[I]f circumstances do not permit donation, experimentation to advance knowledge seems to be preferable to outright destruction.”

593. *Ibid.*, rec. 8(2) at 53.

594. See *Crimes against the Foetus*, *supra*, note 7.

## A. Access

In a number of countries, discussion papers have proposed limiting, or legislation has limited, access to medically assisted procreation to stable heterosexual couples who are sterile or infertile or carry a transmissible genetic disorder. The interest of the child (often expressed as the child's right to have a father, a mother and a stable family) and society's interest in protecting the family unit, which is fundamental in our society, are the two arguments most commonly advanced to support such restrictions.

Before it can be determined whether it is necessary and appropriate to entrench such limits in legislation, the above-mentioned criteria must be analysed in terms of the individuals likely to request such medical assistance, and the other values, principles and interests that come into play. For the purposes of this analysis, we considered infertile or sterile persons (physiological infertility), persons who are unable or do not wish to procreate through sexual relations with the opposite sex (social infertility) and persons likely to transmit a genetic disorder (genetic infertility).<sup>595</sup>

Most of those who turn to medically assisted procreation are physiologically infertile. As a rule, the access criteria proposed for these individuals are that they be living as a heterosexual couple and that they be stable. The appropriateness of these criteria is not entirely clear. The criteria of heterosexuality and family status will be discussed later in connection with social infertility; our focus here will be on *stability*.

The criterion of stability, desirable though it may be, raises a number of questions. First, would it be fair to apply this criterion in cases of artificial insemination and in vitro fertilization when the stability of the couple or individual is not a factor in natural procreation, hormone treatment or surgery to correct infertility problems (other forms of medically assisted procreation)? While it is true that the use of gametes from a third person can cause special problems (disclosure of the child's origins and so on), we believe that the objective of using the stability criterion, that is, the welfare of the child, would be more easily attained by ensuring proper support before, during and after the child is conceived.<sup>596</sup> Second, this type of criterion is arbitrary and difficult to evaluate, and because it involves the application of non-medical criteria by health professionals it creates the risk of discrimination.<sup>597</sup> We

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595. For the purposes of studying the limitations referred to above, we have to use a definition of infertility broader than the one used in the medical community (see *supra*, chap. 1). This approach is conceived to take into account not only the pathological but also the social aspect of infertility. See The National Bioethics Consultative Committee, *Discussion Paper on Access to Reproductive Technology* (Adelaide: The Committee, 1990) at 8: "Beliefs, social values, expectations and judgements all contribute to the social construction of infertility and to the way we value it and its alleviation."

596. See *infra* at 156-57.

597. See Benjamin Freedman, P.J. Taylor, Thomas Wonnacott and Katherine Hill, "Criteria for Parenting in Canada: A Comparative Survey of Adoption and Artificial Insemination Practices" (1988) 3 C.F.L.Q. 35. The article is the result of a study funded by the Strategic Grants Program in the Human Context of Science and Technology, Social Sciences and Humanities Research Council of Canada; see *ibid.* at 36-37.

therefore feel it would be inappropriate to include in legislation stability — or, for that matter, any other criterion based on parental aptitude — as one of the criteria for determining access to medically assisted procreation.<sup>598</sup>

The situation of people who are physiologically and genetically capable of procreating but for personal reasons cannot or do not wish to do so in the context of a heterosexual union poses a more difficult problem. These people fall into two categories: single people and homosexual people. Access to medically assisted procreation for these people raises the whole question of equality rights<sup>599</sup> as compared to protection of the child and the traditional family. It would be difficult for the state to consider any legislative limit on access to the various technologies used in medically assisted procreation without taking into account the spirit and letter of the *Canadian Charter of Rights and Freedoms*.<sup>600</sup> However, we need only consult various legislative provisions and recommendations made in other countries to see that the special situation of these individuals is rarely accepted as grounds for using medically assisted procreation. In fact many jurisdictions make access to medically assisted procreation conditional on physiological infertility, sterility or the existence of transmissible genetic disorders, or simply limit access to heterosexual couples.<sup>601</sup>

Making access to medically assisted procreation conditional on the existence of pathological conditions (sterility, physiological and genetic infertility) may seem normal, since the technologies were developed to circumvent these problems. However, we cannot ignore the fact that establishing such a condition with respect to artificial insemination<sup>602</sup> would deny access to single people and to homosexual people.<sup>603</sup>

Such limitations therefore raise the question of non-discriminatory access to available medical technologies. This means weighing a number of different interests: on the one hand, the interest of single people and homosexual people who express a desire to have children and to use the available technologies, as would infertile or sterile persons living as part of a heterosexual couple, to overcome the obstacles they face; and on the other, the interest of the child and society's interest in protecting the traditional family with two heterosexual parents.

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598. It should be noted, however, that some reports have taken the opposite position. See, e.g. OLRC, *supra*, note 2 at 275: "Eligibility to participate in an artificial conception programme should be limited to stable single women and to stable men and stable women in stable marital or nonmarital unions." The report of the Barreau du Québec, *supra*, note 3 at 36, recommends that access be limited to stable couples, married or unmarried. For more details, see appendix A, *infra* at 177.

599. See "Section 15 Equality Rights," *supra* at 92.

600. See *supra* at 82, 88ff, 90, 94 and 96-88.

601. See appendix A, *infra* at 177.

602. We have already stated that in vitro fertilization is different. Unlike artificial insemination, IVF and its derivatives are aimed primarily at female infertility. See *supra* at 98.

603. A legislative limit on access must not create disparity between the groups referred to in s. 15 of the *Charter* or analogous groups. See "Section 15 Equality Rights," *supra* at 92.

The conflict between respect for the rights guaranteed by the *Charter* and protection of the traditional family unit leads to a number of fundamental questions. How far do we wish to go in protecting rights and freedoms, especially the right to equality? How far do we wish to extend the definition of the family? Do we wish to include homosexual families and single-parent families in that definition?

For some, the interest of the child and society's interest in preserving families with two heterosexual parents must take precedence over the fundamental rights of single people and homosexual people. According to this position, having the freedom to choose one's sexual orientation is one thing, but depriving a child of a father and a mother is something else entirely. The technologies used in medically assisted procreation must be used to overcome sterility and infertility (physiological and genetic), not as an easy way out of the consequences of a social choice.

For others, who make the analogy with the criteria used in adoption, these objections are an expression of old prejudices.<sup>604</sup> Furthermore, through the years the state has not intervened to protect the traditional family, the structure of which has been greatly eroded.<sup>605</sup>

Resolving the issue of access to medically assisted procreation technologies thus requires a thorough examination of the family unit at the dawn of the twenty-first century. Are we prepared not only to accept single-parent families and families with two homosexual parents, but also to place them on an equal footing, in terms of our social values, with families with two heterosexual parents? If so, should we not, in the interest of consistency, change our family laws in order to incorporate these new definitions? Or do we wish instead to make protection of the traditional family a public interest that would take precedence over the rights and freedoms guaranteed by the *Charter* and thus limit the right to procreate as we limit the right to marry in our society?

In considering these questions, we could draw on similar situations in the area of "natural" procreation, where single-parent families and families with two homosexual parents are a reality.

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604. See *supra* at 96-98; and Knoppers, *supra*, note 284 at 216: "It is ironic that while adoption laws are being relaxed in order to permit unmarried individuals of either sex to adopt, social prejudices are preventing single women from having access to techniques that would enable them to bear and give birth to children that may in some cases be at least 50 per cent genetically their own." See also *supra*, notes 466 and 467.

605. A recent decision by the Federal Court of Appeal in a matter involving labour relations reversed a ruling by a federal human rights tribunal that in effect broadened the definition of family to include homosexual couples. The tribunal's ruling followed a complaint under the *Canadian Human Rights Act*, *supra*, note 454. See *Mossop*, *supra*, note 458 at 35: "Even if we were to accept that two homosexual lovers can constitute 'sociologically speaking' a sort of family, it is certainly not one which is now recognized by law as giving its members special rights and obligations."

For the moment, taking current social conditions into account, the Commission is of the opinion that with regard to artificial insemination, protection for the traditional family should not be incorporated in legislation at the expense of the right to equality.<sup>606</sup> Moreover, given the nature of artificial insemination, we believe that state intervention in this area should be kept to a minimum.<sup>607</sup> With respect to in vitro fertilization, the issue of the right to equality creates few problems.<sup>608</sup> However, since these technologies raise the question of the allocation of scarce and costly resources, a legislative limit on access could prove necessary. In any event, caution dictates that such action be taken in accordance with the principles of fundamental justice.<sup>609</sup>

Finally, the use of medically assisted procreation by persons who are physiologically capable of procreating but are carriers of a genetic disorder leads to the question of choosing which genetic disorders justify access to medically assisted procreation, and of which gametes and embryos should be considered "acceptable." There is a risk, in making such choices, of opening the door to eugenic practices. This concern also raises another issue, namely, the selection of donors or donor characteristics.

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606. In October 1988, the Spanish parliament passed a law on medically assisted procreation under which access is not limited to married couples. Single women and women cohabiting with men are eligible. See appendix A, *infra* at 177-78. OLRC, *supra*, note 2 at 157: "[A] majority of the Commission has come to the conclusion 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." The OLRC states in its first recommendation (at 275) that the technologies should be used only for medical reasons, except in the case of single women who are fertile and genetically healthy. The report of the Ministère de la Santé et des Services sociaux, *supra*, note 504, s. 11, states at 176 that artificial insemination must be available to single women regardless of their status. Canadian Bar Association, *supra*, note 278 at 22: "After much discussion, the committee concluded that there was no need to legislate criteria of eligibility. While this might leave the situation open to personal prejudices of the treating physician, the committee further concluded that present legislation prohibiting discriminatory practices should provide sufficient protection." In Sweden, on the other hand, the technologies are available to married or cohabiting couples only, and the husband's consent is required; see appendix A, *infra* at 177-78, note 55. The Norwegian parliament has adopted a law regulating AI and IVF that limits access to married couples who have given their consent and have undergone a medical and psychosocial examination by a physician; see appendix A, *infra* at 177-78, note 56. Council of Europe, *Human Artificial Procreation* (Strasbourg: The Council, 1989) at 17:

After careful examination of these arguments, realising the medical nature of these techniques and taking into account the importance of ensuring the welfare of the future child, the committee reached the conclusion that the availability of the artificial procreation techniques should be limited to heterosexual couples with a medical need. This determination intends to eliminate the cases where the future child would inevitably be born as an "orphan."

For more details about the position of other countries and states, see appendix A, *infra* at 177-78. For the reports that have limited access to infertile persons and persons at risk for transmitting genetic disorders to their children, see appendix A, *infra* at 178.

607. See *supra* at 90.

608. See *supra* at 98.

609. See *supra* at 89ff.



Using medically assisted procreation technologies to avoid transmitting a genetic predisposition or a characteristic trait that is deemed undesirable<sup>610</sup> or to choose the sex or select the desired qualities of the unborn child is unacceptable.<sup>611</sup> In more general terms, such practices lead the way to the development of a traffic in gametes and embryos with particular qualities,<sup>612</sup> breed intolerance of human imperfection and disrupt the demographic and social balance between the sexes for future generations, and could have a tremendous impact on these “made-to-measure” children. It therefore seems appropriate to generally limit individual freedoms in the name of respect for human dignity.

What genetic disorders justify the use of medically assisted procreation? This question can be answered indirectly by permitting the selection of gametes and embryos for specific qualities only in situations where the goal is to prevent the transmission of a serious genetic disease. Limiting the selection of donors and donor characteristics would also discourage unwarranted use of the available technologies.

It is one thing to allow the medical profession to address, as much as possible, the concerns of couples about the homogeneity of the family unit; it is quite another to allow couples to ask for particular donor characteristics or for the manipulation of gametes and embryos so that the child fits the stereotypes of society or satisfies the whims of the future parents, and the Commission is not prepared to recommend such a step.<sup>613</sup> It is therefore important that the description of the donor’s characteristics be limited to essential details and that identification of the specific features of gametes and embryos be permitted solely to prevent the transmission of a serious genetic disease.<sup>614</sup> For example, it would be acceptable in cases where the purpose of sex determination would be to prevent the conception of a child with a sex-linked disease such as hemophilia.

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610. “Characteristic trait” is opposed here to serious genetic diseases such as Tay-Sachs disease, thalassemia, Duchenne muscular dystrophy, hemophilia and Huntington’s disease.

611. C. Overall, “Introduction” in Overall, ed., *supra*, note 129, I at 18:

A significant effect of reproductive technologies is that they seem to enable us to make more and more detailed specifications of what kinds of children we do and do not want to have. The apparently innocent goal, the positive goal, of having strong, healthy, thriving offspring, changes into a more negative goal of avoiding or getting rid of children with certain supposedly undesirable characteristics.

See appendix A, *infra* at 178-79.

612. The Repository for Germinal Choice in California, otherwise known as the “Nobel Prize sperm bank,” is one example. See Arthur Caplan, “California Sperm Bank Is a Loony Notion” *The [Montreal] Gazette* (24 November 1989) B-3: “The bank claims to have deposits in its fridge from noteworthy scientists, some corporate success stories and at least one Olympic athlete. Nearly 100 babies have been created using sperm from the Repository for Germinal Choice. Couples who want to obtain sperm must be married and must show themselves to be persons of achievement and ability.”

613. See appendix A, *infra* at 178-79.

614. See the report of the Ministère de la Santé et des Services sociaux, *supra*, note 504 at 65; see also appendix A, *infra* at 179.

In order to ensure compliance with these limits, the activities of banks and infertility clinics and the import of gametes and embryos must be controlled. And if they are to be effective, the limits must be applied uniformly throughout Canada.

## RECOMMENDATIONS

1. Legislation governing access to medically assisted procreation technologies should respect the right to equality. Access should be limited only in terms of the cost and scarcity of resources. Where limitation is necessary, selection should not be based on unlawful grounds for discrimination within the meaning of federal and provincial legislation (family status, marital status, sexual orientation, and so on).

2. To eliminate the possibility of eugenic practices, the selection of gametes and embryos with specific qualities should be prohibited, except where the objective is to prevent the transmission of serious genetic diseases.

### B. Commercialization

The existence of surplus embryos, and the donation, storage and import of gametes and embryos make the possibility that these genetic products may be considered objects of commerce<sup>615</sup> an attractive one. Society is thus forced to question the very nature of these products and consider a new definition of the person in law, namely, what can be deemed an object of commerce, or reified.<sup>616</sup>

Modern medicine has brought a new dimension<sup>617</sup> to the commercialization of the human body and its products and substances. The U.S. case of *Moore v. Regents of the*

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615. See *supra* at 40.

616. Bernard Keating, "Le statut moral de l'embryon humain: une approche attentive à la question des fondements de l'éthique," unpublished doctoral thesis. Quebec, Graduate School of Laval University, 1990 at 138-40:

[TRANSLATION]

Questioning the status of the human embryo means drawing a line between persons and things. This distinction is essential, as we dispose of things and respect persons. Things have a price; persons are priceless. To consider embryos as persons would be to acknowledge the limits of our ability to treat them as we see fit. It is established that a person can never be the mere means to an end. The stakes are very high. . . . Does accepting to treat human life, amid the obscurity of its origin, as an object not imply that a less than absolute respect for the person has already been accepted?

617. On the question of the commercialization of human organs, see *Procurement and Transfer of Human Tissues and Organs*, *supra*, note 250.

*University of California*<sup>618</sup> provides ample evidence of the complexity of the problems created by commercialization.<sup>619</sup>

The unique nature of gametes and embryos, as noted by the Uniform Law Conference of Canada, which excludes them from its definition of tissues,<sup>620</sup> raises a number of questions. While the nature and use of gametes and embryos raises issues pertaining to human dignity and leads us to reflect upon the moral or symbolic value to be accorded these genetic substances and upon the reification of the human being, the commercialization of gametes and embryos poses a similar problem of safety both for the woman in whom they are implanted and for the future child. Finally, commercialization has a bearing on freedom of commerce.

## 1. Embryos

Commercialization of the embryo must be prohibited outright for this purpose, as it should be for experimentation.<sup>621</sup> Treating the embryo as a thing that is an object of commerce and including it in the consumer market constitute a direct assault on human dignity.<sup>622</sup> But assuming that the embryo may be the object of a limited number of legal

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618. 249 Cal. Rptr. 494 at 498, 504 (Cal. App. 2d Dist. 1988):

This appeal raises fundamental questions concerning a patient's right to the control of his or her own body, and whether the commercial exploitation of a patient's cells by medical care providers, without the patient's consent, gives rise to an action for damages. This appears to be a case of first impression. . . .

We have approached this issue with caution. The evolution of civilization from slavery to freedom, from regarding people as chattels to recognition of the individual dignity of each person, necessitates prudence in attributing the qualities of property to human tissue. There is, however, a dramatic difference between having property rights in one's own body and being the property of another. . . . We are not called on to determine whether use of human tissue or body parts ought to be "gift based" or subject to a "free market." That question of policy must be determined by the Legislature. In the instant case, the cell-line has already been commercialized by defendants. We are presented a *fait accompli*, leaving only the question of who shares in the proceeds.

This ruling was partly upheld by 793 P. 2d 479 (Cal. 1990). The part of the ruling dealing with the general principle recognizing the patient's rights to control his or her own body was upheld. However, the principle was based merely on the doctrine of informed consent and the nature of the physician-patient relationship. For more details, see *Procurement and Transfer of Human Tissues and Organs*, *supra*, note 250.

619. Legal thought on the subject is developing rapidly at present, and the diversity of the solutions proposed is a clear sign that development must continue. For example, the theory of attribution put forward by Jean-Christophe Galloux in "De la nature juridique du matériel génétique ou la réification du corps humain et du vivant" (1989) 3 R. recherche jur. 1 at 1-31, implies an absolute but functional notion of the extra-commerciality of the human body. Hermitte concludes that a new category is needed and proposes the category of "things of human origin intended for human use." She subdivides products of the human body into "products that are not objects of commerce," "products that are not objects of exchange," "objects of remunerated exchange," "commodities," etc. See *supra*, note 207 at 325.

620. *Uniform Human Tissue Donation Act* (1989), *supra*, note 236; see *supra*, note 237. See also the opinion expressed by the Commission, *supra* at 122-23.

621. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 49.

622. *Ibid.*

transactions, we must make certain that it does not become a commodity, at the mercy of the laws of supply and demand.<sup>623</sup>

## 2. Gametes

Making gametes mere objects of commerce may also violate the fundamental notion of human dignity. The specific nature of gametes (virtual sources of life) and the objective of gamete donation (allowing infertile people to become parents) are ill-suited to commerce in our society. The donation of gametes must remain an altruistic act. Moreover, competition between banks may lead to eugenic practices. For example, there is the risk of banks attracting and accepting only donors with certain qualities or characteristics that are deemed more desirable than others, thereby responding to a commercial stereotype of the ideal male parent.<sup>624</sup> To attain these objectives, a bank might, for example, pay a donor on the basis of his characteristics. Even if the couple were not allowed to determine what characteristics they wanted, the reputation of some banks for the “quality” of their donors could have the same result: a form of eugenics would be practised.<sup>625</sup>

Further, commercialization of gamete donation may compromise the “quality” of the gametes used. Monetary incentives increase the risk of donors failing to disclose some or all of the information needed to assess their suitability.<sup>626</sup> Moreover, the desire of banks to maximize their profits may have an adverse effect upon medical screening and selection.

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623. See Evelyn Shuster, “Seven Embryos in Search of Legitimacy” (1990) 53:6 *Fertil. Steril.* 975 at 977:

[A] position most widely held is that embryos have only special or limited interests in life and thus should not be treated as actual persons with full moral rights. However, because they are potential persons, the embryos belong to the order of being and not of having. They are neither things nor properties. They cannot be bought, sold, or returned. Individuals do not have ownership rights to do whatever they want with them.

624. Council for Science and Society, *supra*, note 533 at 41-42:

If commercial sperm banks were set up (as has already happened in the USA) this could give rise to some objectionable practices. Highly “desirable” donors might be tempted to sell their semen for large sums of money. Sperm from Nobel prize winners is already advertised in the USA, playing on people’s desire to be parent to a genius and ignoring the adverse factor of sperm from ageing men.

625. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 53-54: “The Commission is of the opinion that new recommendations concerning not only sperm banks but embryo banks as well should be drawn up, so as to establish clear and precise standards, and guard against the drawbacks and dangers of uncontrolled expansion and commercialization of such banks.”

626. OLRC, *supra*, note 2 at 169:

[W]e are also of the opinion that the need for a sound family history, and for information concerning whether a donor has contracted a sexually transmitted disease between the initial genetic screening and the donation, compels the conclusion that donors should not be induced to donate gametes by the lure of a reward, lest they suppress important information about themselves. The risk of such suppression, and its cost to those upon whom the burden will fall, outweigh any benefit achieved by permitting unrestricted payments.

Accordingly, the Commission recommends that individual donors of sperm should be allowed to be paid their reasonable expenses.

See also *ibid.*, rec. 15 at 276.

Thus, the possible assault on human dignity and the risks inherent in commercialization warrant the limitation of individual freedoms, in particular, freedom of commerce. However, since people may not be willing to come forward unless their expenses are covered, reasonable expenses incurred by donors should be reimbursed.<sup>627</sup>

Finally, in view of the need to ensure optimum quality of genetic screening and selection, banks should be able to be reimbursed for reasonable costs related to their operations.<sup>628</sup>

## RECOMMENDATION

**3. (1) All commercialization of the donation of gametes and embryos should be prohibited. Only reimbursement of reasonable expenses incurred by donors should be permitted.**

**(2) Gamete and embryo banks should not be permitted to operate on a profit basis. However, banks should be allowed to be reimbursed for reasonable costs related to their operations.**

### C. Surrogacy

We must state at the outset that incidence of the phenomenon of surrogate motherhood is very difficult to evaluate. A study of surrogacy practices carried out in the summer of 1988 for the Law Reform Commission of Canada found:

The major finding of this study is that preconception contracts involving Canadians are a phenomenon of very moderate scope but considerably more frequent than all of the people (with one exception) with whom we talked and who considered themselves knowledgeable in the area estimated. Taking our low overall estimate (i.e., allowing only 11 cases for Quebec) we end up with a grand total of 104 cases in Canada. Taking our higher estimate (allowing 25 cases for Quebec) we end up with a total of 118 cases.

Either estimate greatly exceeds what was quoted to us as a reasonable estimate for the overall incidence. In order to appreciate this finding, it must be remembered that we have been extremely stringent in excluding cases if there was any doubt concerning them. We thus feel confident that these numbers represent a very conservative estimate which probably greatly underestimates the real extent of the phenomenon.

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627. In the same vein, see appendix A, *infra*, notes 65 and 66 at 179. See also *An Act to amend the Uniform Child Status Act*, *supra*, note 199, s. 11.5; see *supra*, note 253.

628. See appendix A, *infra*, note 67. However, the OLRC report, *supra*, note 2 at 172, would allow banks to make some profit; see appendix A, *infra* at 180.

We also conducted an analysis of socio-economic characteristics of contractual mothers, fathers, and fathers' wives utilizing Keane's agencies. Overall, contractual mothers belong to a lower social class than fathers and fathers' wives. It cannot be assumed that this analysis tells us anything about the participants in informal preconception contracts. We do not have sufficient information to make educated guesses about the socio-economic characteristics of this latter group of people.<sup>629</sup>

Even setting aside the contractual<sup>630</sup> and commercial aspects of surrogacy, the use of surrogates is the subject of much controversy. Uncertainty about the impact of the practice on the parties involved — especially the surrogate and, most of all, the child — raises major concerns about possible psychological risks.<sup>631</sup> While the use of a family member or friend as a surrogate may be less shocking to some, the risks remain. The relationship between the parties may even complicate the outcome. The child may also be exposed to significant physical risks if the surrogate, knowing she has to surrender the child at birth, acts in a negligent manner and fails to take the precautions needed to create the healthy environment that is vital to normal development of the fetus.

There are some who feel that, beyond these questions of safety, surrogacy contravenes the fundamental values of our society, in particular human dignity and the protection of the traditional family.<sup>632</sup> They argue that the use of a surrogate dehumanizes maternity, devalues gestation<sup>633</sup> and violates the child's right not to be treated as a thing that can be the subject-matter of a contract. Deliberately conceiving a child in order to surrender it to a third person at birth indicates a lack of respect for the unborn child and for life itself. Some argue in the name of these greater interests that individual freedoms should be limited and that surrogacy in any form should be prohibited.

For others, the psychological risks, while they are serious, amount to nothing more than speculation, given the lack of knowledge about the true nature of the bond that is established during gestation.<sup>634</sup> This argument, therefore, cannot be used as grounds for

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629. Eichler and Poole, *supra*, note 530 at 45-46. The study shows very clearly, at least, that the phenomenon is shrouded in secrecy and extremely difficult to evaluate: an appendix includes a series of very interesting tables.

630. We saw in chap. 2 that, as the law currently stands, the contractual aspect of surrogate motherhood runs counter to the principles of contract law and family law; see "Legality and Legitimacy," *supra* at 65 and "The Enforceability of Surrogacy Contracts," *supra* at 84.

631. These arguments have been made by the OLRC, *supra*, note 2 at 230. See also Barreau du Québec, *supra*, note 3 at 28; and Warnock Report, *supra*, note 421 at 45.

632. See, e.g., Barreau du Québec, *supra*, note 3 at 28. See also A.M. Capron and M.J. Radin, "Choosing Family Law over Contract as a Paradigm for Surrogate Motherhood" (1988) 16:1-2 Law Med. Health Care 34 at 36-37.

633. Baudouin and Labrusse-Riou, *supra*, note 210 at 111: [TRANSLATION] "Gestation is thus no longer a step in the establishment of a permanent mother-child relationship. It is reduced to a temporary function of production. It does not serve to create an emotional bond, but is used merely as a form of technical support." See Barreau du Québec, *supra*, note 3 at 29.

634. See OLRC, *supra*, note 2 at 231.

prohibition. The physical risks could be controlled by giving proper medical attention,<sup>635</sup> possibly mandatory, to the surrogate. Regarding the risks to the institution of the family, not everyone is convinced that surrogate motherhood represents an injurious infringement.<sup>636</sup>

We may not be in a position to assess the psychological impact of surrogate motherhood, but it does not take a comprehensive study to conclude that caution is needed. While control of surrogate motherhood may reduce the physical risks, regulation would imply state approval and the legitimization of surrogacy agreements.<sup>637</sup> As noted earlier,<sup>638</sup> endorsing surrogacy contracts would be at odds with a fundamental principle of family law: custody of a child must be determined according to the child's best interest and not the wishes of the parents as expressed in a contract.

The principle of human dignity leads us to conclude that a child cannot be the subject-matter of a contract and must under no circumstances be treated as a thing.<sup>639</sup> This principle should take precedence over individual freedoms. Treating a child in any other manner could change our perception of the human being. Provisions should perhaps be made at the national level to express this fundamental value in such a way that it cannot be challenged and to discourage all activity related to surrogate motherhood.<sup>640</sup> Accordingly, surrogacy agreements should not be recognized in law: they must remain absolutely null and void.<sup>641</sup> This conclusion is consistent with the existing principles of contract and

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635. *Ibid.*

636. *Ibid.* at 232. See Canadian Bar Association, *supra*, note 278 at 28: "The committee was not convinced that recognition of surrogacy agreements would undermine stability of the family."

637. See Warnock Report, *supra*, note 421 at 46-47.

638. See *supra*, note 630.

639. See *supra* at 40-41 and in particular note 209.

640. R. Alta Charo, "Reproductive Technologies and Bioethics in the United States: Looking Back, Looking Ahead" in Christian Byk, ed., *Artificial Procreation: The Present State of Ethics and Law* (Lyon: Lacassagne, 1989) 249 at 255: "In fact, following the controversial Baby M case, the legislative trend in the U.S. appeared to veer towards prohibition and away from the relatively supportive early state statutes in Arkansas, Kansas, and Nevada, which had regularized portions of the procedure without explicitly approving it or making the contracts enforceable." The New York State Task Force on Life and the Law, *Surrogate Parenting: Analysis and Recommendations for Public Policy* (New York: The Task Force, 1988) at 127:

Given the potential risks to the children born of surrogacy, children are best served by policies designed to discourage the practice.

The Task Force members feel deep sympathy for infertile couples, many of whom experience a profound sense of loss and trauma. Nevertheless, the Task Force concluded that society should not support surrogacy as a solution. The practice will generate other social problems and harm that reach beyond the infertile couples who seek a surrogate arrangement.

641. Similarly, see appendix A, *infra* at 180-82, note 76, and table 4 at 210-13. However, Ontario (OLRC, *supra*, note 2 at 233) opted for regulation of surrogacy. The Canadian Bar Association (*supra*, note 278 at 29) commented as follows on the system proposed by the OLRC:

family law. The interest of the child must remain the basis for any decision respecting custody, and freedom of contract must be limited accordingly.<sup>642</sup>

The commercial aspect of surrogacy agreements raises various questions for society. For some, the idea that a woman might rent her womb is an affront to human dignity and integrity.<sup>643</sup> Others point to the possibility of disadvantaged women being exploited by women with economic power. Surrogacy agreements are also thought to be degrading for the child, who is exchanged for a sum of money and treated as a mere object of commerce. Putting a monetary value on a child is harmful not only to the child but also to society. The commercial aspect of surrogacy breaches a fundamental value: the human being is not an object of commerce.<sup>644</sup>

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In terms of a regulatory scheme, the committee considered the approach recommended by the Ontario Law Reform Commission, which proposed a system of prior judicial screening and approval, as opposed to the traditional ex post facto review. The committee concluded that such a system was too cumbersome and likely not to be followed, even if legislated. It would establish a separate system for a type of assisted reproduction, something that should be avoided in principle unless good reason exists. The fact in these arrangements of deliberately creating a child for the purpose of surrendering its care to another is not sufficient distinction to warrant development of a unique approach and scheme. The committee has noted that most jurisdictions that have legislated in this area have maintained the traditional ex post facto review.

"Surrogacy" arrangements should be assimilated as much as possible into the existing model for adoptions.

The Canadian Bar Association, *ibid.* at 30 recommends "not to encourage surrogacy but to facilitate it in rare circumstances when the birth mother chooses to honour the agreement in a situation that gives every possible protection to herself."

642. See "Legality and Legitimacy," *supra* at 65 and "The Enforceability of Surrogacy Contracts," *supra* at 84.

643. See Warnock Report, *supra*, note 421 at 45.

644. This view is reflected in most jurisdictions around the world. See appendix A, *infra* at 180-82 and table 4 at 210-13. R. Alta Charo, "Surrogate Parenting: Analysis and Recommendations for Public Policy" (1989) 10:1 J. Leg. Med. 251 at 255: "The OTA report documents that commercial surrogacy has been disapproved in every governmental report in the world except that of the Ontario Law Reform Commission." In April 1990, The National Bioethics Consultative Committee in Australia released its first report on surrogate motherhood: The National Bioethics Consultative Committee, *Surrogacy, Report 1* (Adelaide: The Committee, 1990) at 36:

6.4 It is therefore recommended that:

- (a) Surrogacy should not be totally prohibited.
- (b) Surrogacy should not be freely allowed.
- (c) Surrogacy practice should be strictly controlled by uniform legislation.
- (d) Uniform legislation should include the following:
  - (i) All surrogacy agreements be rendered unenforceable
  - (ii) Controlling mechanisms for agencies
  - (iii) Advertising controls.

See also The National Bioethics Consultative Committee, *Discussion Paper on Surrogacy 2 — Implementation* (Adelaide: The Committee, 1990).



Individual freedoms are often restricted in similar circumstances.<sup>645</sup> For example, adoption and child protection laws specifically prohibit the sale of children.<sup>646</sup> However, even if such provisions were applicable to children born of surrogates, they might not apply to the sale of children outside the context of adoption.<sup>647</sup> Because the existing provisions apply only where the transaction is intended to result in the adoption of a child,<sup>648</sup> if no petition for adoption is brought to establish parentage,<sup>649</sup> no one can be prosecuted. Further, even where a petition for adoption is filed, if the judge is not apprised of the fact that an exchange of money occurred previously, the transaction goes unpunished.

Prohibiting the sale of human beings is a fundamental value that, being a matter on which there is consensus, must influence the law. The role of lawmakers is to take action that at a given time unambiguously expresses society's values and views on such a fundamental issue.

The argument that surrogacy does not constitute the sale of a child but rather payment for a service does not withstand scrutiny because the intended result and purpose of the surrogacy agreement is to transfer custody of the child. In surrogacy, unlike in adoption, the child is conceived specifically to be surrendered in return for a sum of money. It should be remembered that the payment often represents more than the expenses incurred. Further, the role played by intermediaries and the fees they are paid emphasize the commercial aspect of the transaction. Even if the transaction were not the sale of a child, the result would be too much like a sale to be treated differently. Any attempt to commercialize

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645. Even those who advocate protection of the right to procreate generally feel that protection does not extend to the commercial aspect. See, e.g., Charo, *supra*, note 310 at 108:

As a commercial ban interferes only with an asserted right to pay for surrogacy, not with the right to procreate, and as women's self-reported motivations for becoming surrogates usually include non-commercial considerations, such as a desire to help other people, a commercial ban should be upheld as a rational expression of state interest that does not unduly interfere with the right to procreate. This conclusion is shared by at least two state courts.

It should be remembered that in *Baby M* (*supra*, note 302), the Supreme Court awarded custody of the child to the father of the child and granted visitation rights to the surrogate mother, but also ruled as follows:

We invalidate the surrogacy contract because it conflicts with the law and public policy of this State. While we recognize the depth of the yearning of infertile couples to have their own children, we find the payment of money to a "surrogate" mother illegal, perhaps criminal, and potentially degrading to women. [at 1234] . . . This is the sale of a child, or, at the very least, the sale of a mother's right to her child, the only mitigating factor being that one of the purchasers is the father. Almost every evil that prompted the prohibition on the payment of money in connection with adoptions exists here. [at 1248] . . . In sum, the harmful consequences of this surrogacy arrangement appear to us all too palpable. In New Jersey the surrogate mother's agreement to sell her child is void. Its irrevocability infects the entire contract, as does the money that purports to buy it. [at 1258]

See also *Doe v. Kelley*, *supra*, note 310.

646. See *supra* at 67-69 and note 309.

647. See *supra* at 68.

648. Except for Manitoba; see *supra*, note 311.

649. See "Legal Parentage," *supra* at 69.

surrogacy (payment to surrogates and intermediaries) should be expressly prohibited. A recommendation to this effect would follow the logic of the prohibitions that currently apply to adoption and child protection.<sup>650</sup> Given the nature of such a prohibition and the need for uniform intervention, the Commission feels that the *Criminal Code* may be the right medium.<sup>651</sup>

However, while the commercial aspect of surrogate motherhood merits prohibition, the Commission feels that subjecting the infertile couple, who have already experienced the anguish of infertility, and the surrogate, who is trying to provide a solution to their problem, to the stigma of criminality and the ensuing consequences seems excessive and might still not dissuade couples who are only seeking to realize a legitimate desire. A criminal prohibition could drive the entire practice of surrogacy underground, with all the risks that entails.<sup>652</sup> Under-the-table agreements increase the possibility of irresponsible practice and make recourse to the courts virtually impossible because of the fear of reprisals. Such intervention could therefore prove very damaging for the child both physically and psychologically. Subjecting the parties immediately involved (the surrogate, her spouse and the social parents) to criminal prosecution could thus do more harm than good. Even if their actions are reprehensible, we are not convinced that it is appropriate to subject the parties to criminal proceedings. A total prohibition would not contribute adequately to the search for a solution to the problem and would not be warranted in terms of the principles of criminal law.<sup>653</sup> In any event, such a prohibition would certainly not be in the interest of the already-conceived child. Who should be given custody of the child once the parents have been prosecuted, found guilty and possibly imprisoned?

To ensure greater effectiveness in attaining the desired goal (preventing the development of a "child market" and discouraging people from engaging in traffic in children), the Commission is of the opinion that the *Criminal Code* should prohibit activity by paid intermediaries. Since paid intermediaries are the ones who create, set the conditions for and encourage such a market, discouraging people from engaging in activity of this nature would have a tremendous impact on the commercialization of surrogate motherhood. By not being subject to criminal sanctions, the immediate parties would be encouraged to lay charges against intermediaries. People would be dissuaded from engaging in such trade,

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650. See "Commercial Aspects of Surrogacy," *supra* at 67 and "The Enforceability of Surrogacy Contracts," *supra* at 84. It should be borne in mind, however, that Ontario and British Columbia permit some payments in adoption cases under certain conditions. In British Columbia, payment would be possible if it were authorized by a court of law; see *Adoption Act*, *supra*, note 309, s. 15.1. For Ontario, see *Child and Family Services Act*, 1984, *supra*, note 309.

651. *Our Criminal Law*, *supra*, note 580. As we have seen, however, current provisions of the *Criminal Code* do not cover the phenomenon adequately. See *supra* at 69.

652. Regarding obstacles to the effectiveness of legislative intervention, see Kidder, *supra*, note 9 at 112ff., at 117: "[S]udden legal changes don't always produce the results intended by the judges or lawmakers. . . . Sometimes laws which were passed to produce one effect end up having either unintended side effects or opposite effects from those intended." On the phenomenon of those covered by a law changing the impact of that law, see in particular *ibid.* at 136-37.

653. See *Our Criminal Law*, *supra*, note 580 at 33.

as the risk to intermediaries would be too high: a conspiracy of silence would not protect them. Before becoming involved in such activities, intermediaries would have to consider the fact that they could well face charges (if, for example, the surrogate conducted herself improperly during the pregnancy, if she refused to surrender the child at birth, or if the social parents refused the child).

Preventing the commercialization of surrogate motherhood is a desirable objective, and if it is to be achieved legislative intervention is needed. However, consideration must be given to the real impact of such intervention and other equally important factors, such as the safety of the child. A total ban on surrogacy could give the impression that the problem was resolved, but this would not be the case. We believe it is more realistic and effective to stop only the activities of paid intermediaries than to try to prevent all surrogacy agreements between individuals. Such a position would bring Canada in line with the vast majority of the countries that have considered the matter.<sup>654</sup>

## RECOMMENDATION

### **4. Surrogacy contracts must remain absolutely null and void. Further, acting as a paid intermediary in such an agreement should be a criminal offence.**

The preceding recommendation is not unanimous. According to the minority view, it is both inappropriate and inefficient to criminalize only the remuneration of intermediaries in surrogacy arrangements. In the opinion of the minority, either of two alternative approaches would be more appropriate than that favoured by the majority.

The object of the proposed criminal prohibition is to stigmatize traffic in human beings. Commercialized surrogacy is seen by the majority as a form of trafficking in babies that should be prohibited. The situation is not really different from that in which people engage in the buying and selling of children already born. The anguish of infertility and the burden of carrying the child do not alter the reprehensible character of the activity. These factors may justify leniency in sentencing, but they do not exonerate the parents or the surrogate from criminal culpability. If the activity is considered sufficiently reprehensible to warrant criminal sanction, then the minority feel that, logically, all parties who engage in it should be subject to that sanction.

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654. Charo, *supra*, note 310 at 108. See, e.g., the *Surrogacy Arrangements Act 1985*, *supra*, note 421, which prohibits surrogacy on a commercial basis and criminalizes the activities of specialized agencies or other third parties. The statute does not prohibit all forms of payment to the surrogate. The Warnock Report, *supra*, note 421 at 46-47, calls for sanctions for intermediaries and professionals, whether they operate for profit or on a non-profit basis. The United Kingdom White Paper does not share this view, however. Department of Health and Social Security, *Human Fertilisation and Embryology: A Framework for Legislation* (London: HMSO, 1987) para. 73 at 12: "The Government does not however consider that it is appropriate, nor necessarily in the child's best interests, to bring the practice of surrogacy other than the operation of commercial agencies within the scope of the criminal law and the Bill will not add to the criminal sanctions contained in the 1985 Act." For more details, see appendix A, *infra* at 180 and table 4 at 210-13.

According to the minority, however, simple refusal to accord legal recognition to any contractual arrangements relating to surrogacy would be more effective than criminal prohibition as a means of discouraging surrogate motherhood. All such contracts should be regarded as contrary to public policy and therefore be treated as void *ab initio*. If this were done, there would be two key consequences. First, there would be a presumption that the child is the natural child of the gestational mother. The social parents would have no recourse against her if she were unwilling to surrender the child. Second, intermediaries would not be able to collect any payment for the services they provide, and they could be compelled to refund any payment received. The risk of such an outcome would greatly discourage people from entering into any kind of surrogacy arrangement, especially one involving the payment of money. Such a regime could be supplemented by regulatory offences carrying substantial fines or other penalties. This would constitute an effective deterrent to anyone engaging in commercialized surrogacy.

#### D. Control over Gametes and Embryos

The question of control over genetic products and the limits to be imposed creates problems in terms of both application of existing legislation and principles of law, and respect for the fundamental principles and values of our society, in particular, individual freedoms and human dignity.<sup>655</sup>

The following remarks are made in a context where the technologies used in medically assisted procreation are not yet sufficiently advanced to prevent the creation of surplus embryos. In the long term, we can only hope that this problem will be resolved, but refusing to consider it today on the grounds of moral or ethical principles would in our view be unrealistic.<sup>656</sup>

Uncertainty about the fate of frozen gametes and embryos when, for example, a couple divorces or a dispute arises (whether between partners or between the bank and its clients) and about the nature of the producer's control over his or her gametes, as well as embryos created with them, has given rise to legal disputes for which the law as it currently stands offers no solution. Who has control? What is the basis for that control? In what way is the control restricted? And what limits apply to the way gametes and embryos can be used? Recent case law<sup>657</sup> indicates that the courts are quite embarrassed when asked to decide the fate of frozen gametes and embryos in circumstances of this nature. The rulings also bear witness to the difficulties and risks encountered when such disputes are left entirely to the judicial system. In the *Parpalaix* case,<sup>658</sup> for example, we saw that the central issue, namely the post-mortem use of gametes, was avoided. The ruling of the trial judge in

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655. See Council of Europe, *supra*, note 606 at 11.

656. See *supra* at 122-23.

657. See *supra*, notes 202-204.

658. *Supra*, note 202.

the *Davis* case<sup>659</sup> in the United States illustrates the dangers of absolutism where the status of the embryo is concerned. Finally, it is difficult to accept that a couple should have to seek permission from the courts in order to be able to use their embryos for procreation.<sup>660</sup> The question of control over gametes and embryos therefore creates problems that demand a solution. What legal regime should apply?

## 1. Embryos

The nature of the embryo makes it difficult to determine its status (Is it a person or a thing?) and whether it falls into the private realm of property law or the public realm of the law of persons (who cannot be objects of commerce).<sup>661</sup> Given this impasse, how can the problem of control over the embryo be resolved?

A number of solutions are possible. The lawmaker could create a category for the embryo that would lie between things and persons; adopt rules of law that would borrow from both categories;<sup>662</sup> make the matter subject to the rules of property law;<sup>663</sup> impose a solution to any possible dispute (donation to third persons, destruction or experimentation) through regulation of banks;<sup>664</sup> or refrain from intervening but ensure that the consent of those with control makes provision for the fate of the embryos in specific situations.<sup>665</sup>

659. *Supra*, note 203 at 2. Among the reasons for the decision by Judge Dale W. Young were the following: "(7) Human life begins at conception. (8) Mr. and Mrs. Davis have produced human beings, *in vitro*, to be known as their child or children." For a critical review of this position, see Shuster, *supra*, note 623 at 976ff.

660. *York v. Jones Institute*, *supra*, note 204. See *supra*, note 217.

661. See Keating, *supra*, note 616.

662. Catherine Labrusse-Riou, "Réflexions terminales" in Raphaël Draï and Michèle Harichaux, eds, *Bioéthique et droit* (Paris: P.U.F., 1988) 269 at 275: [TRANSLATION] "It is important that positive law preserve its categories of 'person' as opposed to 'thing', or the notion of civil identity defined by the category 'status of the person,' which cannot be disposed of; but within these categories, one should be imaginative in trying to find rules which themselves can change to accommodate these new situations we face." Louisiana recognizes fertilized ova as having "legal personality" until it is implanted in the uterus. As a "legal person," a fertilized ovum cannot, therefore, be considered property and could take or be the subject of legal action. The gamete donors are considered to be its parents; failing this, the medical clinic is designated the guardian of the conceptus. From this designation stems the prohibition against destroying an *in vitro* embryo that has the potential to develop normally. Although the conceptus has "legal personality" before it is implanted, its inheritance rights do not come into being until its birth and will be bound to the "natural" or adoptive parents (see appendix A, *infra* at 182). In France, the National Ethics Committee has termed the human embryo a "potential person" and therefore subject to the law of persons, not property. See Labrusse-Riou, *ibid.* at 273. Knoppers, *supra*, note 221 at 343ff. The article points out that the recommendations of U.S., European and Commonwealth law reform commissions indicate a consensus on the need to protect genetic material but do not necessarily grant it legal personality.

663. The intentions of the "owners" would prevail. Agreements so signed would have to be respected by divorce law and the law of successions. It would also be possible to make the contract of deposit binding.

664. See Conseil d'État, "Avant-Projet de Loi sur les sciences de la vie et les droits de l'Homme," 1989, s. 10 at 58 [unpublished]; see also appendix A, *infra* at 183. In the event of death, divorce or separation, the gametes would be destroyed.

665. The alternatives as to the fate of the embryos would obviously be limited by the possible use that can be made of them by the person with control in a given situation (expiry of the time limit on freezing, divorce, etc.); see *infra*, rec. 5(3).

Needless to say, leaving the question of control of the embryo to the rules of property law is entirely unethical,<sup>666</sup> but it also seems somewhat premature to suggest that legislatures create a new legal category for these potential living beings. Lawmakers must, however, develop special legal rules that will protect embryos but also permit the ethical debate to continue.<sup>667</sup> Such rules could be developed on the basis of the written, signed consent of the producers given before the embryos are conceived.<sup>668</sup>

While a written statement of consent before embryos are created allows the persons with control to set their terms for the creation of embryos, it is important that they be allowed to change their decision regarding the ultimate fate of the embryos before the embryos are used for the purpose for which they were intended.<sup>669</sup> Of course, in cases where control is shared by a couple, any change would require the consent of both partners.

## RECOMMENDATION

**5. (1) Before conceiving embryos for future personal use, the person or persons with control should be required to make a written statement of intentions as to the fate of the embryos in such circumstances as the death of a person with control, abandonment of the parental project, expiry of the time limit on freezing, or a divorce or other dispute between the persons with control. A person with control should be able to change, in writing, his or her stated intentions regarding the fate of the embryos as long as the embryos have not been used for their intended purpose; in cases where control over the embryos is shared by two people, both must agree to any changes.**

But who should have control? In principle, control over an embryo should be based on both the genetic contribution and the intention of the parties, but what happens when these conflict?

When the embryos are the genetic product of a couple, the partners' interests are equal and also outweigh the potential interest of the bank or clinic that has the embryos in its possession. Thus, the embryos that resulted from the union of the couple's gametes should be jointly controlled by the couple, who alone should have the authority to decide the fate of surplus and frozen embryos. Implantation of any embryos should therefore first be agreed to by the couple. Consequently, the clinic or bank would have no right to keep the embryos or to go against the wishes of the couple in any way. Its only rights would be those expressly granted.

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666. The Commission has written that the law must never treat embryos or fetuses as mere objects. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 49.

667. Regarding the important question of the status of the embryo, see Keating, *supra*, note 616.

668. See Shuster, *supra*, note 623 at 977. See also John A. Robertson, "Prior Agreements for Disposition of Frozen Embryos" (1990) 51 Ohio St. L.J. 407.

669. See *supra* at 52.

In cases where the embryos are partly the product of a donation from a third person, while it is clear that the donor cannot claim to have rights over the embryos,<sup>670</sup> there are questions regarding the status of the partner who has no genetic link to the embryos. While the wishes of each party have to be considered, the genetic link must give the partner whose gametes were used a greater interest than the other partner. In the event of a dispute over the fate of the embryos, the wishes of the genetically linked partner must prevail.

In cases where the embryos were conceived using donated sperm and eggs (that is, where embryos are not genetically linked to the future parents), control must rest with the bank or clinic that has the embryos in its possession.

## RECOMMENDATION

**5. (2) Control over embryos conceived using gametes from a couple should be exercised jointly by the partners. Control over embryos conceived using gametes from only one of the partners and a donor should vest in the partner genetically linked to the embryos. Control over embryos conceived with donated gametes should vest in the bank or clinic that has the embryos in its possession.**

What is the scope of the control over embryos? What choices can the parties make in terms of disposing of the embryos? Is there a greater interest that would warrant imposing limits on the decisions a couple may make with regard to the disposition of embryos? The Commission has already expressed its opinion of the best way to dispose of surplus embryos; it would prefer that, rather than be destroyed, they be donated for implantation or, failing that, for experimentation. No solution is perfect: the response to those who in the name of a "parental plan" oppose donation could be that destruction is perhaps equally unacceptable. But what then?

It would be appropriate at this point to reaffirm the position we have taken: the person or persons with control may donate the embryos for implantation, donate them to science to be used within the stated limits, or have them destroyed.<sup>671</sup> Otherwise stated, the options for using embryos available to those who have control over them should be limited to implantation, experimentation and destruction.<sup>672</sup>

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670. We will later discuss the rights of donors over their gametes.

671. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 52; Robertson, *supra*, note 216 at 10: "The consensus emerging from the Ethics Advisory Board, the Warnock Committee, the American Fertility Society, and most other ethics commissions throughout the world that have studied the matter is that special respect for embryos does not require treating them as actual persons or prohibiting couples from opposing transfer." See also Robertson, *ibid.* at 10 n. 15.

672. See also Shuster, *supra*, note 623 at 977.

## RECOMMENDATION

**5. (3) The possible uses of embryos should be limited to implantation, experimentation and destruction; however, implantation should be prohibited beyond the time limit on freezing.**

If the person with control decides to donate his or her embryos, it is important that he or she also state in writing the conditions he or she wishes to attach to the donation, that is, any conditions as to how the embryos may be used.<sup>673</sup> It is also important that the person be able to change the conditions or withdraw consent at any time before the embryos are used.<sup>674</sup>

## RECOMMENDATION

**5. (4) The person with control over an embryo who decides to donate the embryo should be required, before the donation is made, to make a written statement expressing his or her consent to the donation, and stating the conditions attached to the donation respecting the utilization of the embryo. That person should also be able to change those conditions or withdraw consent by making a written statement to that effect at any time before the donated embryo is used; in cases where control over the embryo is shared by two partners, both must agree to any change.**

## 2. Gametes

Should we treat gametes differently than mere material property? This is a question that must be broached in the context of a broader consideration of the legal regime to be applied to the human body and its parts and substances.<sup>675</sup> The ultimate procreative purpose of genetic material further underlines the need for such a study. It goes without

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673. See *supra* at 50-51.

674. See *supra* at 50-51. The possible conditions will be limited by the allowable use of the embryos by the persons with control; see *supra*, rec. 5(3).

675. Hermitte, *supra*, note 207 at 325. Hermitte suggests that the human body and parts and substances thereof fall into the category of "things of human origin intended for human use," between persons and things. Galloux, *supra*, note 619 at 3-4, 31, on the other hand, rules out the possibility of creating a category other than the categories of persons and things:



saying that gametes cannot be considered persons, yet designating them as things would be to ignore their specific nature.

As noted earlier,<sup>676</sup> the specific biological nature of spermatozoa and ova led the Commission to state that gametes and embryos cannot be considered simple cells or simple tissues.<sup>677</sup> Gametes are virtual sources of new human life and must be treated in a manner similar to embryos.

Control over gametes could be covered by private law but without being subject to the system of law reserved for things, and could also be governed by the intentions of the producer. A written statement of intent would assure persons depositing their gametes for storage that their right of control would be recognized and would make it possible to indicate the measures to be taken when, for example, the storage period expired or the persons no longer wished to use the stored gametes. Such consent would also allow persons donating their gametes to set conditions for using the gametes and to withdraw their consent before the gametes are used.

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[TRANSLATION]

The division of the legal world into two distinct categories, things and persons, is a fact of life; without it, the law could not be. This *summa divisio* of the law has two corollaries: the categories of legal reality are specific and exclusive. They are specific in that they denote beings of a particular essence or nature, and they are contradictory: a being cannot be thing and person at the same time; it is impossible to shift from one category to the other unless the essence of the being is deprived of all permanence, and this the law does not allow. They are exclusive in that the law affords no room for a third category: this is simply the traditional application of the principle of the excluded middle accepted in our system of law. . . .

Genetic material, whether of animal, vegetable or human origin, and whether it is seen from a material or an informational perspective, is a thing. This view makes analysis of the legal problems created by genetics consistent with both scientific knowledge and our system of law based on specific categories. It confirms the fundamentally metabiological and unconventional nature of the person. Attributing personal qualities to human genetic material is tantamount to rupturing the fundamental unity of the living being and to giving persons and things circumstantial definitions the criterion for which would be embodiment. This somewhat irrational approach creates the risk of arbitrariness in law. It ultimately exposes the person to biological reductionism, the inevitable consequence of denying his or her metaphysical dimension.

Real qualification does not involve any devaluation of the living being. Nor does it imply appropriation or commerce: the fundamental categories of things communally owned and things that are not objects of commerce remind us of this. It does not deny the value of genetic material and the human body. Rather, it confirms the notion that value lies not in the nature of the thing, but in the intimacy and necessity of the bond between the thing and the person. It is therefore in terms of the legal regime of these "genetic things" that the law must promote the defence of the living being and the protection of the dignity of humankind.

Galloux does, however, use the notions of extracommerciality and attribution in order to limit legal commerce (legal action the purpose of which is to create, modify or extinguish rights) in products of the human body. See Galloux, *supra*, note 208.

676. See *supra* at 122-23.

677. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 53.

## RECOMMENDATION

### **6. (1) Control over gametes should vest in the producer.**

**(2) A person depositing his or her gametes for future personal use should be required, before the deposit, to make a written statement expressing his or her intentions as to the fate of the gametes in such circumstances as the death of the person with control, abandonment of the parental project or expiry of the time limit on freezing. The depositor should be able to change, in writing, his or her stated intentions regarding the fate of the gametes before any embryos are created or the gametes are used for their intended purpose.**

Where a producer donates his or her gametes, it is important that he or she state in writing the conditions he or she wishes to attach to the donation, that is, any instructions as to how the gametes may be used.<sup>678</sup> It is also important that the person be able to change the conditions or withdraw his or her consent.<sup>679</sup>

## RECOMMENDATION

**6. (3) A person who donates his or her gametes should be required, before the donation is made, to make a written statement expressing his or her consent to the donation and stating the conditions attached to his or her donation respecting the use of the gametes. The donor should be able to change these conditions or withdraw his or her consent by making a written statement to that effect at any time before embryos are created or the donated gametes are used.**

**(4) Possible uses of gametes should be limited to fertilization, experimentation and destruction; fertilization should be prohibited beyond the time limit on freezing.**

### **3. Post-Mortem Use of Gametes and Embryos**

Should we limit the possibility of using gametes and embryos following the death of the producers or one of the partners? Should we prohibit their use by the surviving partner? Should the definition of the family be extended to include post-mortem procreation? This raises the whole question of limits on individual freedoms and the force of contracts.

The answers to these questions may depend on the policies adopted regarding access to medically assisted procreation. Opting to protect the two-parent family would mean imposing a limit on freedom of contract. However, if no policy is adopted in an effort

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678. See *supra* at 50-51. The options regarding the fate of gametes will of course be limited by the way the persons with control can use them; see *supra*, rec. 6(4). With respect to the time limit on freezing, see *infra*, rec. 12(2).

679. See *supra* at 50-51.

to protect the two-parent family, do we necessarily have to allow restitution to the surviving partner? Some will argue that the psychological problems such a situation may create, both for the surviving partner and for the child, cast doubt on the appropriateness of giving precedence to freedom of contract, and that caution would appear to be in order. For this reason, and given the very nature of the parental plan, it may be concluded that control over gametes and embryos in the event of the death of a producer should be limited to the following options: non-directed donation, experimentation or destruction.<sup>680</sup>

On the other hand, it may be objected that the phenomenon is still so new that it is difficult to raise any cogent arguments to justify restricting freedom in this regard. The Commission holds the view that the restitution of gametes or embryos to the surviving partner after the death of a producer should not be prohibited. Provisions dealing with parentage and succession in cases of post-mortem use will therefore have to be introduced.<sup>681</sup>

The Commission is aware that the solutions proposed in its recommendations on the control over gametes and embryos call for the exercise of provincial jurisdiction. Nevertheless, we felt it was desirable to state our position, as we believe it is essential to standardize the rules of law that will be needed to resolve these conflicts.

## E. Parentage

### 1. Donation of Gametes and Embryos

The parentage of children born as a result of medically assisted procreation raises the issue of the possible application by the courts of existing legislation and principles of law. We have already seen that the current rules of legal parentage are inadequate in some new situations created by medically assisted procreation, and it is difficult to anticipate how they would apply in cases of dispute.<sup>682</sup>

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680. For example, the Council of Europe (*supra*, note 606 at 37) does not permit post-mortem use of gametes, citing the welfare of the child and the risk of break-up of the family unit. The Barreau du Québec (*supra*, note 3 at 24ff.) also recommends prohibiting such use because it deliberately creates an orphan and may cause serious psychological damage if the circumstances are disclosed. France prohibits post mortem use in the interest of preserving the two-parent family. See appendix A, *infra* at 186, in particular note 135.

681. In England, for instance, the post-mortem use of gametes by the surviving partner is neither prohibited nor encouraged. When they consent to the storage of their gametes and embryos, the couple is required to make provision for disposition in the event of death. If there are no specific instructions to this effect, the embryos will not be kept. Before implantation, the surviving partner must receive counselling. Australia holds the view that post-mortem use should be neither regulated nor prohibited. Spain permits post-mortem use if insemination takes place no later than six months after the death. The child is deemed the father's descendant only if he or she is recognized by the father in his will or in some other notarized document; otherwise there is no legal connection with the deceased. For the proposals of other countries and more details, see appendix A, *infra* at 186. Regarding the provisions on parentage and the law of successions, see *infra* at 187ff.

682. See *supra* at 56ff.

The main problems we identified as being associated with the donation of gametes and embryos included: the attribution of responsibilities arising from the paternity of a donor who has no wish to become a father; disavowal of a child whose conception was desired; the possibility of paternity challenges by third parties or a producer and a claim of paternity by the latter; the legal status of the child; and the division of maternity into gestational maternity and genetic maternity.<sup>683</sup> These problems lead us to consider the relative importance to be attached to the future parents' expressed intentions and to the biological and social criteria for paternity and maternity. However, the diversity of the rules governing parentage in Canada<sup>684</sup> shows that even in the area of natural procreation there is no clear answer. This makes the complexity of the problem even more evident and underscores the difficulty of finding a solution in the area of medically assisted procreation. Despite these difficulties, however, the Commission believes that some problems can no longer be eluded. Where donated gametes or embryos are used, parentage should reflect the intentions expressed by the parties at the time of the donation, namely the donor's wish to have no legal connection to the child,<sup>685</sup> and the desire of the couple or recipient to assume responsibility for the child.<sup>686</sup>

Parentage law must therefore provide: (1) the circumstances in which a presumption of paternity may be challenged; (2) that no bond of filiation can be established between a donor and the child; and (3) that any child born as a result of medically assisted procreation is deemed to be a legitimate child.<sup>687</sup>

## RECOMMENDATION

**7. (1) Provincial parentage laws should reflect the intentions of couples who use medically assisted procreation; accordingly, actions to disavow paternity by a father who gave his consent or to challenge paternity by a third party on the grounds that a donation from a third person was used should not be allowed.**

**(2) It should not be possible to establish a bond of parentage between a donor and the child.**

**(3) Legislation that still makes a distinction between legitimate and illegitimate children should recognize children born as a result of medically assisted procreation as having the status of legitimate children.**

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683. We will see that this problem is of special significance in the area of surrogate motherhood; see *infra* at 148.

684. See *supra* at 57-58.

685. The Uniform Law Conference has reaffirmed that a sperm donor is not the father of a child born as a result of his donation and has no right or obligation to the child; see *An Act to amend the Uniform Child Status Act*, *supra*, note 199, s. 11.4(2); see *supra*, note 278.

686. *Ibid.*, s. 11.2.

687. *Ibid.*, ss 11.2 and 11.4.

Finally, since we propose that post-mortem fertilization with the gametes of a deceased partner not be prohibited, it is essential that new provisions dealing with inheritance rights be introduced. The Commission believes that children born as a result of assisted procreation should not inherit unless there is a specific reference to that effect in the will.<sup>688</sup>

## RECOMMENDATION

**8. Provincial succession laws should be harmonized to establish that children born as a result of the post-mortem use of gametes or embryos may not inherit unless there is a specific reference to that effect in the will of the deceased producer.**

### 2. Surrogacy

Although surrogacy contracts are in all likelihood absolutely null and void under Canadian law as it stands at present,<sup>689</sup> the parentage of a child born under such a contract may be subject to contestation. The effect of the rule whereby the woman who gives birth is the legal mother is clear in cases where the surrogate is genetically linked to the child. She is both the genetic and the gestational mother. The social mother can rely only on her intent to become a parent. If the surrogate decides to keep the child, the dispute then becomes a question of custody and is settled by the courts in light of the interest of the child in the particular case.

However, the use of surrogates raises a new issue in law, namely the right of the social mother who is also genetically linked to the child to claim and prove her legal maternity, just as the genetic father could claim and prove paternity.<sup>690</sup> The interest in promoting sound application of the principles and rules of existing law thus comes up against the conflict between the interests of the gestational mother, the genetic mother and the child. The interest of the child in having clear parentage and a stable and loving family environment is not open to question. When maternity is divided among the genetic, gestational and social mothers, it is difficult to rule in favour of one or the other. Clearly, the link that is formed between the surrogate and the child during gestation is important and can hardly be compared to the link that may be established with the surrogate's husband during the pregnancy. It is therefore easier for the biological father to oppose his interest to that of the surrogate's husband than for the genetic mother to challenge the surrogate's interest. Yet we cannot ignore the interest of the genetic mother who attaches to her "donation" an expression of her intent to become a mother. Further, assessing the interest

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688. For a similar view, see White Paper, *supra*, note 654, para. 60 at 10. For a general discussion, see appendix A, *infra* at 186.

689. See *supra* at 65-67.

690. It should be noted that this is not a right arising from the contract, since the contract is in all likelihood absolutely null and void, but rather a question of legal parentage.

of the child in having as a mother his or her gestational or genetic mother becomes an arbitrary exercise because we do not have the knowledge to make such a decision. Making such a choice now, even in the name of the child's stability, may be damaging in the long run.

We recognize the shortcomings of current law and the general interest in anticipating and resolving questions of parentage and the interest of the child in this context. However, we feel that it would be hasty to adopt just any rule to solve the problem of stability by choosing between gestational and genetic maternity.<sup>691</sup> Since experience and the existing rules are based on a different reality, namely the uniqueness and indivisibility of maternity, we cannot simply extend them to medically assisted procreation without more insight. We believe the fairest solution would be to let this new phenomenon unfold in the courts and in society before a rule is imposed.<sup>692</sup> At this stage, the interest of the child would be better protected by a court assessment of each case. The status quo leaves the door open to the judicial discretion that may be essential to the resolution of such disputes.

For these reasons, the rule whereby the woman who gives birth is necessarily the legal mother of the child should not, as it relates to surrogate motherhood, be entrenched in legislation.

## II. Medically Assisted Procreation and Safety

Based on the preceding chapters, we can conclude that medically assisted procreation raises serious questions of safety for the people using the technologies and for the resulting children. Examples include problems related to low success rates; significant variation in the way such rates are calculated and interpreted; the physical and psychological risks; the lack of standards in record keeping; and the lack of national data.

### A. Success Rates: The Importance of Informed Consent

The confusion surrounding the success rates of certain technologies leads us to question whether infertile couples are in a position to choose the option that is best for them.<sup>693</sup> Indeed, the different methods of reporting success rates<sup>694</sup> make interpretation very difficult, and yet an understanding of the rates is essential to informed consent.<sup>695</sup>

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691. See, however, *An Act to amend the Uniform Child Status Act*, *supra*, note 199; see also *supra*, note 325.

692. See *Anna J. v. Mark C.*, *supra*, note 324. Ms. Johnson was the first surrogate mother to claim parental rights to and custody of a child to which she was not genetically linked.

693. See *supra* at 5 and 13-15.

694. *Ibid.* Louise Vandelac, "La face cachée de la procréation artificielle" (1989) 213 *La Recherche* 1112 at 1114; [TRANSLATION] "Whereas in the public's mind the success rate of IVF and GIFT measures probability for each attempt to have a child, biomedical teams tend to view it simply as their own rate of success in certain phases of the process."

There are as many success rates as there are methods of calculation."

695. See *supra* at 62-63 regarding the need for free and informed consent.

In addition, the available success rates for artificial insemination are based on studies that for the most part were done when fresh sperm was being used.<sup>696</sup> These rates are therefore no longer conclusive because more recent studies have shown that the freezing of sperm, which is necessary today primarily to prevent the transmission of AIDS, reduces motility, longevity and ability to fertilize by half.<sup>697</sup> New studies should therefore be conducted to provide infertile couples with more realistic success rates.

In chapter 1, we demonstrated the complexity and lack of consistency in the way results are reported in the area of IVF and GIFT. Since success rates vary depending on the numerator and denominator chosen, it is not surprising to learn that the reported rates create confusion and do not make for easy comparison.

Given the very low success rates of IVF<sup>698</sup> and the vulnerability of infertile couples (for whom medically assisted procreation is often the last chance to conceive a child), it is essential that couples who choose this technology — as well as related procedures and GIFT — give free and informed consent. For this reason, clinics should be required to report actual results in a uniform manner, so that reliable statistics are readily accessible.<sup>699</sup>

To make possible a complete assessment of these results, it is therefore important that the content of clinical reports be standardized.<sup>700</sup> The statistics should show not only the number of pregnancies achieved or children born, but also the number of ectopic pregnancies, the number of spontaneous abortions, the number of embryos implanted, the rate of multiple pregnancy, the rate of birth defects and other possible problems.<sup>701</sup>

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696. See *supra* at 27.

697. *Ibid.*

698. See *supra* at 15-17.

699. We view this as a measured reaction compared with the proceedings recently taken by U.S. authorities against clinics that allegedly promoted their success rates unfairly and fraudulently. See Proposed Consent Agreement with Analysis to Aid Public Comment, *supra*, note 562; *Federal Trade Commission v. Jacobson*, *supra*, note 562. Compare *R. v. Gregory*, *supra*, note 561.

700. See *supra* at 15.

701. See *supra* at 17ff. On the subject of success rates and the need for national controls, Vandelac, *supra*, note 694 at 1116, writes as follows:

[TRANSLATION]

It is surprising that the notion of success rates is not homogeneously redefined in terms of the number of children conceived through IVF and healthy at the age of one month compared to the total number of superovulations. This would reduce the impact of multiple transfers in success rates and would lead to reconsideration of multiple transfers and IVF itself.

Some reports, such as those by Australia, Wagner and the OMS, and the recent opinion by the Conseil du statut de la femme in Quebec tend to share this view and call for tighter regulation of artificial fertilization, as well as a redefinition of and greater transparency in statistics. However, public officials seem slow to react.

From another standpoint, analysing such data on a national basis would provide insight into the problems medically assisted procreation creates for our society and the people involved. The lack of uniformity in the methods used to report success rates and the general dearth of statistics are obstacles to proper evaluation of the current situation. We should require not only that the results obtained by clinics be reported uniformly, but also that the data be centralized and analysed on a national level. The standardization and centralization of data describing clinical activities and analysis of those data are essential because they make it possible to monitor practices. This could be done by establishing a national registry.

A confidential and voluntary national registry has already been set up by one group of health professionals. However, the very fact that the registry is voluntary creates major problems that make it virtually useless.<sup>702</sup>

To ensure that clinical reports are available, that the data are centralized, analysed and used to produce reliable statistical reports, and that the statistics can be accessed, clinics should be required to submit annual reports to a central registry managed by an administrative agency that we will discuss later. As stated earlier, these reports should include data on the use of all medically assisted procreation technologies, and a standard reporting method should be used; minimum content should be set and the presentation of data fixed. Statistical reports produced using the clinical reports should be available to the public.

## RECOMMENDATION

**9. Clinics offering medically assisted procreation services should be required to submit written annual reports to a central registry; the minimum content of the reports should be set and the data should be presented in a prescribed form.**

### B. Risks

#### 1. Physical Risks

The main risks associated with the use of gametes from a third person are the transmission of infectious or genetic diseases and consanguinity if the sperm of a particular donor is used too often.<sup>703</sup>

The risk of transmitting genetic and infectious diseases is greatly reduced if the donor is properly assessed and the gametes used are properly screened.<sup>704</sup> It is therefore important not only that standards for screening and selection be introduced, but also that they be applied consistently.

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702. See *supra* at 16-17.

703. See *supra*, note 163; see also *supra*, note 181.

704. See *supra* at 5, 26-27 and 32-33.



Unlike blood donations,<sup>705</sup> gamete and embryo donations are not currently subject to any national regulations,<sup>706</sup> yet the need for national standards was noted in one of the first Canadian reports on medically assisted procreation.<sup>707</sup> Further, a 1981 report to the Minister of National Health and Welfare on the storage and use of human sperm recommended that “[f]ederal regulations governing standards for the acquisition, preservation and importation of human sperm be established.”<sup>708</sup> No legislative action was taken, however. All that has happened since is that a number of organizations have adopted guidelines.<sup>709</sup>

The uncertainty surrounding the application of uniform selection, screening and storage criteria makes it difficult to ensure the essential quality<sup>710</sup> of the gametes and embryos used in medically assisted procreation. Donor selection, screening of donations and storage conditions are important factors in the safety of both mothers and their children alike, as neither are able to protect themselves against these risks.<sup>711</sup>

705. The *Food and Drugs Act*, *supra*, note 298, and its regulations set standards for, *inter alia*, advertising, labelling, sale, import, handling, storage and the number of donations permitted. The Canadian Red Cross Society also has standards in some of these areas. See *Procurement and Transfer of Human Tissues and Organs*, *supra*, note 250.

706. See *supra* at 64.

707. British Columbia Royal Commission on Family and Children's Law, *supra*, note 470 at 33:

As an overall protection for all concerned, it is felt that the Health Protection Branch, Canada National Health and Welfare, should be responsible for the *establishment of standards* and for the surveillance of the safety of the whole operation of sperm collection, processing, storage, packaging and dispensing, just as they would for a pharmaceutical product.

Because seminal fluid does not fall within the categories of foods, drugs, or devices which have been legislated as the mandate of the Health Protection Branch, a new legislation at the federal level would be required before such responsibilities can be vested within that agency [emphasis added].

Further, the final recommendation in the report reads:

The Health Protection Branch, Health and Welfare, Canada, should be requested to take on responsibility for surveillance of human sperm banking, with associated collection, processing, distribution and documentation services. Appropriate *federal legislation* to provide this mandate should be proposed [emphasis added].

708. *Report on Human Sperm 1981*, *supra*, note 148 at xii.

709. See, e.g., the Canadian Fertility and Andrology Society, *supra*, note 11. The Society's guidelines cover such matters as donor selection and genetic screening. However, see *supra*, note 300, and accompanying text. We stated *supra* at 32, that even though the merits of screening for infectious and genetic diseases have been widely discussed and advocated around the world, there is still concern that some clinics may choose not to follow such guidelines, as they have no legal force; see also *supra* at 64. Rona Achilles, "Donor Insemination: The Future of a Public Secret" in Overall, ed., *supra*, note 129, 105 at 111 writes as follows:

The importance of screening sperm donors became particularly apparent with the advent of acquired immunodeficiency syndrome (AIDS). Several guidelines for screening of donors have been issued by medical associations. However, my own exploratory study, as well as a broader survey of U.S. physicians, indicated that most physicians did not follow the guidelines — only forty-four percent report testing for human immunodeficiency virus (HIV) antibodies.

The author refers to her own previous work, *The Social Meanings of Biological Ties: A Study of Participants in Artificial Insemination by Donor*, Doctoral Thesis, University of Toronto, 1986; Curie-Cohen, Luttrell and Shapiro, *supra*, note 282 at 585-90; and *Artificial Insemination: Practice in the United States*, *supra*, note 181 at 37.

710. The word "quality" is used in terms of safety, not eugenics.

711. Of course the various professional bodies and associations will have to be involved in developing these standards in the public interest.

## RECOMMENDATION

**10. Uniform and mandatory standards for the selection, screening and storage of gametes and embryos, and the selection and screening of donors, should be developed at the national level.**

Since the use of fresh semen entails a considerable risk of transmitting diseases such as AIDS and screening must take into account the latency period of these diseases, it is important that donated sperm be frozen and that donors be properly screened.<sup>712</sup> The down side of such a policy is clear: clinics and banks have to wait some time before they can use donated sperm and are forced to repeat the required tests after each sperm donation. Further, such a policy completely rules out the possibility of using fresh semen for IVF, GIFT and AID, thereby reducing the success rate of these procedures. Despite these disadvantages, the Commission believes that clinics that use donated sperm in AI, IVF and GIFT must be required to use frozen sperm, and that clinics and banks that recruit donors must be required to test donors for the screening of the above-mentioned diseases.<sup>713</sup> These requirements are similar to those currently applied to blood donation.

## RECOMMENDATION

**11. Donated sperm should be frozen and should not be used for fertilization until the donor has been properly tested for evidence of the AIDS virus.**

Freezing gametes and embryos creates certain problems, however. Science still does not know a great deal about the impact of prolonged cryopreservation, and the principle of generations may be completely altered because an embryo could in theory be reimplanted after a very lengthy period of freezing. These problems have led some countries to limit the length of time embryos and gametes may be frozen.<sup>714</sup>

The Commission recognizes that these limits are completely arbitrary<sup>715</sup> given the current level of expertise, but believes it is important from a safety and sociological standpoint to put a time limit on freezing. In setting the maximum freezing time, however, it is important to consider the fact that too strict a limit (for example, one that would allow embryos to be frozen for only a very brief period) would force women to deal with the risk and inconvenience of more frequent superovulation and egg retrieval or else the risk of having a larger number of embryos implanted per cycle. For the moment, the

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712. See *supra* at 26-27 and 32-33.

713. See appendix A, *infra* at 191-92.

714. See appendix A, *infra*, table 3 at 207-209.

715. *Biomedical Experimentation Involving Human Subjects, supra*, note 7 at 53.

Commission reaffirms the five-year limit recommended in its working paper on experimentation.<sup>716</sup> However, the Commission would like to see more extensive research carried out nationally on time limits and, more specifically, on the effects of cryopreservation. The task of conducting the study could be given to a central agency which we will discuss later.

## RECOMMENDATION

**12. (1) Embryos should not be frozen for more than five years. Further, the federal government should encourage research on the effects of cryopreservation in order to reassess this five-year limit.**

Unlike embryos, gametes can be frozen even before a couple makes plans to have a child, because the reason for freezing may be the prospect of infertility in a person about to undergo medical treatment or surgery.<sup>717</sup> In light of this fact, we believe a limit of ten years is more appropriate.<sup>718</sup> The earlier comments regarding the need for more extensive research on the effects of cryopreservation apply here as well.

## RECOMMENDATION

**12. (2) Gametes should not be frozen for more than ten years. Further, the federal government should encourage research on the effects of cryopreservation in order to reassess this ten-year limit.**

To minimize the risk of consanguinity, it is also important that a limit be placed on the number of times gametes from the same donor may be used.<sup>719</sup>

However, since the risk depends on such factors as the density and mobility of the population served by the bank or clinic, it is important that the limit be flexible enough to take these factors into account. Studies will have to be conducted in this area.

## RECOMMENDATION

**13. A limit should be placed on the number of times gametes from the same donor may be used. Further, the studies needed to set an appropriate limit should be encouraged.**

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716. *Ibid.* See also Act 35/1988, of November 22, on Techniques of Assisted Reproduction, s. 11 (Spain); Conseil d'État, *supra*, note 664; *Human Fertilisation and Embryology Act 1990*, *supra*, note 421, s. 14; White Paper, *supra*, note 654 at 9; Canadian Bar Association, *supra*, note 278 at 33-37. For more details, see appendix A, *infra* at 191-92 and table 3 at 207-209.

717. See *supra* at 27.

718. See *Human Fertilisation and Embryology Act 1990*, *supra*, note 421, ss 4, 14; White Paper, *supra*, note 654 at 9.

719. See *supra* at 28. In comparative law, see appendix A, *infra* at 192-93.

Finally, we have already indicated that some clinics import gametes from the United States.<sup>720</sup> The existence of international traffic in these products raises the question of whether the standards applied in other countries are sufficient. It is therefore essential to ensure that imported gametes and embryos also meet our national standards.<sup>721</sup>

## RECOMMENDATION

### **14. The import of gametes and embryos should be restricted to certified banks. Imported gametes and embryos should have to meet Canadian standards.**

IVF and GIFT entail additional risks of their own, most of them resulting from superovulation and multiple pregnancies.<sup>722</sup> The rate of multiple pregnancy is of particular interest here because it raises the question of the appropriateness of limiting the number of embryos implanted or eggs fertilized per treatment cycle. We showed at the beginning of our study that transferring more than one embryo increases the chances of conceiving but also increases the possibility of multiple pregnancy. Given the high risks associated with multiple pregnancies,<sup>723</sup> a limit on the number of embryos implanted per cycle would seem to be in order.<sup>724</sup> It is not clear, however, that such a limit would help reduce the rate of multiple pregnancy. It should be remembered that the number of embryos transferred is not the only factor affecting the chances of conception and the chances of multiple pregnancy. We have already seen that transferring three embryos may in fact result in a higher rate of multiple pregnancy than transferring four.<sup>725</sup> It is therefore essential that greater importance be attached to the specific circumstances of each case (age of the woman, previous pregnancies, and so on). An arbitrary limit would not attain the desired goal, namely ensuring the safety of the mother and the unborn children.

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720. See *Report on Human Sperm 1981*, *supra*, note 148 at 13.

721. Some genetic products may fall within the scope of the *Food and Drugs Act*, *supra*, note 298. However, the uncertainty as to whether gametes and embryos are included and the need for specific standards mean that more direct intervention is needed. Regarding this matter and the application of the *Quarantine Act*, *supra*, note 558, s. 5, and the *Customs Tariff*, R.S.C. 1985, (3d Supp.), c. 41, see *Procurement and Transfer of Human Tissues and Organs*, *supra*, note 250. It is, to say the least, surprising that safety is carefully regulated in the area of animal genetic products, but there are no specific provisions dealing with human gametes and embryos. It is interesting to note that Canada last year exported more than 1,200 frozen animal embryos and 2 million doses of animal sperm under a national regulatory system. The system provides for the licensing of some 48 national services that transfer genetic material to be used for reproduction and requires permits to import and export fertilized and unfertilized gametes. Last June, Parliament updated this disease control system in the *Health of Animals Act* (*supra*, note 560). See *Animal Disease and Protection Regulations*, *supra*, note 560, ss 32, 50, 59, 84 and 115, administered by Agriculture Canada under the *Animal Disease and Protection Act*, replaced by the *Health of Animals Act*, *supra*, note 560, ss 2, 14, 16 and 19.

722. It was stated *supra* at 17, that the rates of spontaneous abortion, multiple pregnancy, ectopic pregnancy and Cesarean section are substantially higher than the rates observed in the general population.

723. See *supra* at 17ff.

724. See *supra* at 20. The Interim Licensing Authority in the United Kingdom and the Reproductive Technology Accreditation Committee in Australia have implemented recommendations limiting to three or, in extreme cases, four the number of embryos that may be implanted.

725. See *supra* at 20.

The development of technologies that use the normal cycle of ovulation, thus eliminating the risks associated with the drugs used in superovulation and reducing the risk of multiple pregnancy, is certainly to be encouraged. Pending more conclusive results, the primary focus must be to reduce the rate of multiple pregnancy.

## RECOMMENDATION

**15. Every effort should be made to reduce the risk of multiple pregnancy and to promote the development of technologies that follow the normal cycle of ovulation. Accordingly, the federal government should encourage studies and research aimed at reducing the multiple-pregnancy rate and developing technologies that follow the normal cycle of ovulation. Further, clinics should be required to document and justify the number of embryos implanted in each treatment cycle.**

### 2. Psychological Risks

False hopes based on unrepresentative success rates, the consequences of high failure rates with some technologies, the psychological impact of the various stages in IVF and GIFT procedures, and genetic intervention by a third person represent significant psychological risks for people who decide to resort to medically assisted procreation.

Behind the low success rates lie the pain and anguish of couples for whom the process has failed.<sup>726</sup> Other sources of stress and anxiety are the high cost of some treatments, the physical demands placed on the person being treated and the different steps they entail.<sup>727</sup>

Finally, using a donation from a third person to form a family unit can also create psychological risks for the future parents and the child. The psychological stress of keeping such a secret, the consequences of unprepared disclosure, the possible frustration of the

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726. On the subject of success rates, Vandaele (*supra*, note 694 at 1115) writes: [TRANSLATION] "The success rate masks . . . the pain and anguish of those who have suffered miscarriages, ectopic pregnancies or stillbirths and had to deal with the accompanying risks, pain, dashed hopes, complications and hospitalization." Carolyn M. Mazure and Dorothy A. Greenfeld, "Psychological Studies of In Vitro Fertilization/Embryo Transfer Participants" (1989) 6:4 J. In Vitro Fert. Embryo Transfer 242 at 248: "The other most common emotional experience appears to be that of a grief reaction when treatment does not yield a pregnancy." See also *ibid.* at 250 on the same subject. Regarding the attitude and feelings generated by infertility, see *ibid.* at 243-44:

Freeman *et al.* reported that in their pretreatment interviews of 200 IVF/ET couples, 49% of the women and 15% of the men considered infertility the most upsetting experience in their lives as compared with other serious losses such as death or interpersonal stressors such as divorce. Mahlstedt *et al.* asked IVF/ET participants to return questionnaires by mail at the end of a treatment cycle or when pregnancy status was known. In this study, participants were also asked to compare stress from infertility, death, and divorce. Of those who had experienced divorce or death of a close friend or family member, . . . 63% reported that infertility was as stressful or more stressful than divorce, and 58% reported infertility as stressful or more so than death of a loved one.

727. Mazure and Greenfeld, *supra*, note 726 at 248-49.

father with regard to the child and the mother (if she has a biological link with the child) and the identity problems the child may experience cannot be ignored. The need for support therefore goes beyond medical assistance in conceiving a child. Because people diagnosed as infertile (often after years of failure and investigation of the problem) are fragile and face difficult choices, they must be very well informed about what lies ahead for them. In order to be able to make a free and informed decision, it is important that the infertile couple be given the option of consulting experts (psychologists, physicians and others) at any time during and after medically assisted procreation technologies are used, regarding all of the risks, physical<sup>728</sup> and psychological, as well as the actual success rates. Clinics that offer medically assisted procreation services should therefore be required to provide counselling services.<sup>729</sup> We will come back to this question in our discussion of the certification of clinics.

## RECOMMENDATION

**16. Every clinic offering medically assisted procreation services should be required to provide to persons using medically assisted procreation, either before, during or after the application of a technology, counselling services whereby these persons could obtain from experts (psychologists, physicians and so on) the assistance and information they might need concerning the specific problems involved in medically assisted procreation.**

### C. Record Keeping

Proper medical records are not only essential in terms of regulation,<sup>730</sup> the compiling of statistics and the carrying out of studies on the long-term effects of various technologies, but may also prove extremely important in terms of the physical and psychological health of the child. Medical information about a child's genetic heritage may be needed to give the child optimum medical care. It is therefore essential that this information be kept and that it be accessible.<sup>731</sup>

728. See *supra* at 17ff.

729. See *supra* at 23. In New South Wales, counselling is mandatory; see appendix A, *infra* at 193. Rec. 19 of the Warnock Report (*supra*, note 421 at 82) reads as follows: "Counselling should be available to all infertile couples and third parties at any stage of the treatment, both as an integral part of NHS [National Health Service] provision and in the private sector." The Ontario Medical Association guidelines (*supra*, note 85 at 28) include a general provision on the need for counselling services: "Special attention should be given to the emotional support and needs of couples and their families. For many couples, IVF is not appropriate treatment for their infertility. Counselling should, therefore, be available for all couples to provide a forum to discuss the alternatives to IVF."

730. Knoppers and Sloss, *supra*, note 269 at 681: "Linkage and tracing through complete and long-term record keeping are necessary to effectively regulate and evaluate the choice of gametes." Such control also makes it possible to trace contaminated gametes and the people who donated and received them.

731. See "The Right to Be Informed of One's Biological Origins," *supra* at 90. At 91 we stated that refusing to disclose information needed to protect life and health would be a violation of the right to security of the person conceived through medically assisted procreation. See also art. 583 of Bill 125, *supra*, note 196.

However, keeping such records and ensuring access to the information they contain raise the question of respect for the privacy of the parties, in particular their right to anonymity. Information about the identity of the parties should therefore be kept separate from the medical records, and clinics should set up a system that would enable physicians to link donors to recipients and thus to the children conceived using their donations. The system would ensure access to the necessary medical and genetic information but would not violate the right of the parties to privacy.<sup>732</sup> In view of this right, only information needed to attain the desired objectives should be collected, and clinics should be responsible for protecting the confidentiality of the information they hold.<sup>733</sup>

Yet identifying information<sup>734</sup> and social information<sup>735</sup> may have a bearing on the psychological well-being of the child. This raises the whole question of the right of the child to know the circumstances of his or her birth and the identity of his or her progenitors.<sup>736</sup> As stated above,<sup>737</sup> this is not an entirely new issue for us. In the area of adoption, some provinces have set up systems to enable adopted children to locate their biological parents.<sup>738</sup> It is recognized that searching for and finding one's biological parents, or at least knowing who they are, fills a major psychological need in children who are adopted, and an analogy can undoubtedly be made with children conceived as a result of a donation.

The interest a child may have in knowing the circumstances of his or her birth is, on the one hand, at odds with respect for the parents' privacy. Forcing the parents to disclose to the child information about his or her origins could be perceived as an unconstitutional infringement of the fundamental right of the parents to make the decisions that they feel are appropriate in the course of raising their children. Further, it is very difficult to determine the child's interest objectively. As the OLRC has noted, "[t]he social and psychological ramifications of disclosure are simply not clear; one cannot accurately predict the

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732. For the various positions held abroad, see appendix A, *infra* at 194ff.

733. A number of provisions to this effect are included in *An Act to amend the Uniform Child Status Act*, *supra*, note 199. These provisions make physicians responsible for keeping records, but access to records which may be related is made possible by a central registry. Responsibility for protecting the confidentiality of this information rests with the agency that receives it.

734. Identifying information has to be kept in any case because it is essential in terms of donor liability.

735. This may include information about the ethnic origin, profession, education, religious affiliation and interests of the parties involved. See, e.g., Ministry of Community and Social Services, *Adoption Disclosure Services* (Toronto: The Ministry, 1987) at 5.

736. Lori B. Andrews, "Legal and Ethical Aspects of New Reproductive Technologies" (1986) 29:1 Clin. Obstet. Gynecol 190 at 198: "Some individuals who were conceived through artificial insemination and are now in their 20s and 30s feel that they have suffered emotionally as a result of being created with donor sperm. Like adoptees, some artificial insemination children feel that, for reasons of their psychological and medical well-being, they need to learn about or meet their biological fathers, the sperm donors." To the same effect, see Achilles, *supra*, note 709 at 110.

737. See *supra* at 60-61 and 90ff.

738. See *supra* at 60-61 and note 281.

implications in individual cases.”<sup>739</sup> Such decisions must take into account the personality and needs of the particular child and must be left to the discretion of the parents.<sup>740</sup>

On the other hand, the interest of the child is also at odds with the donor’s interest in remaining anonymous. This therefore requires a balance to be struck between the donor’s right to privacy and the child’s right to know about his or her origins.

While identifying information has to be kept (as it is essential to establishing donor liability), it should be disclosed only if the donor consents when the child makes the request.<sup>741</sup>

At the request of the child or the parents, non-identifying social information should, however, be disclosed. Such general information is important to the child’s psychological development and in no way infringes the donor’s privacy.<sup>742</sup>

## RECOMMENDATIONS

**17. (1) Clinics should be required to keep records (on the donor, the mother and the child) that allow physicians to link the donor to the recipient while protecting the anonymity of the parties.**

**(2) Only the information needed to attain the following objectives should be collected: to permit access to medical and genetic information that may be needed to obtain optimum medical care; to meet the psychological needs of the child; to ensure proper clinical reports; and to permit studies on the long-term effects of the various technologies used in medically assisted procreation.**

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739. *Supra*, note 2 at 187.

740. Even in Sweden, where the child has the right to know about his or her origins, disclosure is left to the parents.

The travaux préparatoires of the new legislation begin by affirming the importance of parental frankness and honesty towards the child. Parents ought therefore to tell the child about its origins at the earliest suitable opportunity. It has not been found appropriate to legislate on this point. Instead it is observed that, during the psychosocial counselling procedure which proceeds insemination, the physician should try to make the prospective parents understand the importance of being frank with the child.

Göran Ewerlöf, “Artificial Insemination Legislation and Debate” (1985) 29 *Current Sweden* 1 at 7.

741. It is interesting to note that in Sweden, while the enactment of a law that recognized the child’s right to know about his or her origins initially led to a significant drop in the number of donors, it took only a few months for the situation to correct itself. Achilles, *supra*, note 709 at 105-15: “[W]ithin months the number of donors had risen to previous levels, and reports indicate that a different kind of donor is becoming involved in programs.” See also Bertil Wennergren, “Consequences of New Regulations in Reproductive Medicine and Human Embryo Research in Their Relationship with Science, Ethics and Law. The Swedish Approach” in Byk, ed., *supra*, note 640, 387 at 389; and Lena Jonsson, “Artificial Insemination in Sweden” in *Sortir la maternité du laboratoire*, *supra*, note 493, 148 at 154.

742. See *supra* at 90. Most recent reports on adoption and medically assisted procreation have recommended that non-identifying information be made available and that identifying information be disclosed only with the consent of the biological parents. See Knoppers and Sloss, *supra*, note 269 at 693-96.



**(3) Clinics should be responsible for protecting the confidentiality of the information they hold.**

**18. The legal parents or the child should be able to request disclosure of non-identifying information, in particular social information (such as ethnic origin, profession, education, religious affiliation and interests of the donor). However, identifying information should be disclosed only with the donor's consent.**

In light of the recent ruling in *R. v. Thornton*,<sup>743</sup> we can conclude that where a donor intentionally conceals important information or gives false information, such failure or negligence may be subject to prosecution under the *Criminal Code*, either section 180 (public mischief) or section 219 (criminal negligence).<sup>744</sup> It is therefore essential that donors' names be kept and that donors be prevented from using their right to remain anonymous in order to obtain immunity against criminal prosecution related to a false disclosure or a failure to disclose.<sup>745</sup>

## **RECOMMENDATION**

**19. It should be possible to reveal to the prosecuting authorities the identity of any donor who fails to provide information or who provides false information for the purpose of a criminal prosecution related to such false disclosure or failure to disclose.**

### **D. Long-term Evaluation**

The uncertainty that prevails regarding the possible risks associated with medically assisted procreation means that vigilance is needed. For example, while the use of frozen gametes and embryos does not appear to pose a threat to safety at present, caution forces us to recommend that studies continue to monitor and examine the long-term effects of cryopreservation on health and safety. Generally, the long-term impact of the technologies on children born as a result of assisted procreation should also be monitored. And if studies on long-term effects are to be carried out, it is essential that records be properly kept and that data be compiled and made available nationally.<sup>746</sup>

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<sup>743</sup> *Supra*, note 270.

<sup>744</sup> See ss 180, 216 and 219 of the *Criminal Code*. Judge Flanigan in *R. v. Thornton* (*supra*, note 270) wrote at 34 of his decision: "Again it is my view that the Code has provided at least three sections that could cover the actions of the accused in this case. These include the sections dealing with criminal negligence, public mischief, and the sections relied upon by the Crown, that is, s. 180 and s. 216."

<sup>745</sup> To the same effect, see the *Report on Human Sperm 1981*, *supra*, note 148 at 22. For more details, see appendix A, *infra* at 196.

<sup>746</sup> Recs 9 and 17, *supra*, address these concerns.

## RECOMMENDATION

**20. Studies should be undertaken to determine and measure the long-term effects of medically assisted procreation technologies on the resulting children.**

### III. Implementing the Recommendations

#### A. Controlling Practice

Considering the inadequacy of the controls now in place,<sup>747</sup> and in order to effectively address the various aspects of public safety, we feel it is essential to regulate certain aspects of the activities of clinics and banks.<sup>748</sup> A system of certification could impose conditions and restrictions.<sup>749</sup> Obtaining certification would thus be conditional on clinics and banks meeting certain prerequisites (for example, the requirement to set up a counselling service and a filing system<sup>750</sup>), while compliance with other standards,<sup>751</sup> duties,<sup>752</sup> restrictions<sup>753</sup> or prohibitions<sup>754</sup> would be needed to maintain certification. This would make it possible to determine, for example, whether clinics and banks are observing the prohibitions on the selection and commercialization of gametes and embryos.<sup>755</sup> Finally, the system would also make it possible to regulate other aspects of medically assisted procreation, such as the forms used to record the intentions of those with control over gametes and embryos.<sup>756</sup>

## RECOMMENDATION

**21. (1) A system of certification for clinics and banks should be established in order to regulate the following issues:**

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<sup>747</sup>. See *supra* at 101ff.

<sup>748</sup>. See “Regulation of Procedures,” *supra* at 112. See also the recommendations on standards for the selection, screening and storage of gametes and embryos (rec. 10) and the recommendations that impose requirements (recs 9, 11 and 15 to 19), restrictions (recs 5(4), 6(4) and 12 to 14) or prohibitions (recs 2 and 3) on clinics and banks. The Commission recommended in *Biomedical Experimentation Involving Human Subjects* (*supra*, note 7) that standards governing the creation, expansion and management of sperm and embryo banks should be developed (*ibid.*, rec. 8(3) at 54).

<sup>749</sup>. Concerning the effects of certification, see, *inter alia*, *supra*, rec. 14.

<sup>750</sup>. See *supra*, recs 16 and 17.

<sup>751</sup>. Standards concerning, *e.g.*, selection, screening and storage of gametes and embryos; see *supra*, rec. 10.

<sup>752</sup>. See *supra*, recs 9, 11 and 15 to 19.

<sup>753</sup>. See *supra*, recs 5(4), 6(4) and 12 to 14.

<sup>754</sup>. See *supra*, recs 2 and 3.

<sup>755</sup>. See *supra*, recs 2 and 3.

<sup>756</sup>. See *supra*, recs 5 and 6.

- (a) national standards for the selection, screening and storage of gametes and embryos;**
- (b) the requirement to submit annual reports to a central registry and the content of the reports;**
- (c) the requirement to freeze donated sperm and use it only after the donor has been properly tested for evidence of the AIDS virus;**
- (d) the duty to justify in writing the number of embryos implanted per treatment cycle;**
- (e) the duty to establish counselling services and the composition and duties of such counselling services;**
- (f) the duty to keep medical records and the content of those records;**
- (g) the duty to establish a system that allows the physician to link donors to recipients while protecting the anonymity of the parties;**
- (h) the duties pertaining to access to identifying and non-identifying information;**
- (i) the restrictions pertaining to the allowable use and time limits on the freezing of gametes and embryos, the frequency of use of gametes from the same donor and the import of gametes and embryos;**
- (j) the prohibitions pertaining to the selection and commercialization of gametes and embryos; and**
- (k) the conditions attached to the donation of gametes and embryos, the notion of control over gametes and embryos, the manner in which the person having such control may express his or her intentions and the terms and conditions governing the exercise of such intentions.**

We must also ensure that private clinics do not circumvent proposed quality-control requirements by, for example, using fresh semen from their own network of donors, since such action could jeopardize the safety of the mother and the unborn child. Accordingly, it is important to restrict the practice of medically assisted procreation to certified clinics and to introduce sanctions for unauthorized operations.<sup>757</sup> In addition, it is important to

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<sup>757</sup> We are including artificial insemination here even though it is less invasive and more private in nature, because uncontrolled use of the technology could be harmful to the child. As stated earlier, it is essential that, for example, donors be carefully selected, that sperm undergo proper screening, and that identifying medical, genetic and social information be kept. Such controls would also ensure compliance with the restrictions on the selection of gametes and embryos: see *supra*, rec. 2. See also appendix A, *infra* at 197-98.

ensure that clinics and banks comply with the various prohibitions, restrictions and duties recommended in response to the various problems associated with the use of medically assisted procreation technologies (regarding, for example, the selection, commercialization and use of gametes and embryos).<sup>758</sup>

## RECOMMENDATION

**21. (2) The application of medically assisted procreation technologies should be restricted to certified clinics, and only certified banks should be permitted to store, preserve and import gametes and embryos.**

### B. The Need for a National Agency

How can all these recommendations be implemented? Whether they relate to principles, the administration of justice or public safety, the nature and purpose of the proposed recommendations are such that they require centralized, uniform control of medically assisted procreation. To such administrative control must be added the establishment of the certification system, regulatory activities, the monitoring of practices<sup>759</sup> and the establishment of a central registry. It is also essential, on the national level, to encourage the necessary research and studies and to undertake long-term studies.

The need for uniformity, whether in terms of social choices or control of practices or medically assisted procreation in general, and the need to avoid interprovincial “procreative tourism,” mean that the federal, provincial and territorial governments must work together to establish national controls.<sup>760</sup>

It is certainly appropriate to co-ordinate and control the use of medically assisted procreation technologies, and it would be easy in a centralized country to create a statutory agency with the necessary powers and duties. In Canada, however, where the jurisdiction needed to exercise such control is shared by the federal government and the provinces, the two levels of government must work with the professionals involved to develop national controls.

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758. Similarly, see appendix A, *infra* at 197-98. This form of control would enhance the controls applied by professional associations that normally protect the public against malpractice or unlawful medical practice and provide ethical benchmarks.

759. This includes monitoring of compliance with regulatory duties, restrictions and prohibitions; see *supra* at 161.

760. Regarding the need for co-operation between the federal and provincial governments, see, *inter alia*, OLRC, *supra*, note 2, recs 9 and 17(2) at 276-77.

Creating a national agency with regulatory powers under both the federal and the provincial governments seems to be the best way of ensuring that our recommendations have the desired effect.<sup>761</sup>

We prefer this approach to the enactment of a general law on medically assisted procreation. Creating a national administrative agency would ensure the flexibility needed in this extremely complex field. Such an agency would provide for systematic intervention and proper control and would make it possible to solve problems that the law is currently unable to solve.

The agency should be a multidisciplinary team of qualified individuals. Its role would be to protect the public; grant certification; regulate certain aspects of the activities of banks and clinics and medically assisted procreation in general (certification criteria, terms and conditions of consent to donation and storage, and so on); ensure compliance with the various duties, standards, restrictions and prohibitions; establish a central registry; identify real problems on the basis of national data; analyse the various success rates and compile statistics; ensure long-term control through studies on the technical, medical and psychological aspects of medically assisted procreation; prevent exploitation and commercialization in the area of medically assisted procreation; promote any research and studies deemed necessary (research to determine the maximum freezing time for gametes and embryos, or aimed at reducing the number of multiple pregnancies or developing technologies that follow the natural cycle of ovulation, and so on); and advising the various governments on these matters. To fulfil this role, the agency would have to be empowered to inspect certified banks and clinics and, in cases of non-compliance with the applicable standards, duties, restrictions or prohibitions, amend, revoke or suspend their certification.

## RECOMMENDATION

**22. (1) The federal, provincial and territorial governments, in conjunction with the professionals involved, should explore the possibility of establishing a national regulatory agency in the area of medically assisted procreation.**

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761. The Warnock Report (*supra*, note 421, para. 13.3 at 79) recommended establishment of the Statutory Licensing Authority, a regulatory agency independent of the government. Among other things, the Authority would control and regulate infertility services, gamete and embryo storage, research, licences and a central registry. The Interim Licensing Authority has assumed these duties pending the adoption of a statute establishing the Statutory Licensing Authority. In November 1990, the Human Fertilisation and Embryology Authority was created under the *Human Fertilisation and Embryology Act 1990*, *supra*, note 421, s. 5. This agency should be fully operational in the summer of 1991 and should replace the Interim Licensing authority; see appendix A, *infra* at 199.

**(2) The powers and duties of the national agency should be as follows:**

**(a) to grant certification;**

**(b) to set out in regulations the various standards, duties, restrictions and prohibitions referred to in recommendation 21(1) and to ensure compliance with those regulations;**

**(c) to establish a central registry;**

**(d) to identify problems on the basis of national data;**

**(e) to analyse the various success rates and compile statistics;**

**(f) to ensure long-term control through studies on the technical, medical and psychological aspects of medically assisted procreation;**

**(g) to prevent exploitation and commercialization in the area of medically assisted procreation;**

**(h) to promote any research and studies deemed necessary;**

**(i) to advise the various governments on these matters; and**

**(j) to inspect certified banks and clinics and, if need be, to amend, revoke or suspend their certification.**

**(3) The federal government should take the initiative of organizing meetings to discuss the establishment of such an agency.**

## Summary of Recommendations

**1. Legislation governing access to medically assisted procreation technologies should respect the right to equality. Access should be limited only in terms of the cost and scarcity of resources. Where limitation is necessary, selection should not be based on unlawful grounds for discrimination within the meaning of federal and provincial legislation (family status, marital status, sexual orientation, and so on).**

**2. To eliminate the possibility of eugenic practices, the selection of gametes and embryos with specific qualities should be prohibited, except where the objective is to prevent the transmission of serious genetic diseases.**

**3. (1) All commercialization of the donation of gametes and embryos should be prohibited. Only reimbursement of reasonable expenses incurred by donors should be permitted.**

**(2) Gamete and embryo banks should not be permitted to operate on a profit basis. However, banks should be allowed to be reimbursed for reasonable costs related to their operations.**

**4. Surrogacy contracts must remain absolutely null and void. Further, acting as a paid intermediary in such an agreement should be a criminal offence.**

**5. (1) Before conceiving embryos for future personal use, the person or persons with control should be required to make a written statement of intentions as to the fate of the embryos in such circumstances as the death of a person with control, abandonment of the parental project, expiry of the time limit on freezing, or a divorce or other dispute between the persons with control. A person with control should be able to change, in writing, his or her stated intentions regarding the fate of the embryos as long as the embryos have not been used for their intended purpose; in cases where control over the embryos is shared by two people, both must agree to any changes.**

**(2) Control over embryos conceived using gametes from a couple should be exercised jointly by the partners. Control over embryos conceived using gametes from only one of the partners and a donor should vest in the partner genetically linked to the embryos. Control over embryos conceived with donated gametes should vest in the bank or clinic that has the embryos in its possession.**

(3) The possible uses of embryos should be limited to implantation, experimentation and destruction; however, implantation should be prohibited beyond the time limit on freezing.

(4) The person with control over an embryo who decides to donate the embryo should be required, before the donation is made, to make a written statement expressing his or her consent to the donation, and stating the conditions attached to the donation respecting the utilization of the embryo. That person should also be able to change those conditions or withdraw consent by making a written statement to that effect at any time before the donated embryo is used; in cases where control over the embryo is shared by two partners, both must agree to any change.

6. (1) Control over gametes should vest in the producer.

(2) A person depositing his or her gametes for future personal use should be required, before the deposit, to make a written statement expressing his or her intentions as to the fate of the gametes in such circumstances as the death of the person with control, abandonment of the parental project or expiry of the time limit on freezing. The depositor should be able to change, in writing, his or her stated intentions regarding the fate of the gametes before any embryos are created or the gametes are used for their intended purpose.

(3) A person who donates his or her gametes should be required, before the donation is made, to make a written statement expressing his or her consent to the donation and stating the conditions attached to his or her donation respecting the use of the gametes. The donor should be able to change these conditions or withdraw his or her consent by making a written statement to that effect at any time before embryos are created or the donated gametes are used.

(4) Possible uses of gametes should be limited to fertilization, experimentation and destruction; fertilization should be prohibited beyond the time limit on freezing.

7. (1) Provincial parentage laws should reflect the intentions of couples who use medically assisted procreation; accordingly, actions to disavow paternity by a father who gave his consent or to challenge paternity by a third party on the grounds that a donation from a third person was used should not be allowed.

(2) It should not be possible to establish a bond of parentage between a donor and the child.

(3) Legislation that still makes a distinction between legitimate and illegitimate children should recognize children born as a result of medically assisted procreation as having the status of legitimate children.



**8. Provincial succession laws should be harmonized to establish that children born as a result of the post-mortem use of gametes or embryos may not inherit unless there is a specific reference to that effect in the will of the deceased producer.**

**9. Clinics offering medically assisted procreation services should be required to submit written annual reports to a central registry; the minimum content of the reports should be set and the data should be presented in a prescribed form.**

**10. Uniform and mandatory standards for the selection, screening and storage of gametes and embryos, and the selection and screening of donors, should be developed at the national level.**

**11. Donated sperm should be frozen and should not be used for fertilization until the donor has been properly tested for evidence of the AIDS virus.**

**12. (1) Embryos should not be frozen for more than five years. Further, the federal government should encourage research on the effects of cryopreservation in order to reassess this five-year limit.**

**(2) Gametes should not be frozen for more than ten years. Further, the federal government should encourage research on the effects of cryopreservation in order to reassess this ten-year limit.**

**13. A limit should be placed on the number of times gametes from the same donor may be used. Further, the studies needed to set an appropriate limit should be encouraged.**

**14. The import of gametes and embryos should be restricted to certified banks. Imported gametes and embryos should have to meet Canadian standards.**

**15. Every effort should be made to reduce the risk of multiple pregnancy and to promote the development of technologies that follow the normal cycle of ovulation. Accordingly, the federal government should encourage studies and research aimed at reducing the multiple-pregnancy rate and developing technologies that follow the normal cycle of ovulation. Further, clinics should be required to document and justify the number of embryos implanted in each treatment cycle.**

**16. Every clinic offering medically assisted procreation services should be required to provide to persons using medically assisted procreation, either before, during or after the application of a technology, counselling services whereby these persons could obtain from experts (psychologists, physicians and so on) the assistance and information they might need concerning the specific problems involved in medically assisted procreation.**

17. (1) Clinics should be required to keep records (on the donor, the mother and the child) that allow physicians to link the donor to the recipient while protecting the anonymity of the parties.

(2) Only the information needed to attain the following objectives should be collected: to permit access to medical and genetic information that may be needed to obtain optimum medical care; to meet the psychological needs of the child; to ensure proper clinical reports; and to permit studies on the long-term effects of the various technologies used in medically assisted procreation.

(3) Clinics should be responsible for protecting the confidentiality of the information they hold.

18. The legal parents or the child should be able to request disclosure of non-identifying information, in particular social information (such as ethnic origin, profession, education, religious affiliation and interests of the donor). However, identifying information should be disclosed only with the donor's consent.

19. It should be possible to reveal to the prosecuting authorities the identity of any donor who fails to provide information or who provides false information for the purpose of a criminal prosecution related to such false disclosure or failure to disclose.

20. Studies should be undertaken to determine and measure the long-term effects of medically assisted procreation technologies on the resulting children.

21. (1) A system of certification for clinics and banks should be established in order to regulate the following issues:

- (a) national standards for the selection, screening and storage of gametes and embryos;
- (b) the requirement to submit annual reports to a central registry and the content of the reports;
- (c) the requirement to freeze donated sperm and use it only after the donor has been properly tested for evidence of the AIDS virus;
- (d) the duty to justify in writing the number of embryos implanted per treatment cycle;
- (e) the duty to establish counselling services and the composition and duties of such counselling services;
- (f) the duty to keep medical records and the content of those records;
- (g) the duty to establish a system that allows the physician to link donors to recipients while protecting the anonymity of the parties;

- (h) the duties pertaining to access to identifying and non-identifying information;**
- (i) the restrictions pertaining to the allowable use and time limits on the freezing of gametes and embryos, the frequency of use of gametes from the same donor and the import of gametes and embryos;**
- (j) the prohibitions pertaining to the selection and commercialization of gametes and embryos; and**
- (k) the conditions attached to the donation of gametes and embryos, the notion of control over gametes and embryos, the manner in which the person having such control may express his or her intentions and the terms and conditions governing the exercise of such intentions.**

**(2) The application of medically assisted procreation technologies should be restricted to certified clinics, and only certified banks should be permitted to store, preserve and import gametes and embryos.**

**22. (1) The federal, provincial and territorial governments, in conjunction with the professionals involved, should explore the possibility of establishing a national regulatory agency in the area of medically assisted procreation.**

**(2) The powers and duties of the national agency should be as follows:**

- (a) to grant certification;**
- (b) to set out in regulations the various standards, duties, restrictions and prohibitions referred to in recommendation 21(1) and to ensure compliance with those regulations;**
- (c) to establish a central registry;**
- (d) to identify problems on the basis of national data;**
- (e) to analyse the various success rates and compile statistics;**
- (f) to ensure long-term control through studies on the technical, medical and psychological aspects of medically assisted procreation;**
- (g) to prevent exploitation and commercialization in the area of medically assisted procreation;**
- (h) to promote any research and studies deemed necessary;**
- (i) to advise the various governments on these matters; and**
- (j) to inspect certified banks and clinics and, if need be, to amend, revoke or suspend their certification.**

**(3) The federal government should take the initiative of organizing meetings to discuss the establishment of such an agency.**

## APPENDIX A

### Comparative Study of Foreign and Canadian Texts Dealing with Medically Assisted Procreation

#### Introduction<sup>1</sup>

Medically assisted procreation has been the focus of numerous studies and reports in recent years. These studies and reports have led some countries to adopt new legislation. Before analysing the measures that have been recommended or adopted, we should briefly explain the initiatives taken in this area in countries other than Canada, as well as in Canada and in Quebec.<sup>2</sup>

In Australia, the state of Victoria was the first to pass general legislation regulating medically assisted procreation and surrogate motherhood.<sup>3</sup> The Commonwealth of Australia and other states have also enacted legislation,<sup>4</sup> and all Australian states have produced reports on medically assisted procreation.<sup>5</sup> Finally, the Family Law Council has issued recommendations on surrogacy contracts,<sup>6</sup> and the National Bioethics Consultative Committee has investigated the problems associated with access to information and with surrogacy.<sup>7</sup>

In Denmark, the Danish Council of Ethics broached the issue of medically assisted procreation in 1990.<sup>8</sup> In 1988, Spain passed a law on all medically assisted procreation

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1. The reader will find at the end of this appendix a list of the texts referred to, listed and numbered according to country, *infra* at 214-20.
  2. For an overview of the state of the law around the world, see Jan Stepan, ed., *International Survey of Laws on Assisted Procreation* (Zurich: Schulthess Polygraphischer, 1990). See also EASTERN EUROPE 1.
  3. VICTORIA 1. See also VICTORIA 2.
  4. COMMONWEALTH OF AUSTRALIA 1; SOUTH AUSTRALIA 1 and SOUTH AUSTRALIA 2; WESTERN AUSTRALIA 1; NEW SOUTH WALES 1 and NEW SOUTH WALES 2; QUEENSLAND 1 and QUEENSLAND 2; TASMANIA 1; NORTHERN TERRITORY 1.
  5. SOUTH AUSTRALIA 3; WESTERN AUSTRALIA 2; NEW SOUTH WALES 3, NEW SOUTH WALES 4 and NEW SOUTH WALES 5; QUEENSLAND 3; VICTORIA 3 and VICTORIA 4.
  6. AUSTRALIA 1.
  7. COMMONWEALTH OF AUSTRALIA 2 and COMMONWEALTH OF AUSTRALIA 3. In October 1990, the National Bioethics Consultative Committee released two discussion papers; see COMMONWEALTH OF AUSTRALIA 4 and COMMONWEALTH OF AUSTRALIA 5.
  8. DENMARK 1; the report includes recommendations aimed at protecting human substances, and draft regulations on artificial insemination.

technologies, based on the work of the Council of Europe.<sup>9</sup> In 1989, the Council of Europe authorized the release of the report of its ad hoc Committee of Experts on Progress of Biomedical Sciences (CAHBI) in the hope that it would help harmonize the regulation of medically assisted procreation by member states.<sup>10</sup>

In the United States, some 30 states have passed legislation on the parentage of children born as a result of artificial insemination by donor (AID).<sup>11</sup> Louisiana and Pennsylvania have passed laws to regulate the clinical use of in vitro fertilization (IVF), and Ohio has done likewise for AID.<sup>12</sup> The increasingly frequent use of surrogacy has led to a number of statutes being passed<sup>13</sup> and to a large number of bills being introduced.<sup>14</sup> The New York Task Force on Life and the Law published recommendations and draft legislation on surrogacy in 1988,<sup>15</sup> and the American Fertility Society and its ethics committee have issued recommendations and guidelines on medically assisted procreation technologies.<sup>16</sup>

France has not passed any legislation on these matters, with the exception of *Décret n° 88-327*, which approaches medically assisted procreation from the perspective of professional control and hospital organization.<sup>17</sup> However, France's Conseil d'État released a report in 1988 dealing specifically with medically assisted procreation,<sup>18</sup> and a draft bill giving effect to the recommendations in the report has since been tabled in the French National Assembly.<sup>19</sup>

In 1987, the Norwegian parliament passed a law regulating artificial insemination and in vitro fertilization<sup>20</sup> on the basis of recommendations made in a legislative proposal.<sup>21</sup>

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9. See SPAIN 1. See also SPAIN 2 and SPAIN 3 at 241.

10. COUNCIL OF EUROPE 1. However, the committee did not give the report official recommendation status.

11. See, e.g., LOUISIANA 1; MISSOURI 1, s. 210.824; NEW YORK 1, s. 1. See also UNITED STATES 5.

12. LOUISIANA 2, ss 121 to 133; PENNSYLVANIA 1, s. 3213; OHIO 1, ss 3111.30 to 3111.38. See also UNITED STATES 4 at 249; LOUISIANA 4, s. 1062.1, and DELAWARE 1, s. 2801, regarding tests to screen gamete donations; ILLINOIS 1, para. 6(7), regarding the sale of and experimentation on fetuses; TEXAS 1, s. 3A, regarding insurance coverage of services.

13. See, e.g., ARKANSAS 1, s. 9-10-201; INDIANA 1, ss 31.8.1.2 to 31.8.2.1; KENTUCKY 1; LOUISIANA 3; MICHIGAN 1, ss 722.853 to 722.861; NEBRASKA 1; NEVADA 1, ss 127.287 and 127.288. See also UNITED STATES 3.

14. See NEW YORK 2 at 99 n. 13. See also draft legislation in the following states: Alabama, Arizona, Connecticut, Delaware, Florida, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Wisconsin.

15. See the *Proposed Surrogate Parenting Act*, NEW YORK 2 at A-1.

16. Only the most recent recommendations are cited; see UNITED STATES 1 and UNITED STATES 2.

17. FRANCE 1.

18. FRANCE 6.

19. See FRANCE 5. The proposed legislation amends the *Code de la santé publique* (FRANCE 2), the *Code civil* (FRANCE 3) and the *Code pénal* (FRANCE 4). The affected provisions are cited following each section of the preliminary draft legislation.

20. NORWAY 1.

21. NORWAY 2.

In the United Kingdom, the *Surrogacy Arrangements Act 1985*<sup>22</sup> deals with surrogate motherhood, while the *Human Fertilisation and Embryology Act 1990*<sup>23</sup> covers all the technologies used in medically assisted procreation. The latter statute followed the recommendations of the first significant study in this area, carried out under the direction of Dame Mary Warnock,<sup>24</sup> which produced a legislative proposal, the White Paper.<sup>25</sup> Further, annual reports are prepared by the Interim Licensing Authority,<sup>26</sup> an agency established as a result of the Warnock report that operates without enforcing authority.

The Riksdag in Sweden passed legislation on artificial insemination in 1984<sup>27</sup> and IVF in 1988.<sup>28</sup> In December 1990 the parliament of the former Federal Republic of Germany passed a law aimed primarily at protecting embryos and preventing "misuse" of medically assisted procreation.<sup>29</sup>

In Canada, the first published studies dealt only with artificial insemination. The report of British Columbia's Royal Commission on Family and Children's Law was released in 1975,<sup>30</sup> while the report of the Advisory Committee on the Storage and Utilization of Human Sperm was submitted to the Minister of National Health and Welfare in 1981.<sup>31</sup>

The issue of medically assisted procreation was first addressed as a whole in a 1985 report by the Ontario Law Reform Commission. The underlying principle was that the state should not intervene in matters of procreation, but the report concluded that legislative intervention was needed because of the implications of medically assisted procreation for people other than the prospective parents.<sup>32</sup>

In March 1987, the Law Reform Commission of Saskatchewan released a short report and a proposal for legislation on artificial insemination that focused primarily on the legal status of the child and the donor.<sup>33</sup>

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22. UNITED KINGDOM 1.

23. UNITED KINGDOM 2.

24. UNITED KINGDOM 5.

25. UNITED KINGDOM 6.

26. UNITED KINGDOM 4. See also UNITED KINGDOM 3.

27. SWEDEN 1. Regulations have also been adopted, see SWEDEN 3.

28. SWEDEN 2. See also SWEDEN 4 and SWEDEN 5 at 387.

29. See GERMANY 1.

30. BRITISH COLUMBIA 1.

31. CANADA 3.

32. ONTARIO 1 at 119-20.

33. SASKATCHEWAN 1.

In June 1989, the British Columbia Branch of the Canadian Bar Association released a report on medically assisted procreation; the main elements of the report were adopted as basic CBA policy in March 1990.<sup>34</sup>

In its February 1990 report, the Canadian Advisory Council on the Status of Women took a different approach to medically assisted procreation, giving primary consideration to the prevention of infertility.<sup>35</sup>

Finally, the Canadian Fertility and Andrology Society issued guidelines on artificial insemination by donor in 1988<sup>36</sup> and recently co-published with the Society of Obstetricians and Gynaecologists of Canada an analysis of all medically assisted procreation technologies.<sup>37</sup>

In Quebec, the ad hoc committee of the Barreau du Québec issued its recommendations on medically assisted procreation in April 1988.<sup>38</sup> In 1988<sup>39</sup> and April 1989,<sup>40</sup> the Department of Health and Social Services released reports dealing respectively with the incorporation of the technologies in the Quebec health-care system and the approach to be taken in this area. And finally, the Conseil du statut de la femme has since 1985 been focusing special attention on medically assisted procreation. Seven reports and various communiqués collected during an international forum organized by the Council were used to prepare an overview of the issues<sup>41</sup> that was submitted to the Quebec government in May 1989. In December 1990, the Minister of Justice of Quebec tabled Bill 125, *Civil Code of Québec*, five articles of which deal specifically with medically assisted procreation.<sup>42</sup>

Many important initiatives have been taken in an effort to understand the implications of medically assisted procreation. The substance of the measures that have been taken or recommended is analysed in three main sections: general principles; safety of medically assisted procreation technologies; and medical control and regulation.

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34. CANADA 2.

35. CANADA 1. The report treats medically assisted procreation as experimentation.

36. CANADA 4.

37. CANADA 5.

38. QUEBEC 1.

39. QUEBEC 5. In a dissenting opinion in the 1988 report, Francine McKenzie criticized the liberalism that characterizes the determination of infertility (one year of sexual intercourse without contraception) and the selection of candidates (candidates may already have had children or been voluntarily sterilized). She condemned the relentless procreative activity to which women may fall victim, the trivialization of the serious social risks inherent in assisted reproduction technologies, and the triumph of technology over human concerns, and expressed her opposition to the expansion of and additional funding for fertility clinics in Quebec. See *Opinion synthèse de Madame McKenzie*, issued in a press release from the Conseil du statut de la femme, 18 April 1988.

40. QUEBEC 6.

41. QUEBEC 4; see also QUEBEC 3.

42. QUEBEC 7, arts 579 to 583.

## I. General Principles

Some aspects of medically assisted procreation involve choices with respect to principles and values. These aspects include access, commercialization, surrogacy, control over gametes and embryos, and parentage.

### A. Access

Access to medically assisted procreation is a major issue addressed in most of the legislation and reports that deal with the matter. Restrictions are common, and France's Conseil d'État goes so far as to recommend criminal sanctions against physicians who violate them.<sup>43</sup> However, some countries suggest that no criteria be imposed and that the decision on access be left to the physician.<sup>44</sup> Where criteria are used, there are two types: personal and medical.

#### 1. Personal Criteria

The personal criteria most often considered in determining access include marital status, sexual orientation, stability and spousal consent.

The marital status of those who wish to use the technologies is not a restrictive criterion. Except in Norway,<sup>45</sup> the laws and reports do not require that couples be actually married.

The sexual orientation of the couple and whether or not the prospective parents are a couple are criteria that severely restrict access. A number of countries recommend that only heterosexual couples be accepted.<sup>46</sup> However, the Ontario Law Reform Commission report allows single women access,<sup>47</sup> and the reports of the Quebec Department of Health and Social Services<sup>48</sup> and the American Fertility Society<sup>49</sup> would give women access to artificial insemination regardless of their status. Spanish statutes,<sup>50</sup> the Canadian

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43. FRANCE 5, s. 10 — FRANCE 2, L. 675. See also NEW SOUTH WALES 1, s. 9, NEW SOUTH WALES 3, para. 6.14, rec. 8, and NEW SOUTH WALES 4, rec. 9 at 66-67, which provide that physicians who fail to consider certain factors in their choice of treatment are deemed to have engaged in "professional misconduct."

44. UNITED KINGDOM 5, rec. 24 at 82, and UNITED KINGDOM 6, para. 78; CANADA 1 at 26-27, and CANADA 2 at 22.

45. NORWAY 1, s. 4. It should be noted that the draft legislation gave access to unmarried couples.

46. See, e.g., SOUTH AUSTRALIA 2, ss 13(3), 13(4) and 13(7); VICTORIA 1, ss 10 to 13A; this policy would not apply to AI. COUNCIL OF EUROPE 1, guideline 1; FRANCE 5, s. 10 and pp. 27-28 — FRANCE 2, L. 668-10 and L. 675; NORWAY 1, s. 4; SWEDEN 1, s. 2, SWEDEN 2, s. 2, and SWEDEN 5 at 388; QUEBEC 1 at 36-37, rec. 3, QUEBEC 4 at 13, recs 2.1 and 3.1, and QUEBEC 5, rec. 38 (for IVF). See also, table 1, *infra* at 201-202.

47. ONTARIO 1, rec. 5.

48. QUEBEC 5, rec. 11, allowing [TRANSLATION] "single women, whatever their status."

49. UNITED STATES 1, guideline IV.

50. SPAIN 1, s. 6, SPAIN 2 at 237, and SPAIN 3 at 242.



Fertility and Andrology Society<sup>51</sup> and the Danish Council of Ethics<sup>52</sup> all accept single women or women who are part of a homosexual couple. Finally, some countries do not exclude single women.<sup>53</sup>

The stability of the couple<sup>54</sup> and the spouse's consent to the procedure<sup>55</sup> are sometimes required.

## 2. Medical Criteria

The medical criteria most commonly used in determining access include medical and social assessment, infertility and the transmission of genetic disorders.

A medical assessment, possibly including psychological and social evaluation, is sometimes mandatory,<sup>56</sup> and evaluation of the welfare of the unborn child is recommended in some instances.<sup>57</sup>

It is often stated that those who wish to obtain access to artificial procreation technologies must be infertile, sterile or likely to transmit a genetic disease.<sup>58</sup> For

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51. CANADA 4 at 10; CANADA 5 at 28, rec. 11: "[D]ecision to restrict access to treatment should not be based on discriminating or stereotypical judgments."

52. DENMARK 1 at 95, rec. 5.1 at 124 and reg. 2.1 at 131.

53. UNITED STATES 2 at 24S; UNITED KINGDOM 2, ss 13(6); BRITISH COLUMBIA 1, recs 3, 4, 5 and 14 : favours adoption access criteria. NEW SOUTH WALES 1, ss 3(1), 7(2)d and 9. NEW SOUTH WALES 3 at 43-44, para. 6.14 and rec. 7, and NEW SOUTH WALES 4, rec. 7 at 65 (however, the following factors must be considered: whether the woman is part of a couple; the infertility of the couple or the risk of transmission of a genetic disorder; the welfare and interest of the child; the stability of the family; the need for counselling; age and physical and mental health of the prospective parent(s)).

54. See, e.g., NEW SOUTH WALES 1, s. 9. NEW SOUTH WALES 3, para. 6.14, rec. 7, and NEW SOUTH WALES 4, rec. 7 (stability considered but not necessarily conclusive); ONTARIO 1, rec. 5, and CANADA 4 at 10; QUEBEC 1 at 36. See also, table 2, *infra* at 203-205. *Contra*: CANADA 1 at 26-27.

55. VICTORIA 1, ss 10 to 13A (this requirement does not apply in the case of AI) and QUEENSLAND 3, rec. B(2) (vii); DENMARK 1, reg. 1.1 at 131; SPAIN 1, s. 6, SPAIN 2 at 237, and SPAIN 3 at 242; OHIO 1, ss 3111.34 and 3111.35, and UNITED STATES 1, guideline IV; FRANCE 5, s. 10 and p. 28; FRANCE 2, L. 668-11 and L. 675; NORWAY 1, s. 4; UNITED KINGDOM 5, recs 21, 22 and 27 at 82-83; SWEDEN 1, s. 2, SWEDEN 2, s. 2, SWEDEN 3 and SWEDEN 5 at 388-89; BRITISH COLUMBIA 1, rec. 1, and CANADA 3 at 27 and rec. 3.4. *Contra*: NEW SOUTH WALES 3, rec. 10, and NEW SOUTH WALES 4, rec. 8 at 65-66; CANADA 2 at 15.

56. VICTORIA 1, s. 18; NEW SOUTH WALES 1, s. 9, NEW SOUTH WALES 3, para. 6.14, rec. 7, and NEW SOUTH WALES 4, rec. 7 at 65 (the medical assessment is considered but not mandatory); SPAIN 1, ss 2 and 6; NORWAY 1, s. 5; SWEDEN 1, s. 3; BRITISH COLUMBIA 1, recs 3, 4, 5 and 14. *Contra*: QUEBEC 5, rec. 39 (the requirements cannot be stricter than for natural procreation).

57. NEW SOUTH WALES 1, s. 9, NEW SOUTH WALES 3, para. 6.14, rec. 7, and NEW SOUTH WALES 4, rec. 7 at 65; VICTORIA 1 (see s. 1(9), schedule 3, of the *Infertility (Medical Procedures) Regulations 1988*); COUNCIL OF EUROPE 1, guideline 1; UNITED KINGDOM 2, para. 13(5); SWEDEN 1, s. 3.

58. SOUTH AUSTRALIA 2, paras 13(3) and 13(7); NEW SOUTH WALES 1, s. 9, NEW SOUTH WALES 3, para. 6.14, rec. 7, and NEW SOUTH WALES 4, rec. 7 at 65 (couples only, must be considered but is not mandatory); QUEENSLAND 3, recs B(2) (i) and B(2) (ii); VICTORIA 1, ss 10 to 13A (except for AI); COUNCIL OF EUROPE 1,

example, several states in Australia require one to two years of alternative treatment.<sup>59</sup> and the report by the Quebec Conseil du statut de la femme recommends increasing from one year to two years the period of unprotected intercourse without conception needed to prove infertility.<sup>60</sup> With respect to the transmission of genetic disorders, France's Conseil d'État requires a high probability of transmitting an incurable disorder,<sup>61</sup> the Council of Europe a serious genetic disorder or disease which, in the opinion of the attending physician, would result in early death or severe disability.<sup>62</sup>

Finally, choosing the sex of the child is not normally permitted unless there is a risk of transmitting a serious sex-linked hereditary disease,<sup>63</sup> and "minimal" matching of the donor's features with those of the spouse of the inseminated woman is generally advised.<sup>64</sup>

## B. Commercialization

The laws and recommendations of many countries prohibit the commercialization of medically assisted procreation. The prohibition may be stated in general terms, or specific reference may be made to the gratuity of donations or to prohibition of the sale of gametes and embryos.<sup>65</sup> Compensation is therefore limited to reimbursement of the reasonable expenses incurred by donors (traveling expenses, medical expenses, lost income).<sup>66</sup>

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guideline 1; FRANCE 5, s. 10 and pp. 26-27; FRANCE 2, L. 668-10 and L. 675-1; NORWAY 1, ss 8 to 12; ONTARIO 1, rec. 1 (except for single women); QUEBEC 1 at 36 and rec. 3, QUEBEC 4 at 13 and rec. 2.1, and QUEBEC 5, recs 11 and 38 (for AID). It should be noted that some jurisdictions accept the techniques as treatments for infertility but in their recommendations on access do not require infertility. See, e.g., UNITED KINGDOM 5, recs 4 to 7 and 28 at 80 and 83.

59. VICTORIA 1, ss 10 to 13A, VICTORIA 4, para. 3.6 and QUEENSLAND 3, rec. B(2) (ii).

60. QUEBEC 4 at 10 and recs 1.5, 2.1 and 3.1. See also QUEBEC 5, rec. 2, which suggests reviewing the one-year period.

61. FRANCE 5, s. 10 — FRANCE 2, L. 668-10.

62. COUNCIL OF EUROPE 1, guideline 1.

63. UNITED STATES 2 at 20S; UNITED KINGDOM 5, paras 9.11, 9.12 and rec. 29 at 83; COUNCIL OF EUROPE 1, guideline 1; GERMANY 1, s. 3; CANADA 5 at 46-47, rec. 28. QUEBEC 4 at 13 and rec. 2.6, QUEBEC 5, rec. 12. *Contra*: ONTARIO 1, rec. 28.

64. UNITED KINGDOM 5, para. 4.21; COUNCIL OF EUROPE 1 at 19-20; UNITED STATES 1, guideline VIII and OHIO 1, s. 3111.35; CANADA 4 at 6-7; CANADA 5 at 30, rec. 13; QUEBEC 5, rec. 16.

65. NEW SOUTH WALES 1, s. 12; VICTORIA 1, ss 11 to 13A; DENMARK 1, rec. 11.1 at 127; SPAIN 1, ss 5 and 20; COUNCIL OF EUROPE 1 at 25 and guidelines 9(1) and 9(2); ILLINOIS 1, para. 6(7); LOUISIANA 2, s. 122; FRANCE 5, s. 10 — FRANCE 2, L. 668-6 and L. 668-13; UNITED KINGDOM 2, s. 12 and para. 41(8), and UNITED KINGDOM 4, guideline 15d); SWEDEN 1, s. 7, and SWEDEN 2, s. 4; CANADA 1 at 28; QUEBEC 1 at 23, and recs 3 and 7, QUEBEC 4 at 13, rec. 2.4, QUEBEC 5, recs 20, 51 and 53, QUEBEC 6 at 61, and QUEBEC 7, art. 25.

66. NEW SOUTH WALES 1, s. 12, and NEW SOUTH WALES 3, para. 10.9, rec. 24; QUEENSLAND 3, rec. C(5)(vi); VICTORIA 1, ss 11 to 13A, and appendix 4, s. 3; COUNCIL OF EUROPE 1, guideline 9(1); UNITED STATES 1, guideline VII(C), and UNITED STATES 2 at 45S, 49S and 52S; FRANCE 5, s. 10 FRANCE 2, L. 668-6 (lost income is not covered); UNITED KINGDOM 5, para. 4.27, rec. 26 at 82, and UNITED KINGDOM 6, para. 63; BRITISH COLUMBIA 1 at 23; ONTARIO 1, rec. 15; CANADA 3 at 27, CANADA 4 at 9, and CANADA 5 at 41, rec. 25; QUEBEC 1 at 23, and QUEBEC 5, rec. 21.

Where they are mentioned, gamete and embryo banks that operate for profit are generally prohibited.<sup>67</sup> However, the Ontario report would allow duly licensed and regulated gamete banks to operate on a commercial basis, subject to government control. A fee comprising expenses and perhaps a reasonable profit would be established, but sales would be restricted to physicians, hospitals and other licensed banks.<sup>68</sup>

### C. Surrogacy

The countries that have taken a position on surrogacy have chosen to ban, discourage or, in very rare cases, regulate the practice.

A complete prohibition of all forms of surrogacy is relatively rare.<sup>69</sup> Instead, countries try to discourage surrogate motherhood and to tackle the commercial aspect of the practice. Thus, they prohibit even non-commercial activity by agencies or other intermediaries;<sup>70</sup> the use of any advertising related to surrogate motherhood;<sup>71</sup> and paying or accepting any financial or other compensation in connection with a surrogacy contract.<sup>72</sup>

Other countries do not prohibit surrogacy, permit gratuitous contracts, or have refrained from passing legislation to counter private agreements. Accordingly, intermediaries working

67. See, e.g., COUNCIL OF EUROPE 1 at 25 and guideline 9(2) (costs of collection, retrieval, storage, implantation and medical services may be reimbursed); FRANCE 5, s. 10 — FRANCE 2, L. 668-13; QUEBEC 5, rec. 53, and QUEBEC 6 at 61. See also the general prohibitions in the preceding notes.

68. ONTARIO 1, recs 17 and 18: the suggested approach is similar to that used by the Canadian Red Cross Society. See also CANADA 5 at 39, rec. 23, which recommends that, in the absence of adequate public funding, commercial banks be established.

69. GERMANY 1, s. 1(1)7; FRANCE 5, s. 16 — FRANCE 4, s. 353.1; QUEENSLAND 2, ss 2 and 3; QUEBEC 1 at 27-30 and rec. 17. See also DENMARK 1 at 100, which opposes surrogate motherhood but does not propose changes to criminal legislation on the matter. With respect to U.S. law, see UNITED STATES 3.

70. SOUTH AUSTRALIA 1, s. 10h; NEW SOUTH WALES 5, recs 5 and 6 at 44-53; VICTORIA 1, s. 30; AUSTRALIA 1, rec. 17 and para. 6.6.16; COUNCIL OF EUROPE 1, guidelines 15(1), 15(3) and 15(4); MICHIGAN 1, s. 722.859, section 9; NEW YORK 2 at 126, s. 3 of the *Proposed Surrogate Parenting Act*; FRANCE 5, s. 16 and pp. 31-32 — FRANCE 4, s. 353.1; UNITED KINGDOM 1, s. 2, UNITED KINGDOM 5, para. 8.18 and rec. 58 at 86, and UNITED KINGDOM 6, para. 73; QUEBEC 1, recs 18 and 20, QUEBEC 4 at 21 and rec. 4.1, QUEBEC 5, recs 56 and 57, and QUEBEC 6 at 60.

71. See, e.g., SOUTH AUSTRALIA 1, s. 10h; NEW SOUTH WALES 5, rec. 4 at 43-44; QUEENSLAND 2, s. 3; VICTORIA 1, s. 30; AUSTRALIA 1, para. 6.6.16; COUNCIL OF EUROPE 1, guideline 15(3); UNITED KINGDOM 1, para. 3(1); QUEBEC 4 at 21 and rec. 4.2, QUEBEC 5, rec. 56, and QUEBEC 6 at 60.

72. SOUTH AUSTRALIA 1, ss 10g and 10h (for intermediaries); NEW SOUTH WALES 5, rec. 3 and pp. 40-43; QUEENSLAND 2, s. 3; VICTORIA 1, s. 30; AUSTRALIA 1, rec. 17 and para. 6.6.15; COUNCIL OF EUROPE 1, guideline 15(4); MICHIGAN 1, s. 722.859, section 9, and NEW YORK 2 at 126, s. 3 of the *Proposed Surrogate Parenting Act* (except costs permitted in adoption, medical and legal costs, excludes lost wages); UNITED KINGDOM 1, s. 2(3) (except payment to the surrogate mother); CANADA 1 at 28, and CANADA 2, pp. 26-33, and rec. 9(d). *Contra*: NEVADA 1, s. 127.287. See also UNITED STATES 3.

free of charge or on a not-for-profit basis are not prohibited.<sup>73</sup> Reimbursement limited to expenses is possible.<sup>74</sup> In certain cases the parties themselves cannot be prosecuted.<sup>75</sup> Finally, the most frequently recommended measure is to make surrogacy contracts unenforceable in a court of law or declare them null and void.<sup>76</sup>

The American Fertility Society allows surrogate motherhood for strictly medical reasons and views it as a clinical experiment that has to be studied in detail. The parties would be informed of the psychological risks surrogacy may entail.<sup>77</sup>

The report of the Ontario Law Reform Commission recommends the legalization of regulated agreements. A major role is assigned to the courts, which would have to approve agreements before conception but after evaluating the parenting abilities of the future parents, their stability as individuals and as a couple, and the medical reasons for using the procedure. The judge would also have to consider the prospective surrogate: physical and mental health, marital situation and partner's opinion, and the impact on any other children. He or she would have to ensure that blood tests are performed in order to prevent

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73. SOUTH AUSTRALIA 1, s. 10h; VICTORIA 1, s. 30; MICHIGAN 1, s. 722.859; NEW YORK 2 at 126, s. 3 of the *Proposed Surrogate Parenting Act* (the physician may be paid for his or her services); UNITED STATES 2 at 67S; UNITED KINGDOM 1, s. 2.

74. MICHIGAN 1, s. 722.853, section 3a; NEW YORK 2 at 126, s. 3 of the *Proposed Surrogate Parenting Act* (excludes lost wages); UNITED STATES 2 at 67S (accepts the possibility of higher payment); UNITED KINGDOM 1, para. 2(3) (excludes payment received by surrogate mother); ONTARIO 1 at 253-55, rec. 51; CANADA 5 at 42, rec. 26.

75. UNITED KINGDOM 5, para. 8.19, and UNITED KINGDOM 6, para. 73; QUEBEC 5, rec. 57; GERMANY 1, s. 1: [TRANSLATION] "Anyone will be punished with up to three years imprisonment, or a fine, who: ... (vii) attempts to perform artificial insemination or embryo transfer on a woman prepared to permanently give up her child after birth (surrogate mother)." However, subsection (3) excludes the surrogate mother and the social parents from the application of the Act: [TRANSLATION] "(3) ... in the case of section 1(vii), the surrogate mother and the person who wishes to take long-term care of the child will not be punished." However, in other countries, parties may be prosecuted where there is payment or advertising; see *infra*, table 4 at 210-13.

76. SOUTH AUSTRALIA 1, s. 10g; NEW SOUTH WALES 5, rec. 8 at 55-60; QUEENSLAND 2, s. 4; VICTORIA 1, para. 30(3); AUSTRALIA 1, rec. 17 and para. 6.6.15; COMMONWEALTH OF AUSTRALIA 3 at 36; SPAIN 1, s. 10, SPAIN 2 at 237 and SPAIN 3 at 242; COUNCIL OF EUROPE 1, guideline 15(2); INDIANA 1, s. 31.8.2.1; MICHIGAN 1, s. 722.855, section 5; NEW YORK 2, s. 2 of the *Proposed Surrogate Parenting Act*; FRANCE 5, s. 11 — FRANCE 3, s. 342-12; UNITED KINGDOM 2, para. 36(1) (which amends the *Surrogacy Arrangements Act 1985*), UNITED KINGDOM 5, para. 8.19, rec. 59 at 86, and UNITED KINGDOM 6, para. 73; CANADA 2, rec. 9(b) (the surrogacy contract would be valid but not binding on the surrogate); QUEBEC 1, rec. 18, and QUEBEC 7, art. 582. See also UNITED STATES 3.

77. UNITED STATES 2 at 67S. Similarly, see CANADA 5 at 27, rec. 10:

The Societies recommend:

1. that surrogacy be permitted for medical reasons; and
2. that ongoing research be conducted to carefully evaluate the impact of surrogacy on all parties involved.

See also COUNCIL OF EUROPE 1, guidelines 11 and 15(4) (the Council leaves member states free to decide whether or not to prohibit).

any subsequent challenge respecting the child's parentage, approve any possible payment and ensure that the parties agree on the following matters: insurance, death or separation of the applicants, behaviour and diet before and during the pregnancy, diagnostic examinations, terms and conditions for transferring the child, and future relations between the surrogate and the child.<sup>78</sup>

#### D. Control over Gametes and Embryos

Recommendations on control over gametes and embryos often differ considerably from country to country. For example, some countries hold the view that donors have a property right over their gametes,<sup>79</sup> while others feel that the legal system applicable to embryos is that of persons.<sup>80</sup> Louisiana even grants legal existence to *in vitro* embryos until they are implanted.<sup>81</sup> The extent to which the various parties may control gametes and embryos is examined from two different perspectives: the exercise of control and post mortem fertilization.

##### 1. The Exercise of Control

Generally, control of human products is exercised through a consent form which indicates how gametes and embryos may be used.

###### (a) Consent

Consent to the donation and storage of gametes and embryos must in most cases be written and sometimes requires the signatures of both partners.<sup>82</sup> Some countries require that the consent form signed at the time of the donation include the conditions under which

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78. ONTARIO 1, recs 34 to 66; hearings must be held *in camera*, and agencies would be regulated. It should also be noted that one Commissioner objected to the legalization of surrogacy itself: *ibid.* at 287-91. COMMONWEALTH OF AUSTRALIA 3 at 36: it is recommended that surrogacy not be prohibited altogether, but that its application be strictly controlled.

79. NEW SOUTH WALES 3, para. 10.14, and NEW SOUTH WALES 4, rec. 23i) at 86. See, however, UNITED KINGDOM 5, paras 10.11 and 11.17, recs 42 and 62 at 84 and 86, where it is proposed that the embryo be afforded legal protection, without there being property rights over human embryos, and CANADA 2, rec. 10(d) (human tissue not to be treated as a commodity).

80. QUEBEC 1 at 15; FRANCE 5 at 34.

81. LOUISIANA 2, ss. 123-126: the *in vitro* embryo is a legal person, and may take or be subject to legal action through a guardian.

82. QUEENSLAND 3, rec. B(3) (xix), VICTORIA 1, ss 9 to 13A; DENMARK 1, recs 6.1 and 7.1 at 124-25, reg. 3.1 at 132; COUNCIL OF EUROPE 1 at 21-22 and guidelines 4 and 9(3); UNITED STATES 2 at 60S, and UNITED STATES 1, guideline VII(C); FRANCE 5, s. 10 — FRANCE 2, L. 668-5; UNITED KINGDOM 4, guidelines 15 and 16 and UNITED KINGDOM 6, para. 55; BRITISH COLUMBIA 1, recs 9 and 10, CANADA 3 at 27, rec. 3.4, ONTARIO 1, rec. 12, and CANADA 4 at 9-11.

the gametes may be used, stored or destroyed,<sup>83</sup> and that consent to storage include the respective wishes of each partner in the event of death, disagreement or divorce.<sup>84</sup>

Control over gametes can also be regulated through specific provisions. When the producer dies, at the end of the storage period or if the producer cannot be located, three options are open: the gametes can be destroyed;<sup>85</sup> control can revert to the storing agency, which must comply with the expressed wishes of the producer;<sup>86</sup> or the gametes may be used or destroyed at the discretion of the storing agency.<sup>87</sup>

With respect to stored embryos, the same three options are open when the couple dies, at the end of the storage period, in case of disagreement, or if the couple cannot be located: the embryos may be destroyed;<sup>88</sup> control may revert to the storing agency, which must comply with the wishes of the couple;<sup>89</sup> or the embryos may be used or destroyed at the discretion of the storing agency.<sup>90</sup> If only one of the partners dies, the embryos are destroyed<sup>91</sup> or control reverts to the surviving partner.<sup>92</sup>

According to the report of the Ontario Law Reform Commission, an embryo produced by a donor and one of the partners would be subject to the exclusive control of the couple. Control of an embryo produced from two donations would rest with the agency that has the embryo in its possession until the embryo is implanted in the woman for whom it was produced.<sup>93</sup>

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83. SOUTH AUSTRALIA 2, s. 10(3); VICTORIA 1, ss 11 to 13A and NEW SOUTH WALES 3, para. 10.18, rec. 26; SPAIN 1, s. 5; FRANCE 5, s. 10 — FRANCE 2, L. 668-11 and L. 668-12; UNITED KINGDOM 2, appendix 3, ss 2, 3, 6 and 8, UNITED KINGDOM 4, guideline 15d), and UNITED KINGDOM 6, para. 55; ONTARIO 1, recs 13 and 14; CANADA 5 at 31, rec. 14.

84. UNITED STATES 2 at 608; UNITED KINGDOM 2, appendix 3, ss 2 and 3, and UNITED KINGDOM 6, para. 60; CANADA 5 at 40, rec. 24; QUEBEC 5, recs 47 and 48.

85. DENMARK 1 at 97 and rec. 6.1 at 124; COUNCIL OF EUROPE 1 at 23-24 and guideline 7; FRANCE 5, s. 10 — FRANCE 2, L. 668-3; UNITED KINGDOM 2, s. 14, and UNITED KINGDOM 6, para. 57; QUEBEC 1, rec. 9. *Contra*: QUEBEC 5 at 49, rec. 35.

86. NEW SOUTH WALES 3, para. 10.18, and rec. 26; UNITED KINGDOM 6, para. 57.

87. UNITED KINGDOM 5, para. 10.8, rec. 60 at 86.

88. NEW SOUTH WALES 4, recs 2 and 22; DENMARK 1, rec. 6.1 at 124; COUNCIL OF EUROPE 1 at 24-25 and guideline 8; FRANCE 5, s. 10 — FRANCE 2, L. 670; UNITED KINGDOM 2, s. 14, and UNITED KINGDOM 6, paras 57, 58 and 60; ONTARIO 1, rec. 32; QUEBEC 1 at 34.

89. UNITED KINGDOM 6, paras 57, 58 and 60. See also NEW SOUTH WALES 4, para. 5.51, which calls for the status quo until the end of the storage period in cases of disagreement.

90. NEW SOUTH WALES 4, recs 2 and 26; UNITED KINGDOM 5, para. 10.10, rec. 32 at 83; ONTARIO 1, rec. 27(1). See, however, QUEBEC 5, rec. 48, where an ethics committee would decide the fate of the embryos if the couple could not be located, if there were disagreement or if the parental plan were abandoned.

91. DENMARK 1 at 101, rec. 6.1 at 124; FRANCE 5, s. 10 — FRANCE 2, L. 670; UNITED KINGDOM 6, para. 60.

92. NEW SOUTH WALES 4, recs 2 and 25; UNITED KINGDOM 5, para. 10.12, rec. 33 at 83, and UNITED KINGDOM 6, para. 59; ONTARIO 1, rec. 27(1).

93. ONTARIO 1, recs 27(1) and 27(2).

As a rule, explicit consent to any use of gametes and embryos is required, and the wishes expressed by the producers must be respected.<sup>94</sup> The conditions stated at the time gametes are donated may also apply to any embryos produced with those gametes,<sup>95</sup> but an unconditional donation deprives the donor of all control over the use of his or her gametes and any embryos that may result.<sup>96</sup>

The Council of Europe permits donations accompanied by reasonable, non-discriminatory conditions,<sup>97</sup> whereas the Barreau du Québec opposes any donation that includes conditions with which the recipient or couple must comply.<sup>98</sup> Donations to a specific person are sometimes prohibited,<sup>99</sup> but in other jurisdictions there is no objection where regular safety precautions are taken.<sup>100</sup> Consent can generally be changed or withdrawn before the donation is used,<sup>101</sup> although some countries consider it to be irrevocable.<sup>102</sup>

### *(b) Use of Gametes*

Gamete donation is often restricted. The laws of Sweden and Norway prohibit the donation of ova and sperm for in vitro fertilization.<sup>103</sup> The Barreau du Québec would permit the donation of gametes where they are to be used for therapeutic purposes.<sup>104</sup> The Council of Europe states that for purposes of IVF it is preferable to use gametes from the couple.<sup>105</sup> One Quebec report suggests prohibiting ovum donation,<sup>106</sup> while another would place restrictions on such donations: the ovum could not be retrieved solely for the purpose of being donated, and the ovum must come from a woman who is undergoing

94. NEW SOUTH WALES 1, s. 13, NEW SOUTH WALES 4, recs 2, 23 and 24; VICTORIA 1, ss 9 to 13A; DENMARK 1, rec. 4.1 at 123, reg. 4.2 at 132; SPAIN 1, ss 13 to 15; COUNCIL OF EUROPE 1 at 25, and guidelines 8(3) and 17(2); UNITED STATES 2 at 36S and 60S, LOUISIANA 2, ss 126 and 130; FRANCE 5, s. 10 — FRANCE 2, L. 668-12, L. 668-13, L. 669, L. 671, L. 672 and L. 676-2; UNITED KINGDOM 2, appendix 3, s. 5, UNITED KINGDOM 4, guidelines 5 and 6, and UNITED KINGDOM 5, para. 11.24, recs 13 and 14 at 81, UNITED KINGDOM 6, paras 51 and 56; GERMANY 1, s. 4; ONTARIO 1, rec. 12; CANADA 2, rec. 10(b); QUEBEC 1, recs 23, 25 and 27, and QUEBEC 5, recs 45, 47 and 50.

95. COUNCIL OF EUROPE 1, guideline 17(2); UNITED KINGDOM 2, appendix 3, ss 2 and 6; ONTARIO 1, recs 13, 26 and 27(2).

96. NEW SOUTH WALES 3, para. 10.13, and NEW SOUTH WALES 4, rec. 23; ONTARIO 1, rec. 27(2).

97. COUNCIL OF EUROPE 1 at 25 and guideline 9(3); for example, using gametes in another geographic region.

98. QUEBEC 1 at 24.

99. UNITED KINGDOM 4, guideline 13(j), which advises against gamete donations from known persons or close relatives; FRANCE 5, s. 10 and p. 25 — FRANCE 2, L. 668-7; QUEBEC 1 at 24.

100. NEW SOUTH WALES 3, para. 8.4; VICTORIA 1, s. 16; UNITED STATES 2 at 49S-50S and 52S; UNITED KINGDOM 5, para. 6.7; see also QUEBEC 5 at 43.

101. VICTORIA 1, ss 11 to 13A and 15; COUNCIL OF EUROPE 1, guideline 9(3); UNITED KINGDOM 2, appendix 3, s. 4, UNITED KINGDOM 4, guideline 15(b), and UNITED KINGDOM 6, para. 57; ONTARIO 1, recs 13 and 14.

102. SOUTH AUSTRALIA 3 at 25; DENMARK 1 at 99. See also SPAIN 1, s. 5, where the subsequent sterility of the donor is the only ground for revocation; the donor must then repay the costs incurred by the recipient.

103. SWEDEN 2, s. 2; NORWAY 1, s. 12.

104. QUEBEC 1 at 23.

105. COUNCIL OF EUROPE 1 at 26 and guideline 11(1). See also DENMARK 1, recs 7.1a and 7.1b at 125 (minority proposal).

106. QUEBEC 4 at 17, rec. 3.1.

infertility treatment and has enough ova to meet her own needs.<sup>107</sup> Finally, many jurisdictions require, or at least recommend, that sperm from only one donor be used for insemination in any given cycle.<sup>108</sup>

The use of gametes from minors is generally discouraged.<sup>109</sup> Ontario, however, does not object to sperm donations from minors but would not allow ovum donation unless there were informed consent and the ovum were donated at the time of a hysterectomy or other operation.<sup>110</sup> By and large, experimentation on gametes does not raise any problems.<sup>111</sup>

### *(c) Use of Embryos*

Some countries are opposed to embryo donation,<sup>112</sup> while others make embryo donation subject to specific conditions: donors must have resolved their fertility problems, and the recipient couple must be in treatment;<sup>113</sup> donation must be restricted to special circumstances, in particular preventing the embryo from being destroyed or undergoing experimentation,<sup>114</sup> unless consent to donation is given prior to fertilization.<sup>115</sup>

The creation of embryos is often limited to procreation<sup>116</sup> or treatment for the couple; embryos cannot therefore be created solely for the purpose of being donated.<sup>117</sup> Implantation in the same person of embryos from different donors would be permitted by the Ontario Law Reform Commission,<sup>118</sup> but is rejected by some countries.<sup>119</sup>

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107. QUEBEC 5, recs 50 and 51; see also GERMANY 1, ss 1(1)i and ii.

108. NEW SOUTH WALES 3, para. 9.24, recs 22 and 23; VICTORIA 1, s. 26; SPAIN 1, s. 20; SWEDEN 3; CANADA 3, rec. 3.5; QUEBEC 4, rec. 2.8, QUEBEC 5, rec. 26, and QUEBEC 6 at 60.

109. QUEENSLAND 3, rec. B(3)(iii); VICTORIA 1, s. 25 (unless the minor is married); SPAIN 1, s. 5.

110. ONTARIO 1, recs 10 and 11.

111. See, e.g., SPAIN 1, s. 14, and SPAIN 2 at 238 (gametes that have been subjected to experimentation cannot be used subsequently for procreation); see also CANADA 5 at 43-45, rec. 27.

112. NORWAY 1, ss 3 and 12, and SWEDEN 2, s. 2. See also DENMARK 1, rec. 7.1a at 125 (minority proposal); GERMANY 1, s. 1(1)v, does not permit the creation of surplus embryos.

113. LOUISIANA 2, s. 130; FRANCE 5, s. 10 — FRANCE 2, L. 671 and L. 676; QUEBEC 1 at 32-33.

114. COUNCIL OF EUROPE 1 at 26-27, and guidelines 11 and 12; QUEBEC 1, rec. 24 at 39.

115. VICTORIA 1, s. 13. The couple must have received counselling when they gave their consent to the donation. The minister may also authorize donation if the producers of the gametes are deceased or cannot be located (s. 14).

116. SPAIN 1, ss 3 and 20, and SPAIN 3 at 243; LOUISIANA 2, s. 122; GERMANY 1, ss 1 and 2; QUEBEC 6 at 61. See also DENMARK 1, rec. 7.1c at 125 (minority proposal).

117. COUNCIL OF EUROPE 1 at 24-25 and guideline 8(1); FRANCE 5, s. 10 — FRANCE 2, L. 669; QUEBEC 1 at 32, recs 22 and 26, and QUEBEC 5, rec. 49.

118. ONTARIO 1, rec. 26.

119. VICTORIA 1, s. 13; SPAIN 1, s. 20.



Some jurisdictions are opposed to research on embryos,<sup>120</sup> but most prefer to regulate it. Several types of procedures are prohibited (cloning, use of human gametes with gametes from another species, genetic manipulation, parthenogenesis, ectogenesis<sup>121</sup>), and research must in most cases be approved or authorized by some authority.<sup>122</sup> Experimentation on embryos *in vitro* is generally permitted only if the objective is therapeutic or preventive,<sup>123</sup> on embryos that do not have the capacity to develop,<sup>124</sup> or if the goal cannot be attained by some other means.<sup>125</sup>

Some countries do not permit experimentation on embryos *in vivo*<sup>126</sup> and prohibit embryos that have been used in research from being implanted in a woman's uterus except to increase the woman's chances of conceiving,<sup>127</sup> or where the experimentation was of a therapeutic nature.<sup>128</sup> Finally, the creation or collection of embryos solely for the purpose of research is often prohibited.<sup>129</sup>

## 2. Post-Mortem Use of Gametes and Embryos

Post-mortem use of gametes or embryos from a deceased spouse is permitted in some countries.<sup>130</sup> In the United Kingdom, absent a specific provision to that effect in a will,

120. DENMARK 1, rec. 3.1 at 129 (minority proposal); NORWAY 1, ss 3 and 14; UNITED KINGDOM 5 para. 11.18; QUEBEC 4 at 13, rec. 6.4: the Quebec Status of Women Council recommends a moratorium.

121. See, e.g., NEW SOUTH WALES 4, rec. 13 at 71, and VICTORIA 1, s. 6; DENMARK 1, recs 9.1 and 10.1 at 125-26; SPAIN 1, ss 14, 15 and 20; COUNCIL OF EUROPE 1, guidelines 20 and 21; FRANCE 5, s. 10 — FRANCE 2, L. 673; UNITED KINGDOM 2, s. 3 and appendix 2, s. 3, UNITED KINGDOM 4, preamble and guideline 10, UNITED KINGDOM 5, para. 12.3, recs 15, 47 and 48 at 81 and 85, UNITED KINGDOM 6, paras 37, 39, 41 and 42; GERMANY 1, ss 5 to 7; CANADA 2, rec. 10(f).

122. See, e.g., SOUTH AUSTRALIA 2, s. 14; NEW SOUTH WALES 4, recs 17 to 19; VICTORIA 1, ss 6 and 29; DENMARK 1, rec. 4.1 at 123 and recs 12.1 to 13.2 at 127; SPAIN 1, ss 14 and 15, and SPAIN 2 at 238; COUNCIL OF EUROPE 1, guideline 17(2); FRANCE 5, s. 10 — FRANCE 2, L. 673; UNITED KINGDOM 2, s. 11 and appendix 2, s. 3, UNITED KINGDOM 4, guideline 5, and UNITED KINGDOM 5, paras 11.18 and 12.16, recs 11, 43 and 49 at 81, 84-85; ONTARIO 1, rec. 29; CANADA 2, rec. 10(e), CANADA 5 at 43-45, rec. 27; QUEBEC 6 at 61.

123. See, e.g., SOUTH AUSTRALIA 2, para. 14(2); VICTORIA 1, s. 9A; DENMARK 1, rec. 4.1 at 123; SPAIN 1, ss 12 and 16; COUNCIL OF EUROPE 1, guideline 17(1); ILLINOIS 1, para. 6(7); UNITED KINGDOM 2, appendix 2, s. 3, and UNITED KINGDOM 4, guideline 3; QUEBEC 1 at 33-34, rec. 27.

124. See, e.g., SPAIN 1, s. 15, and SPAIN 2 at 238.

125. See, e.g., DENMARK 1, rec. 4.1 at 123; SPAIN 1, ss 15 and 16; COUNCIL OF EUROPE 1, guideline 17(2); UNITED KINGDOM 4, guideline 2.

126. See, e.g., COUNCIL OF EUROPE 1, guideline 19.

127. See, e.g., NEW SOUTH WALES 4, para. 5.24 and rec. 16; DENMARK 1, rec. 9.1 at 125; COUNCIL OF EUROPE 1, guideline 18; UNITED KINGDOM 4, guideline 4, and UNITED KINGDOM 5, para. 11.22, rec. 46 at 85; QUEBEC 1, rec. 27 at 40.

128. ONTARIO 1, rec. 30; SPAIN 1, ss 12 to 16.

129. See, e.g., DENMARK 1, rec. 9.2 at 126; SPAIN 1, ss 3 and 20; COUNCIL OF EUROPE 1, guideline 16; LOUISIANA 2, s. 122; FRANCE 5, s. 10 — FRANCE 2, L. 669; QUEBEC 1 at 32, and recs 22 and 27 at 39-40. *Contra*: NEW SOUTH WALES 4, rec. 14; VICTORIA 1, s. 9A; UNITED KINGDOM 2, appendix 2, s. 3, and UNITED KINGDOM 5, para. 11.30, rec. 45 at 85. See also GERMANY 1, s. 1(1)v.

130. NEW SOUTH WALES 3, para. 12.4, recs 28 and 29, NEW SOUTH WALES 4, recs 38 and 39; SPAIN 1, s. 9, SPAIN 2 at 237, and SPAIN 3 at 243; UNITED KINGDOM 2, s. 28(6). See also UNITED KINGDOM 5, paras 4.4, 10.9 and 10.15 and UNITED KINGDOM 6, paras 59 and 60, where this practice is discouraged. ONTARIO 1, recs 20 and 21; QUEBEC 5, rec. 35.

the procedure must take place before death for filiation between the child and the deceased spouse to be established.<sup>131</sup> In Spain, filiation between the deceased father and the child is possible only if fertilization occurred within six months of death and the father recognized the unborn child in a will or other notarized document.<sup>132</sup> In Australia, a child conceived by means of AI or IVF after the death of a producer is not entitled to inherit unless a specific bequest is made, but has recourse against the estate under another statute.<sup>133</sup> Finally, the Ontario Law Reform Commission recommends that, absent a specific bequest of course, a child be entitled to inherit as long as the child was conceived before the designation of beneficiaries.<sup>134</sup>

Countries that oppose the post-mortem use of gametes and embryos claim that such use is at odds with the welfare of the child, who would be missing a parent.<sup>135</sup>

## E. Parentage

The parentage of children born as a result of gamete or embryo donation is dealt with more frequently than that of children born of a surrogate.<sup>136</sup>

### 1. Gamete and Embryo Donation

Many countries state that gamete donors are in no way linked through filiation or parental responsibility to children born as a result of their donations.<sup>137</sup> However, some jurisdictions limit the application of this principle to cases where the donation is made

131. UNITED KINGDOM 2, para. 28(6); UNITED KINGDOM 5, paras 10.9 and 10.15, recs 61 and 64 at 86, and UNITED KINGDOM 6, paras 59, 60 and 88.

132. SPAIN 1, s. 9.

133. NEW SOUTH WALES 1, ss 3 and 5A, NEW SOUTH WALES 3, para. 12.4, recs 28, 29 and 31, and NEW SOUTH WALES 4, rec. 38.

134. ONTARIO 1, recs 20 and 21.

135. DENMARK 1 at 97 and 101, rec. 6.1; COUNCIL OF EUROPE 1 at 24 and guideline 7(4); FRANCE 5, s. 10 and p. 27 — FRANCE 2, L. 668-3; SWEDEN 3 and SWEDEN 4 at 5. See also GERMANY 1, s. 4; para. 4(1): [TRANSLATION] "Anyone will be punished with up to three years imprisonment or a fine, who . . . iii knowingly fertilises artificially an egg cell with the sperm of a man after his death." QUEBEC 1 at 21 and rec. 6 at 38, QUEBEC 4 at 12, and QUEBEC 5, rec. 35.

136. See also the section dealing with the post mortem use of gametes and embryos.

137. SOUTH AUSTRALIA 1, s. 10c; WESTERN AUSTRALIA 1, s. 7; NEW SOUTH WALES 1, s. 6; QUEENSLAND 1, ss 15 to 18; TASMANIA 1, s. 10c; NORTHERN TERRITORY 1, ss 5D, 5E and 5F; VICTORIA 2, ss 10c to 10f; DENMARK 1 at 96; SPAIN 3 at 243; COUNCIL OF EUROPE 1 at 28-29 and guideline 14; NEW YORK 1, para. 2(b); MISSOURI 1, s. 210.824; FRANCE 5, s. 11 — FRANCE 3, s. 342-9; NORWAY 1, para. 15(2) (by amendment to the *Children Act*); UNITED KINGDOM 2, s. 28, UNITED KINGDOM 5, paras 4.22, 6.8 and 7.6, recs 52 and 55 at 85, and UNITED KINGDOM 6, para. 88; BRITISH COLUMBIA 1, recs 1 and 13; ONTARIO 1, recs 19(2) and 21; SASKATCHEWAN 1 at 9 and s. 4; CANADA 2 at 14 and rec. 1, and CANADA 5 at 33-34, rec. 18; QUEBEC 1, recs 12 and 13 at 38, QUEBEC 5, recs 24 and 25, QUEBEC 6 at 60, and QUEBEC 7, art. 579.

under medical supervision or through an authorized centre.<sup>138</sup> A recent statute in the United Kingdom provides that the sperm donor must have consented to the donation so as not to be considered the father of the child.<sup>139</sup>

Legal maternity is often established through a presumption that the woman who gives birth to a child is the child's legal mother.<sup>140</sup> The Ontario Law Reform Commission recommends that the woman who carries the child with the intent of raising it be recognized conclusively as the mother.<sup>141</sup> Spanish law provides that married couples who consent to the procedure cannot challenge maternal filiation.<sup>142</sup>

The husband of the woman who gives birth to the child is recognized as the child's legal father, either by presumption or as a result of his consent to the procedure,<sup>143</sup> which consent is presumed until proven otherwise in many countries.<sup>144</sup> Finally, according to the Law Reform Commission of Saskatchewan, consent could be given before or after insemination.<sup>145</sup>

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138. In Europe, where the donation is not made through an authorized centre, the donor retains parental obligations and a filial relationship with the child may be established: COUNCIL OF EUROPE 1 at 29, guideline 14(3). See also SASKATCHEWAN 1, ss 2 and 4.

139. UNITED KINGDOM 2, para. 28(6).

140. COMMONWEALTH OF AUSTRALIA 1, s. 60B; SOUTH AUSTRALIA 1, s. 10C; WESTERN AUSTRALIA 1, ss 5 and 7; NEW SOUTH WALES 4, rec. 37; QUEENSLAND 1, s. 17; TASMANIA 1, s. 10C; NORTHERN TERRITORY 1, s. 5C; VICTORIA 2, s. 10E; SPAIN 3 at 242; COUNCIL OF EUROPE 1 at 28-29, guideline 14; ARKANSAS 1, s. 9-10-201; UNITED KINGDOM 2, s. 27, UNITED KINGDOM 5, paras 6.8 and 7.6, recs 55 and 56 at 85-86, and UNITED KINGDOM 6, para. 88; CANADA 2, rec. 2; QUEBEC 1, recs 13 at 38, and QUEBEC 5, rec. 34.

141. ONTARIO 1, rec. 19(1).

142. SPAIN 1, s. 8.

143. COMMONWEALTH OF AUSTRALIA 1, s. 60B; SOUTH AUSTRALIA 1, s. 10d; WESTERN AUSTRALIA 1, s. 6; NEW SOUTH WALES 1, s. 5; QUEENSLAND 1, ss 15 to 17; TASMANIA 1, s. 10C; NORTHERN TERRITORY 1, s. 5D; VICTORIA 2, ss 10C to 10E; SPAIN 3 at 242; COUNCIL OF EUROPE 1 at 29, guideline 14(2); NEW YORK 1, s. 1; MISSOURI 1, s. 210.824; ARKANSAS 1, s. 9-10-201; FRANCE 5 at 29 (in accordance with ordinary law, FRANCE 3, s. 312); NORWAY 1, para. 15(2) (by amendment to s. 9 of the *Children Act*); UNITED KINGDOM 2, s. 28, UNITED KINGDOM 5, paras 4.17, 4.24, 4.25 and 7.6, recs 51, 54 and 56 at 85-86, and UNITED KINGDOM 6, paras 88 and 89; BRITISH COLUMBIA 1, recs 1 and 17; CANADA 3, rec. 1; ONTARIO 1, rec. 19(1); SASKATCHEWAN 1 at 8 and ss 2(a) and 3; CANADA 2, rec. 3; QUEBEC 1 at 25 and recs 11 and 12 at 38, QUEBEC 5, rec. 33, and QUEBEC 7, arts 580 and 581. SWEDEN and some 30 American states have adopted similar legislation, based on the *Uniform Parentage Act* (see UNITED STATES 5 at 244).

144. COMMONWEALTH OF AUSTRALIA 1, s. 60B; SOUTH AUSTRALIA 1, ss 10a and 10d; WESTERN AUSTRALIA 1, ss 3, 5 and 6; NEW SOUTH WALES 1, ss 3 and 5; QUEENSLAND 1, ss 13 and 15 to 17; TASMANIA 1, s. 10C; NORTHERN TERRITORY 1, ss 5A and 5D; VICTORIA 2, ss 10A, 10C, 10D and 10E; UNITED KINGDOM 5, para. 4.24, rec. 54 at 85, and UNITED KINGDOM 6, paras 88 and 89 (proposed amendment to the *Family Law Reform Act* 1987, to include ovum and embryo donations); ONTARIO 1, rec. 19(3); and CANADA 2, rec. 3.

145. SASKATCHEWAN 1 at 8 and s. 3.

In most countries, if the couple is not married the *de facto* husband can generally be recognized as the father of the child if he consented to the procedure.<sup>146</sup> According to the Ontario Law Reform Commission's proposal, the husband or partner of a woman who carries a child with the intention of raising it would be deemed conclusively, if he consented, to be the child's legal father.<sup>147</sup>

Disavowal or contestation of paternity is normally carried out by proving the absence of consent or the fact that the child was born naturally, not as a result of a technology.<sup>148</sup> In France, a partner who consented but no longer recognizes the child once the child is born remains responsible to the mother and child. Further, it is impossible for anyone, the child included, to challenge this filiation on the grounds that there is no biological link.<sup>149</sup>

A child born as a result of medically assisted procreation has the same rights as a legitimate child or a child conceived naturally if the couple that used the technologies is married and the husband gave his consent.<sup>150</sup> Some countries specify that insemination must have been performed under medical supervision,<sup>151</sup> while others require that the birth certificate give no indication as to the method of conception.<sup>152</sup>

## 2. Surrogacy

Many countries that attempt to discourage surrogate motherhood recommend that the presumption attributing legal maternity to the woman who gives birth be applied to surrogacy contracts.<sup>153</sup> Spanish law does not allow a woman to enter into a contract in advance in order to renounce her maternal filiation.<sup>154</sup> The report of the Barreau du Québec states that no preferential right of adoption should be granted to the spouse of

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146. COMMONWEALTH OF AUSTRALIA 1, s. 60B; SOUTH AUSTRALIA 1, ss 10a and 10d; WESTERN AUSTRALIA 1, ss 3, 5 and 6; NEW SOUTH WALES 1, ss 3 and 5; QUEENSLAND 1, ss 13 and 15 to 17; NORTHERN TERRITORY 1, ss 5A and 5D; VICTORIA 2, ss 10A, 10C to 10E; SPAIN 1, s. 6, and SPAIN 3 at 242; COUNCIL OF EUROPE 1, guideline 14(2); UNITED KINGDOM 2, s. 28; CANADA 2, rec. 3; QUEBEC 5, rec. 34, and QUEBEC 7, art. 581.

147. ONTARIO 1, rec. 19(1).

148. COUNCIL OF EUROPE 1 at 29, guideline 14(2); LOUISIANA 1, s. 188; UNITED KINGDOM 5, para. 4.24, rec. 53 at 85; ONTARIO 1, rec. 19(3); QUEBEC 7, art. 580.

149. FRANCE 5, s. 11 and pp. 29-30; FRANCE 3, ss 342-10 and 342-11.

150. COUNCIL OF EUROPE 1 at 28-29; ARKANSAS 1, s. 9-10-201; FRANCE 5 at 29 (legitimate child of husband, FRANCE 3, art. 312); NORWAY 1, para. 15(2); UNITED KINGDOM 5, paras 4.17, 4.24 and 7.6, recs 51, 53 and 56 at 85-86, and UNITED KINGDOM 6, para. 89; BRITISH COLUMBIA 1, rec. 1; CANADA 3 at 33-34 and rec. 1; ONTARIO 1, rec. 21; SASKATCHEWAN 1, s. 3.

151. NEW YORK 1, s. 1; SASKATCHEWAN 1, ss 2(a) and (b).

152. NEW SOUTH WALES 3, paras 11.1 to 11.4, NEW SOUTH WALES 4, rec. 41 at 104; COMMONWEALTH OF AUSTRALIA 2, rec. X; SPAIN 1, s. 7; FRANCE 5 at 29; BRITISH COLUMBIA 1, rec. 17; ONTARIO 1, rec. 20; CANADA 2 at 16, rec. 4. See, however, UNITED KINGDOM 5, paras 4.25, 6.8 and 7.6, and UNITED KINGDOM 6, para. 90, which do not seem to reject recording the method of conception in birth records.

153. NEW SOUTH WALES 5, rec. 9 at 60-62; COUNCIL OF EUROPE 1 at 28-29 and guideline 14; SPAIN 1, s. 10; UNITED KINGDOM 2, s. 27, and UNITED KINGDOM 5, para. 8.20.

154. SPAIN 1, s. 10, SPAIN 2 at 237, and SPAIN 3 at 242.

the biological father.<sup>155</sup> In the United Kingdom, the Interim Licensing Authority recommends that surrogacy by IVF between close relatives be avoided.<sup>156</sup> Finally, some organizations would grant children born as result of this practice the same rights of access to information as adopted children or children born as a result of artificial insemination.<sup>157</sup>

In Arkansas, the biological father and his wife are recognized as the parents of a child born under a surrogacy contract, although the surrogate's name is recorded on the birth certificate.<sup>158</sup> In Michigan, when a dispute arises, the party with physical custody of the child keeps the child until a court, basing its decision on the best interests of the child, determines otherwise.<sup>159</sup>

The report of the Canadian Bar Association, which does not oppose unchallenged gratuitous agreements, recommends that adoption and family laws be amended to facilitate recognition of the social parents as the legal parents in this specific case. No visitation or custody rights would be granted if the surrogate mother refuses to turn the child over, and the surrogate may, if she keeps the child, claim child support from the couple who refuses to adopt.<sup>160</sup> The position and recommendations of the New York Task Force on Life and the Law are similar: in the event of a dispute arising in the performance of a gratuitous agreement, the court must award custody to the surrogate unless there is clear, convincing evidence that the interest of the child would be better served by a different order.<sup>161</sup>

The Ontario Law Reform Commission favours regulating contracts by proposing that maternal and paternal filiation revert to the applicant couple as soon as the child is born. The surrogate could not change her mind; she must turn the child over at that time, if necessary under a court order.<sup>162</sup>

## II. Safety of Medically Assisted Procreation Technologies

Practical standards, record keeping and access to information, as well as donor liability and remedies available to the child, are some of the issues addressed by the legislation and reports surveyed, in the context of ensuring the safety of medically assisted procreation.

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155. QUEBEC 1 at 29-30 and rec. 21 at 39. See also NEW SOUTH WALES 5, rec. 10 at 62-65.

156. UNITED KINGDOM 4, guideline 13(k). See also QUEBEC 5, rec. 58, which opposes the practice of surrogacy contracts with embryo transfer.

157. NEW SOUTH WALES 5, rec. 11; QUEBEC 4 at 20.

158. ARKANSAS 1, s. 9-10-201.

159. MICHIGAN 1, s. 722.861, section 11.

160. CANADA 2 at 26-33 and recs 9(c) to 9(h); the surrogate would have the same time as in the case of adoption to decide if she wants to keep the child.

161. NEW YORK 2 at 136-37, and s. 4 of the *Proposed Surrogate Parenting Act*. The court must also determine visiting rights and child support in relation to the current law. The burden of proof respecting the interests of the child is greater than the preponderance of evidence but less than proof beyond all reasonable doubt.

162. ONTARIO 1, recs 49 and 56 to 59. See also NEW YORK 2 at 99, which cites the Florida bill prohibiting surrogates from revoking their consent to adoption.

## A. Practical Standards

Physical risks, limits on the frequency of use of gametes from a single donor and consultation are areas in which standards are often proposed.

### 1. Physical Risks

To ensure the quality of gametes, the reports recommend that the following measures be mandatory: psychological assessment of the donor and his or her motivation,<sup>163</sup> medical examination of the donor,<sup>164</sup> screening for transmissible or hereditary diseases,<sup>165</sup> genetic screening or family history assessment,<sup>166</sup> blood tests for HIV (human immunodeficiency virus) antibodies,<sup>167</sup> or repetition of HIV screening of the donor at least six months after the donation, before the sperm is used for any purpose.<sup>168</sup>

Some countries require, or at least recommend, that only frozen sperm be used,<sup>169</sup> while others feel it is sufficient to follow the guidelines of the medical profession on the screening and selection of donors.<sup>170</sup>

As to recommendations on the storage of gametes and embryos, the maximum period for storing gametes usually ranges from five to ten years.<sup>171</sup> The freezing of unfertilized

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163. BRITISH COLUMBIA 1, rec. 10; CANADA 3 at 5, and CANADA 4 at 6; QUEBEC 5, rec. 14.

164. DELAWARE 1, s. 2801; OHIO 1, s. 3111.33; UNITED STATES 1, guideline VII, and UNITED STATES 2 at 45S; UNITED KINGDOM 5, para. 4.18; BRITISH COLUMBIA 1, rec. 11; CANADA 3 at 9-10, CANADA 4 at 5, and CANADA 5 at 29-30, rec. 12: "The Societies recommend that donors be required to pass genetic and medical screening tests as set by the professional society."

165. SPAIN 1, s. 5; COUNCIL OF EUROPE 1, guideline 5; OHIO 1, s. 3111.33; UNITED KINGDOM 5, para. 4.18; SWEDEN 3; BRITISH COLUMBIA 1, rec. 11; CANADA 3, rec. 2, and CANADA 4 at 5.

166. NEW SOUTH WALES 3, paras 5.12 and 5.15; QUEENSLAND 3 at 111; SPAIN 1, s. 5; COUNCIL OF EUROPE 1, guideline 5; UNITED STATES 1, guideline VII, UNITED STATES 2 at 45S, and OHIO 1, s. 3111.33; BRITISH COLUMBIA 1, rec. 11; CANADA 3 at 7-9, rec. 2.2, and CANADA 4 at 5-6. See also QUEBEC 1 at 23, which recommends the adoption of minimum uniform standards for selecting and matching donors.

167. UNITED STATES 1, guidelines V, VI and VII; UNITED KINGDOM 4, guideline 13(h); SWEDEN 3; CANADA 1 at 27, and CANADA 4 at 5; CANADA 5 at 38-39, rec. 22; QUEBEC 1 at 23; QUEBEC 5, rec. 17, and QUEBEC 6 at 61. The UNITED STATES and the UNITED KINGDOM also recommend screening for hepatitis B.

168. LOUISIANA 4, s. 1062.1; UNITED STATES 1, guideline VII; SWEDEN 3; CANADA 4 at 5; QUEBEC 4 at 13 and rec. 2.7, QUEBEC 5 at 89-92 and rec. 17, and QUEBEC 6 at 43-45.

169. DENMARK 1 at 97; UNITED STATES 1, guideline VII(D), UNITED STATES 2 at 44S; LOUISIANA 4, s. 1062.1 (except for AIH); UNITED KINGDOM 4, guideline 13(i), UNITED KINGDOM 5, para. 10.1 and rec. 30 at 83 (except for AIH), and UNITED KINGDOM 6, para. 44; SWEDEN 3; CANADA 4 at 5, CANADA 5 at 38-39, rec. 22; QUEBEC 4 at 13 and rec. 2.7, QUEBEC 5, rec. 17, and QUEBEC 6 at 61.

170. NEW SOUTH WALES 3, paras 5.12 and 9.11, recs 4, 17 and 18; UNITED KINGDOM 5, para. 4.5 (for AIH); ONTARIO 1, rec. 8 (recommends national consultation, however, to ensure uniformity); SASKATCHEWAN 1 at 3; CANADA 2 at 19 (provincial gamete banks would ensure quality of gametes and select donors).

171. SPAIN 1, s. 11; COUNCIL OF EUROPE 1, guidelines 7(2) and 7(3); FRANCE 5, s. 10 and p. 23 — FRANCE 2, L. 668-3; UNITED KINGDOM 2, s. 14, UNITED KINGDOM 5, para. 10.8 and rec. 31 at 83, and UNITED KINGDOM 6, para. 54. See also QUEBEC 1, rec. 9 at 38. The reader will find in table 3, *infra* at 206-209, a list of proposed time limits.

eggs is often discouraged.<sup>172</sup> The recommended period for storing embryos ranges from twelve months to ten years,<sup>173</sup> and eggs fertilized in vitro may not be kept for more than fourteen days.<sup>174</sup>

The risks associated with multiple pregnancy, the number of embryos to be implanted and their subsequent reduction have been the subject of some commentary.<sup>175</sup> Further, embryo donation or transfer from one woman's uterus to another's (whether by uterine lavage or any other method) is generally discouraged because of its experimental nature and the risk of pregnancy for the donor.<sup>176</sup>

## 2. The Frequency of Use of Gametes from a Single Donor

Controlling the number of times gametes from the same donor may be used has been recommended, by restricting either the number of uses or the number of children resulting from the gametes.<sup>177</sup> The objective is to prevent the risk of consanguinity and the

172. SPAIN 1, s. 11; UNITED STATES 2 at 57S; NORWAY 1, s. 3; UNITED KINGDOM 4, guideline 11 (ovum freezing is permitted, but subsequent implantation is prohibited), and UNITED KINGDOM 5, para. 10.2 and rec. 9 at 81; QUEBEC 5, rec. 52.

173. SOUTH AUSTRALIA 2, paras 10(3) and 13(6); NEW SOUTH WALES 4, rec. 2 at 55-56, and rec. 22 at 86; DENMARK 1, rec. 6.1 at 124; SPAIN 1, s. 11; COUNCIL OF EUROPE 1, guideline 8(2); FRANCE 5, s. 10 — FRANCE 2, L. 670; NORWAY 1, s. 3; UNITED KINGDOM 2, s. 14, UNITED KINGDOM 4, guideline 8, UNITED KINGDOM 5, para. 10.10, rec. 32 at 83, and UNITED KINGDOM 6, para. 54; ONTARIO 1, rec. 32; CANADA 2, rec. 10(g); QUEBEC 1 at 32-34, QUEBEC 5, rec. 46.

174. SOUTH AUSTRALIA 2, paras 10(3) and 13(6) (the freezing period may not go beyond the point where the embryo would normally be implanted); NEW SOUTH WALES 4, rec. 2 at 55-56 and rec. 15 at 72; SPAIN 1, ss 15 and 20; COUNCIL OF EUROPE 1, guideline 17(2b); FRANCE 5, s. 10 — FRANCE 2, L. 672 (seven-day period); UNITED KINGDOM 2, s. 3, UNITED KINGDOM 4, guidelines 7 and 8, UNITED KINGDOM 5, para. 11.22, recs 12 and 45 at 81 and 85, and UNITED KINGDOM 6, paras 33 and 34; ONTARIO 1, rec. 31; CANADA 2, rec. 10(c); QUEBEC 1, rec. 27 at 39-40.

175. DENMARK 1 at 100: reduction is permitted if medical circumstances so require; SPAIN 1, s. 4: embryos are implanted in numbers deemed sufficient for reasonable chances of pregnancy; UNITED KINGDOM 4, guideline 12: the number of embryos to be implanted is limited to three; UNITED KINGDOM 5, para. 5.4: the number of embryos to be implanted is left to the judgment of the physician; GERMANY 1, s. 1: the number of embryos to be implanted is limited to three; ONTARIO 1, rec. 26: no restriction on the number of embryos to be implanted should be imposed; QUEBEC 5, recs 42 and 43, which accepts implantation of several embryos, but is opposed to reduction.

176. SOUTH AUSTRALIA 2, paras 10(3) and 13(6); COUNCIL OF EUROPE 1 at 27, guideline 12; UNITED STATES 2 at 54S; SPAIN 1, s. 20; FRANCE 5, s. 10 — FRANCE 2, L. 669; UNITED KINGDOM 5, para. 7.5 and rec. 8 at 81; GERMANY 1, s. 1; CANADA 5 at 24, rec. 8; QUEBEC 1 at 19 and rec. 4 at 38. *Contra*: ONTARIO 1 at 146 and rec. 1.

177. SPAIN 1, s. 5; UNITED STATES 1, guideline VII(C), and UNITED STATES 2 at 45S; UNITED KINGDOM 5, paras 4.26 and 6.6, recs 23 and 27 at 82-83; BRITISH COLUMBIA 1, rec. 12; QUEBEC 4 at 13, rec. 2.4, and QUEBEC 5, rec. 22. The following reports recommend a limit but do not set a figure: NEW SOUTH WALES 3, para. 9.15, recs 20 and 21; DENMARK 1, reg. 3.1 at 132 (to be determined by the Danish Board of Health); COUNCIL OF EUROPE 1, guideline 10; FRANCE 5, s. 10 — FRANCE 2, L. 668-9 (to be set by order of the Minister of Health); UNITED KINGDOM 6, para. 87; CANADA 3 at 12 and rec. 2.4; QUEBEC 1 at 24.

transmission of diseases that current medical expertise does not make it possible to detect.<sup>178</sup> Moreover, the Ontario report proposes to leave the number of times gametes from the same donor may be used to be determined on the basis of the physician's judgment and the wishes of the parties.<sup>179</sup>

### 3. Counselling

To assist the parties involved in medically assisted procreation programs, counselling is recommended in some countries<sup>180</sup> and mandatory in others.<sup>181</sup> For example, legislation in the state of Victoria makes counselling mandatory before any procedure, including gamete donation.<sup>182</sup>

## B. Record Keeping and Access to Information

Record keeping and centralization of information, as well as access to information, have been the subject of numerous recommendations.

### 1. Record Keeping and Centralization of Information

All jurisdictions agree on the need to keep records, but there are differing opinions as to how they should be kept. Responsibility for keeping records may rest with the physician or the clinic,<sup>183</sup> and in most cases a system that allows the donor's file to be linked with

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178. See, *e.g.*, COUNCIL OF EUROPE 1 at 25-26.

179. ONTARIO 1, rec. 16.

180. NEW SOUTH WALES 3, para. 7.11, rec. 13; NEW SOUTH WALES 4, rec. 10 at 67-68; COMMONWEALTH OF AUSTRALIA 2, rec. VII; DENMARK 1 at 99; UNITED STATES 1, guideline IV, and UNITED STATES 2 at 47S and 60S; UNITED KINGDOM 2, para. 13(6) and appendix 3, s. 3, UNITED KINGDOM 4, guidelines 13(g) and 15(a), UNITED KINGDOM 5, paras 3.4, 6.6 and 7.7, recs 19 and 27 at 82-83, and UNITED KINGDOM 6, paras 56, 60 and 77; BRITISH COLUMBIA 1 at 10 and rec. 10; CANADA 1 at 26-27, CANADA 3 at 26 and rec. 3.3, and CANADA 4 at 6; QUEBEC 1 at 24 and rec. 5 at 38, QUEBEC 4 at 10, recs 1.5, 2.3, 2.5 and 3.1, and QUEBEC 5 at 58, rec. 36.

181. VICTORIA 1, ss 9 to 13A, 18; SPAIN 1, s. 2; COUNCIL OF EUROPE 1, guideline 4(2).

182. VICTORIA 1, ss 9 to 13A, 18. The counsellor must be approved by the minister. The physician conducting the procedure must ensure that the couple, not just the person undergoing the procedure, have received counselling and that follow-up is arranged.

183. SOUTH AUSTRALIA 2, paras 13(3) and (6) (physician); NEW SOUTH WALES 1, s. 16 (physician), NEW SOUTH WALES 3, para. 13.30 and rec. 37 (physician and clinic), and NEW SOUTH WALES 4, recs 27 to 29 at 90-92 (clinic); COUNCIL OF EUROPE 1, guideline 6 (physician and clinic); SPAIN 1, s. 19 (physician); UNITED STATES 2 at 44S and 76S (physician); UNITED KINGDOM 4, guidelines 13(b) and 14(b) (clinic); CANADA 3 at 23-24 (physician).



the recipient's but still protects anonymity is recommended.<sup>184</sup> One Australian report recommends that when a child is born as a result of a gamete or embryo donation, records be kept indefinitely.<sup>185</sup>

It is often recommended that a central registry containing the records of donors and children born as a result of medically assisted procreation be established and that physicians and clinics be required to report to this registry.<sup>186</sup> However, there are fears about the risk to anonymity that could result from such a registry.<sup>187</sup>

## 2. Access to Information

The anonymity of the donor and the parties is a general rule followed by all countries except Sweden,<sup>188</sup> where donor anonymity has given way to the fundamental right of children to know about their genetic origins.<sup>189</sup> Some state that information obtained from donors enjoys the same guarantee of confidentiality as information obtained from patients,<sup>190</sup> and the terms applicable to consent by the parties to the conditions governing access to information are in some cases addressed.<sup>191</sup>

The terms of access to information differ depending on whether the information is identifying or not. Conditions that warrant disclosure of identity vary: if the person

184. UNITED STATES 2 at 76S; OHIO 1, s. 3111.36; SWEDEN 3; BRITISH COLUMBIA 1, rec. 16; CANADA 3 at 18-25, rec. 3.2; ONTARIO 1, recs 22(3) and 22(5); QUEBEC 5, rec. 24, and QUEBEC 6 at 60.

185. COMMONWEALTH OF AUSTRALIA 2, rec. II. See also SWEDEN 1, s. 3, and SWEDEN 3: records are kept for 70 years.

186. VICTORIA 1, s. 22; QUEENSLAND 3, recs B(3) (xi) and B(3) (xii); COMMONWEALTH OF AUSTRALIA 2, recs IV and VIII; SPAIN 1, s. 5; PENNSYLVANIA 1, s. 3213; UNITED KINGDOM 2, s. 31, UNITED KINGDOM 4, guideline 13(b), UNITED KINGDOM 5, para. 13.9, rec. 16 at 81, and UNITED KINGDOM 6, paras 15, 79, 80 and 85; CANADA 1 at 27, and CANADA 2 at 24-25, rec. 5; QUEBEC 4 at 25.

187. NEW SOUTH WALES 3, para. 13.30, rec. 37, and NEW SOUTH WALES 4, para. 5.52; CANADA 3 at 23.

188. NEW SOUTH WALES 1, s. 14, NEW SOUTH WALES 3, paras 8.2 and 8.13, recs 14 and 16, and NEW SOUTH WALES 4, rec. 34 at 97; QUEENSLAND 3, rec. B(3) (xiii); VICTORIA 1, s. 23; COMMONWEALTH OF AUSTRALIA 2, rec. I; DENMARK 1, rec. 8.1 at 125 and reg. 5.1 at 133; SPAIN 1, ss 2, 5, 19 and 20; COUNCIL OF EUROPE 1, guideline 13; UNITED STATES 1, guideline VII(c), and UNITED STATES 2 at 44S, 50S, 52S, 75S and 76S; FRANCE 5, s. 10 — FRANCE 2, L. 668-8, and FRANCE 4, s. 378; NORWAY 1, s. 10; UNITED KINGDOM 2, ss 31 to 33 and s. 41, UNITED KINGDOM 4, guideline 13(j), UNITED KINGDOM 5, paras 3.2, 6.6 and 7.7, recs 18 and 27 at 82-83, and UNITED KINGDOM 6, paras 83 and 84; BRITISH COLUMBIA 1, recs 1 and 9; ONTARIO 1, rec. 22(4); SASKATCHEWAN 1 at 10 and s. 5(1); CANADA 2 at 24, and CANADA 4 at 10; QUEBEC 1, recs 15 and 16 at 38-39, QUEBEC 5, recs 29 and 31, and QUEBEC 7, art. 583.

189. SWEDEN 1, s. 4, and SWEDEN 5 at 389: the child has a right of access to the donor's complete file when he is deemed sufficiently mature. See also DENMARK 1, rec. 8.1a at 125, and reg. 5.1a at 132, where a minority of the members shared this view in cases of gamete or embryo donation.

190. NEW SOUTH WALES 1, s. 14, NEW SOUTH WALES 3, paras 8.13 and 14.10, and NEW SOUTH WALES 4, rec. 34 at 97; ONTARIO 1, rec. 22(2).

191. See, e.g., COMMONWEALTH OF AUSTRALIA 2, rec. VII: the parties must give their formal consent to the conditions of access to information before any procedure. QUEBEC 6 at 60: the donor must be informed of the type of information to which the child may have access; see also SWEDEN 3.

consents;<sup>192</sup> if there is reasonable cause or in extreme cases;<sup>193</sup> pursuant to a ruling by a specific authority;<sup>194</sup> if there is a risk to life or health;<sup>195</sup> as part of the requirements of the agency that performs the technologies or conducts research; and finally, in connection with enforcement of the law.<sup>196</sup> Further, anonymity could be removed in the future in circumstances that have yet to be determined.<sup>197</sup> Others already grant children who have reached the age of majority access to identifying data on request.<sup>198</sup>

Children may be granted access to non-identifying information in donors' files when they reach the age of 18,<sup>199</sup> when they reach the age of 14,<sup>200</sup> or regardless of their age.<sup>201</sup>

192. SOUTH AUSTRALIA 2, s. 18; NEW SOUTH WALES 1, s. 15 (the right of access is denied to children under 18 years of age, unless they are married); NEW SOUTH WALES 3, paras 8.2 and 13.23, recs 15 and 32, and NEW SOUTH WALES 4, rec. 31 at 92-93; VICTORIA 1, s. 22; COMMONWEALTH OF AUSTRALIA 2, rec. VII, option 2 (the right of access may be exercised only where the child is 18, by written request from a person with a legitimate interest, and the parents must consent if the information requested concerns the child); CANADA 5 at 35-37, recs 19 to 21; QUEBEC 5, recs 31 and 32 (the donor has a right to refuse the disclosure of his or her identity, and the parents may refuse on behalf of the child if he or she is unaware of the method of his or her conception).
193. COMMONWEALTH OF AUSTRALIA 2, rec. VII; UNITED STATES 2 at 44S; QUEBEC 1, recs 14 to 16 at 38-39.
194. NEW SOUTH WALES 1, s. 15, NEW SOUTH WALES 3, para. 8.2, rec. 15, and NEW SOUTH WALES 4, rec. 31 at 92-93 (on permission of the biomedical council); COMMONWEALTH OF AUSTRALIA 2, rec. VII; SPAIN 2 at 237 (in the context of legal proceedings); SWEDEN 1, s. 5 (in the context of legal proceedings where paternity is in dispute); CANADA 2, rec. 6 (court order allowing access to provincial registry); QUEBEC 5, recs 29 and 32 (access to physician and donor allowed where medical reasons so require, or court order).
195. SPAIN 1, ss 5 and 8 (proven danger to the life of the child; however, the disclosure of identity does not prove legal paternity); CANADA 2, rec. 6 (access to provincial registry would be allowed only in cases of medical necessity); CANADA 3 at 27 (congenital or hereditary disease of the child where this information affects the donor's health); SASKATCHEWAN 1 at 12 and s. 5 (for AID, the information may be consulted by physicians and medical staff or under their supervision; the information is admissible as evidence in legal proceedings provided that the identity of the donor is not revealed); QUEBEC 1 at 27, and recs 15 and 16 at 38-39 (on permission of the court, if to save human life or prevent major psychological problems in the child; however, direct contact is not mandatory); QUEBEC 5, recs 29 and 32 (access to physician and donor allowed if necessary for medical reasons), and QUEBEC 7, art. 583.
196. SOUTH AUSTRALIA 2, s. 18; NEW SOUTH WALES 1, s. 15, NEW SOUTH WALES 3, para. 8.2, rec. 15, and NEW SOUTH WALES 4, rec. 31 at 92-93.
197. COUNCIL OF EUROPE 1, guideline 13 (member states may adopt legislation permitting access to the donor's identity and the method of conception); UNITED KINGDOM 6, para. 84; QUEBEC 6 at 60-61; VICTORIA 4, paras 3.14 and 3.36; NEW SOUTH WALES 4, rec. 32 at 95.
198. COMMONWEALTH OF AUSTRALIA 2, rec. VII, option I; UNITED KINGDOM 2, s. 31; QUEBEC 4 at 13 and rec. 2.9. For more details, see QUEBEC 2.
199. NEW SOUTH WALES 5, rec. 11 at 66-67; UNITED KINGDOM 5, paras 4.21, 6.6 and 7.7, recs 20 and 27 at 82-83, and UNITED KINGDOM 6, para. 83. See also SPAIN 1, ss 5 and 19.
200. QUEBEC 4 at 13 and rec. 2.9; QUEBEC 5, rec. 28.
201. NEW SOUTH WALES 1, s. 17 (a person having "good cause" based on welfare of health of a party may have access to the information upon simple agreement with the holder of the records), NEW SOUTH WALES 3, para. 13.23 and rec. 33, and NEW SOUTH WALES 4, recs 30, 32 and 33 at 92-95 (the information may be disclosed to the child, the donor or any person providing evidence of a "good cause" or pursuant to a decision by the biomedical council); VICTORIA 1, ss 20 and 23 and appendix 7; COMMONWEALTH OF AUSTRALIA 2, rec. VII (written request to state registry by a person with legitimate interest or by the parents of the child if the child is a minor); UNITED STATES 1, guideline VII(c), and UNITED STATES 2 at 44S; UNITED KINGDOM 2, s. 31 (the information that may be disclosed to a minor is limited to the existence of a genetic link with potential spouse; counselling must be offered); ONTARIO 1, rec. 22(7) (the issue would be left to the discretion of the attending physician); CANADA 5 at 35-37, recs 19 to 21; QUEBEC 6 at 60.

However, some require a medical reason, such as the discovery of a genetic or hereditary disease.<sup>202</sup> Finally, it is sometimes stated that the decision to tell the child about his or her origins is a private matter.<sup>203</sup>

### C. Liability of Donors and Remedies Available to Children

In some countries, donors who intentionally conceal necessary information or give false information are guilty of an offence.<sup>204</sup> However, France's draft bill states that donors have no liability *vis-à-vis* the child.<sup>205</sup>

With respect to civil remedies, the creation of a specific remedy for children who have sustained injury is generally not recommended because the physician continues to be subject to the rules of tort law.<sup>206</sup>

Finally, it should be noted that the report to the Minister of National Health and Welfare looks at the possibility of creating an agency to review any court actions resulting from the birth of a child with a congenital deformity or serious genetic disease.<sup>207</sup>

## III. Medical Control and Regulation

Uniform state, provincial or national legislation or regulations are recommended in a number of jurisdictions,<sup>208</sup> while others prefer to leave some matters to the professional

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202. COUNCIL OF EUROPE 1, guideline 13; BRITISH COLUMBIA 1, rec. 16.

203. See, e.g., COMMONWEALTH OF AUSTRALIA 2, rec. 1; CANADA 3 at 26, and ONTARIO 1, rec. 22(7); QUEBEC 5, rec. 24.

204. NEW SOUTH WALES 1, s. 11, NEW SOUTH WALES 3, para. 5.18, rec. 5, and NEW SOUTH WALES 4, rec. 35 at 98; VICTORIA 1, s. 27; ONTARIO 1, rec. 23. See also UNITED STATES 2 at 24\$ (moral duty rather than offence); CANADA 3 at 23 (protection of donor anonymity is conditional on donor disclosing genetic and medical information that to the best of his or her knowledge is accurate).

205. FRANCE 5, s. 11 — FRANCE 3, s. 342-9.

206. NEW SOUTH WALES 3, para. 14.9, rec. 41, and NEW SOUTH WALES 4, rec. 11 at 69; SPAIN 1, s. 19; BRITISH COLUMBIA 1, recs 1 and 15; ONTARIO 1, recs 22, 24 and 25; SASKATCHEWAN 1 at 4-5.

207. CANADA 3 at 22.

208. See, e.g., NEW SOUTH WALES 3, para. 5.12, rec. 4 (recruitment and screening of donors); ONTARIO 1, rec. 9 (recruitment and screening of donors); CANADA 3, rec. 2 and p. 15 (acquisition, storage and import of human sperm); CANADA 2, rec. 10(e) (research); CANADA 5 at 39, rec. 23: "The Societies endorse the facilities for the screening, storage and ultimate disposition of frozen donor sperm. Such facilities should be *required by law* to adhere to standards as provided by professional societies such as CFAS for the medical/genetic screening of donors, screening of semen for STD and record keeping." [emphasis added]; QUEBEC 1, rec. 2 at 37.

judgment of physicians,<sup>209</sup> ethics committees<sup>210</sup> and working groups.<sup>211</sup> It has also been recommended that some issues be studied,<sup>212</sup> but most recommendations deal with medical control and regulation of technologies.

## A. Medical Control

There is a definite need for medical control of medically assisted procreation. Legislation provides that the technologies are to be performed by physicians or specialists or under their supervision, or in hospitals or authorized centres.<sup>213</sup> The reports require the medical supervision or intervention of a physician, on the ground that medically assisted procreation technologies are a part of medical practice<sup>214</sup> and, as such, must be carried out in authorized centres or clinics.<sup>215</sup>

With respect to the storage, transfer and import of gametes and embryos, British Columbia recommends the creation of a government-controlled institutional sperm

209. See, e.g., NEW SOUTH WALES 3, recs 7, 12, 17 and 36 (consent forms, counselling, screening tests, record keeping); UNITED STATES 2 at 75S-80S; ONTARIO 1, recs 16 and 24 (frequency of use of gametes from a single donor and access to non-identifying information); SASKATCHEWAN 1 at 3.

210. See, e.g., NEW SOUTH WALES 4, recs 1, 2 and 21 and paras 5.9 to 5.11 (code of ethics for storage and utilization of embryos created by IVF); UNITED STATES 2 at 77S; UNITED KINGDOM 4, guidelines 13(a) and 14(a) (every centre must have access to a multidisciplinary ethics committee that includes women to approve the technologies used); SWEDEN 5 at 389 (research and experimentation).

211. See, e.g., UNITED KINGDOM 5, para. 2.17 and rec. 38 at 84 (national working group made up of health services representatives and practitioners to establish guidelines for organization of services); QUEBEC 5, recs 60 and 61 (multidisciplinary task force to study embryo research and suggest guidelines to Minister of Health).

212. See, e.g., UNITED STATES 2 at 75S (long-term impact on patients); CANADA 1 at 27-28 (infertility, impact of mutagenic factors, origins of male factor infertility, screening programs for chlamydia and gonorrhea), and CANADA 3, rec. 2.5 (long-term effects of donor selection criteria); QUEBEC 5, recs 6, 19 and 44 (causes of and treatments for infertility, contraceptives, alternatives to early voluntary sterilization, improvement of success rates with frozen sperm, risks of multiple pregnancy in relation to number of embryos implanted, improvement of chances of pregnancy with only one embryo transferred); QUEBEC 6 at 60 (infertility, fertility, contraceptives, alternatives to early sterilization).

213. SOUTH AUSTRALIA 2, s. 13; NEW SOUTH WALES 1; VICTORIA 1, ss 7, 9 to 13A and 17; SPAIN 1, ss 18 to 20; LOUISIANA 2, s. 128; OHIO 1, s. 3111.32; FRANCE 1, s. 2; NORWAY 1, ss 2 and 14; SWEDEN 1, s. 3, SWEDEN 2, ss 3 and 4, and SWEDEN 5 at 388-89; GERMANY 1, ss 9, 11 and 12.

214. NEW SOUTH WALES 3, para. 4.7, rec. 2, and NEW SOUTH WALES 4, rec. 5 at 62; DENMARK 1 at 97 and 99; COUNCIL OF EUROPE 1 at 20-21 and guideline 2; UNITED STATES 2 at 75S-77S; FRANCE 5, s. 10 — FRANCE 2, L. 668-2 and L. 675; UNITED KINGDOM 5, paras 3.1, 4.5 and 13.7, rec. 3 at 80; BRITISH COLUMBIA 1, rec. 6; ONTARIO 1, rec. 3; CANADA 2 at 17-18 and rec. 7.

215. SOUTH AUSTRALIA 3, rec. 7; NEW SOUTH WALES 3, paras 4.6 and 4.7, recs 1 and 2, and NEW SOUTH WALES 4, recs 1, 4 and 6; QUEENSLAND 3, rec. B(1) (iii); DENMARK 1 at 97 and 99; COUNCIL OF EUROPE 1 at 20-21 and guideline 2; FRANCE 5, s. 10 — FRANCE 2, L. 668-2 and L. 675 (for IVF and embryo transfer); UNITED KINGDOM 5, paras 4.16, 5.10, 6.6, 7.4 and 13.7, recs 3 to 7 at 80, and UNITED KINGDOM 6, paras 15, 20, 21 and 27 (for AID, IVF, ovum donation and embryo transfer); QUEBEC 4 at 13, recs 2.2 and 6.2, QUEBEC 5, recs 8, 9, 36, 37 and 64, and QUEBEC 6 at 60 (limit on number of centres). *Contra*: ONTARIO 1 at 153 and rec. 4.

bank.<sup>216</sup> The Barreau du Québec would prohibit the creation of embryo banks devoted exclusively to storage for the purpose of donation or experimentation.<sup>217</sup> Most recommendations state that only authorized gamete banks or institutions may engage in such activities.<sup>218</sup>

## B. Regulation of Technologies

A number of recommendations have been made concerning regulation of the technologies used in medically assisted procreation.

In New South Wales, it is recommended that the Biomedical Council, a statutory multidisciplinary agency comprising equal numbers of women and men, draw up a code of ethics that would outline the conditions for obtaining licences and set clinical standards and standards for research and the recording of information. The Council's role would be to advise the Minister for Health, inform the public, review the maximum storage period for gametes and embryos, settle disputes over access to information, and approve research projects. The overall authorization system would, however, be administered by the Department of Health.<sup>219</sup> There are no special regulatory provisions in the New South Wales legislation on artificial insemination.<sup>220</sup>

A statute passed by South Australia established the South Australian Council on Reproductive Technology, a multidisciplinary agency comprising equal numbers of women and men. The Council's role is to draft a code of ethics including clinical and research standards; advise the Department of Health on matters relating to medically assisted procreation and the conditions for issuing licences to practise; determine the conditions

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216. BRITISH COLUMBIA 1, recs 19 and 21.

217. QUEBEC 1, rec. 26 at 39.

218. DENMARK 1, rec. 6.1 at 124 and reg. 3.1 at 132; SPAIN 1, s. 20 (trade, import or export of embryos are prohibited); COUNCIL OF EUROPE 1 at 20-21 and guideline 2; DELAWARE 1, s. 2801; FRANCE 1, s. 2, FRANCE 5, s. 10 — FRANCE 2, L. 668-2 and L. 676-4; NORWAY 1, ss 3 and 14; UNITED KINGDOM 2, ss 3, 4 and 41, and appendix 2, s. 2, UNITED KINGDOM 5, paras 13.7 and 13.13, recs 3, 17 and 50 at 80, 81 and 85, and UNITED KINGDOM 6, paras 27, 48, 49, 62 and 63; SWEDEN 1, s. 6; BRITISH COLUMBIA 1, recs 19 to 21 (the creation of an institutional bank should be preferred over commercial and private banks except those under federal government supervision); CANADA 2, rec. 8 (the CBA recommends the creation of provincial gamete banks), and CANADA 3 at 14 and rec. 2.5 (import of sperm by commercial banks and creation of private banks outside the jurisdiction of a public agency are prohibited pending the adoption of regulations setting out federal quality standards); ONTARIO 1, recs 17 and 18 (the OLRC would allow banks to operate on a commercial basis as long as they are subject to government control); QUEBEC 1 at 25 and rec. 7 at 38.

219. NEW SOUTH WALES 4, recs 1, 2, 4 and 6. Half the members of the Council would be women because the impact of IVF is greater for women. See also NEW SOUTH WALES 3, paras 4.6 and 4.7, recs 1 and 2.

220. NEW SOUTH WALES 1.

for issuing research permits; conduct certain kinds of research; and inform the public and report to the Department and to Parliament. Permits and licences are issued by the Minister for Health.<sup>221</sup>

The legislation passed in the state of Victoria calls for a system of certification of clinics and consultants by the Minister for Health. Research and research permits are controlled by the Standing Review and Advisory Committee, a multidisciplinary agency that advises the government on all matters related to medically assisted procreation and prepares annual reports for Parliament.<sup>222</sup>

The Danish Council of Ethics proposes the establishment of a regulatory agency to handle the approval of research projects and certification of clinics that wish to offer medically assisted procreation services.<sup>223</sup>

In Spain, a statute dealing with all aspects of medically assisted procreation provides for the establishment of a National Commission on Assisted Reproduction. The multidisciplinary agency would advise and work with the government to compile data and establish operating criteria applicable to clinics and services. It may also be called upon to authorize research projects.<sup>224</sup>

In the United Kingdom, the first reports recommended the establishment of an agency separate from the government that would have regulatory power and would be responsible for monitoring and regulating infertility services, the storage of gametes and embryos, research, licences, and a central register of information.<sup>225</sup> As an interim measure, the Voluntary Licensing Authority — now called the Interim Licensing Authority — a body created jointly by the Medical Research Council and the Royal College of Obstetricians and Gynaecologists, carries out the role of this agency by urging centres to seek certification and apply for licences.<sup>226</sup> The new statute adopted in November 1990, the *Human Fertilisation and Embryology Act 1990*, incorporates these recommendations by creating a regulatory agency called the Human Fertilisation and Embryology Authority, which in turn will set up one or more committees to issue and revoke licences and permits. In addition to being in charge of the register of information, the agency will advise licensees and establish a code of practice dealing with the welfare of the child and the conduct of activities related to medically assisted procreation.<sup>227</sup>

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221. SOUTH AUSTRALIA 2, ss 5, 10 to 12; see also ss 13 to 16, regarding the conditions for issuing permits and the powers of the Department.

222. VICTORIA 1, ss 7 to 9A and 29.

223. DENMARK 1, recs 12.1 to 16.1 at 127-28. Regional agencies could also be established, see DENMARK 1 at 139-47.

224. SPAIN 1, ss 14 to 16 and 21. Section 5 calls for the establishment of a central data registry.

225. UNITED KINGDOM 5, paras 13.3 to 13.13, recs 1 to 3, 16, 17 and 50 at 80, 81 and 85, and UNITED KINGDOM 6, paras 13 to 27, 79 and 85.

226. UNITED KINGDOM 6, para. 9. See also UNITED KINGDOM 4 at 45 and 49.

227. UNITED KINGDOM 2, ss 5, 8, 9, 23, 25 and 31.

In Quebec, the report of the Department of Health and Social Services calls for the development of minimum clinical and ethical standards that would be incorporated in the Department's system of certifying and evaluating clinics. A provincial network of clinics would be set up, and clinics would be responsible for compiling and publishing uniform data on the services provided. Monitoring the evolution of practices would be left to the academic community and to interested agencies.<sup>228</sup> Also, the Status of Women Council suggests that the Department of Health and Social Services set up a multidisciplinary ad hoc committee to supervise the development of certification standards that specialized centres would have to meet, as well as mechanisms for evaluating, monitoring and checking the quality of practices.<sup>229</sup> The government should also set up an ethics advisory body comprising representatives of society at large rather than experts, to advise and express ethical opinions on medically assisted procreation.<sup>230</sup> Finally, enabling legislation should be passed.<sup>231</sup>

In short, the agencies recommended to regulate medically assisted procreation have similar responsibilities and structures.

Although the initiatives taken around the world to identify the issues raised by the technologies used in medically assisted procreation vary in scope, our study of the legislative provisions and recommendations seems to indicate that the advent of these technologies is accepted with at least some reservations and that there is consensus on a number of basic principles.

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228. QUEBEC 5, recs 65 to 76.

229. QUEBEC 4 at 25, recs 6.1, 6.5 and 6.6. The number of certified specialized centres would be limited to five, the number of centres now in existence. At the end of the committee's brief mandate, the recommendations on practical conditions would give way to standards issued by the Department for the recognition of clinics. Periodic monitoring and evaluation would be needed.

230. QUEBEC 4 at 25-26, rec. 6.5. The mandate would include qualitative management of births, evaluation and monitoring of practice and research, and distribution of information to the public. The agency would be given access to the annual reports of certified centres so that it could conduct general evaluations of the services provided. Women should be strongly represented.

231. QUEBEC 4 at 26, rec. 6.6.

TABLE 1: Eligibility for Medically Assisted Procreation Services (Except Surrogacy)

| Text*   | Unmarried<br>Heterosexual Couple                  | Single Woman   | Women in<br>Homosexual Relationship |
|---|---|--|-------------------------------------|
| NEW SOUTH WALES 1                                 | Authorized  | Not excluded, restrictive criteria<br>to be considered | —                                   |
| NEW SOUTH WALES 3 (AI)<br>NEW SOUTH WALES 4 (IVF) |   |  |                                     |
| SOUTH AUSTRALIA 2                                 | Authorized (cohabitation for at<br>least 5 years) | Excluded   | Excluded                            |
| VICTORIA 1  | Authorized  | Excluded for IVF                                       | Excluded for IVF                    |
| BRITISH COLUMBIA 1                                | Authorized  | Not excluded   | Not excluded                        |
| CANADA 2  | Authorized  | Not excluded   | —                                   |
| CANADA 4  | Authorized  | Authorized   | Authorized                          |
| CANADA 5  | Authorized  | Authorized   | Authorized                          |
| ONTARIO 1   | Authorized  | Authorized   | —                                   |
| QUEBEC 1  | Authorized  | Excluded   | Excluded                            |
| QUEBEC 4  | Authorized  | Excluded   | Excluded                            |
| QUEBEC 5  | Authorized  | Authorized for AI                                      | Authorized for AI                   |
| COUNCIL OF EUROPE 1                               | Authorized  | Excluded   | Excluded                            |
| DENMARK 1   | Authorized  | Authorized   | Authorized                          |
| FRANCE 5  | Authorized  | Excluded   | Excluded                            |
| NORWAY 1  | Excluded  | Excluded   | Excluded                            |

\*See List of Texts Cited, *infra* at 214-20.



TABLE 1: Eligibility for Medically Assisted Procreation Services (Except Surrogacy) (*Concluded*)

| Text*                     | Unmarried<br>Heterosexual Couple | Single Woman  | Women in<br>Homosexual Relationship                     |
|---------------------------|----------------------------------|---|---|
| SPAIN 1                   | Authorized                       | Authorized  | —   |
| SWEDEN 1 (AI)<br>SWEDEN 3 | Authorized                       | Excluded  | Excluded  |
| SWEDEN 2 (IVF)            | Authorized                       | Excluded  | Excluded  |
| UNITED KINGDOM 2          | Authorized                       | Not excluded  | —   |
| UNITED KINGDOM 5          | Authorized                       | Not excluded, but preference to<br>heterosexual couples | Not excluded, but preference to<br>heterosexual couples |
| UNITED STATES 1           | Authorized                       | Authorized  | —   |
| UNITED STATES 2           | Authorized                       | Authorized (in special<br>circumstances)                | —   |

\*See List of Texts Cited, *infra* at 214-20.

TABLE 2: Conditions for Access to Medically Assisted Procreation Services (Except Surrogacy)

| Text*  | Infertility or Genetic Disorder                         | Welfare of Child | Stability                      | Consent of Partner           | Other Criteria  | Decision   |
|--|---|------------------|--------------------------------|------------------------------|---|--|
| NEW SOUTH WALES 1<br>NEW SOUTH WALES 3 (AI)<br>NEW SOUTH WALES 4 (IVF) | Considered for couples                                  | Considered       | Considered                     | —                            | Need for counselling, physical and psychological health of future parents | By physician — professional sanction if physician fails to consider criteria, even if they are not mandatory |
| SOUTH AUSTRALIA 2  | Required  | —                | —                              | —                            | —   | —  |
| VICTORIA 1   | 1 year of alternative treatment required, except for AI | Required         | —                              | Required, except for AI      | Counselling mandatory   | By physician   |
| BRITISH COLUMBIA 1   | —   | —                | —                              | Required for married couples | Parental qualities as for adoption required                               | By physician according to criteria — appeal possible   |
| CANADA 2   | —   | —                | —                              | —                            | —   | By physician   |
| CANADA 4   | —   | —                | Required                       | —                            | —   | —  |
| ONTARIO 1  | Required for couples                                    | —                | Required                       | —                            | —   | By physician according to criteria — appeal possible   |
| QUEBEC 1   | Infertility required                                    | —                | Required for unmarried couples | —                            | —   | —  |

\*See List of Texts Cited, *infra* at 214-20.

TABLE 2: Conditions for Access to Medically Assisted Procreation Services (Except Surrogacy) (Continued)

| Text*               | Infertility or Genetic Disorder | Welfare of Child | Stability | Consent of Partner | Other Criteria  | Decision  |
|---------------------|---------------------------------|------------------|-----------|--------------------|---|---|
| QUEBEC 4            | Required                        | —                | —         | —                  | —   | —   |
| QUEBEC 5            | Required                        | —                | —         | —                  | —   | —   |
| COUNCIL OF EUROPE 1 | Required                        | Required         | —         | —                  | Reasonable chance of success — low risk to mother's or child's health | By physician  |
| DENMARK 1           | —                               | —                | —         | Required           | —   | —   |
| FRANCE 5            | Required                        | —                | —         | Required           | Procedure applied by physician or under physician's supervision       | Criminal sanction for anyone who violates the criteria established by the preliminary draft legislation |
| NORWAY 1            | Required                        | —                | —         | Required           | Medical and psychosocial assessment of couple                         | By physician  |

\*See List of Texts Cited, *infra* at 214-20.

TABLE 2: Conditions for Access to Medically Assisted Procreation Services (Except Surrogacy) (*Concluded*)

| Text*                     | Infertility or Genetic Disorder | Welfare of Child | Stability | Consent of Partner           | Other Criteria  | Decision                               |
|---------------------------|---------------------------------|------------------|-----------|------------------------------|---|--|
| SPAIN 1                   | —                               | —                | —         | Required for married couples | Reasonable chance of success; good physical and psychological health; woman must be at least 18 years old | —                                      |
| SWEDEN 1 (AI)<br>SWEDEN 3 | —                               | Required         | —         | Required                     | Medical, psychological and social assessment of couple  | By physician — appeal possible         |
| SWEDEN 2 (IVF)            | —                               | —                | —         | Required                     | —   | —                                      |
| UNITED KINGDOM 2          | —                               | Required         | —         | —                            | —   | —                                      |
| UNITED KINGDOM 5          | —                               | —                | —         | Recommended                  | —   | By physician, who must justify refusal |
| UNITED STATES 1           | —                               | —                | —         | Required                     | —   | —                                      |

\*See List of Texts Cited, *infra* at 214-20.

TABLE 3: Time Limits Applicable to the Storage and Commercial Use of Gametes and Embryos

| Text*                   | Time Limits |                                      | Authorized Payments  |         | Trade**    |            |
|-------------------------|-------------|--------------------------------------|--|---------|------------|------------|
|                         | Gametes     | Embryos                              | Gametes  | Embryos | Gametes    | Embryos    |
| NEW SOUTH WALES 1 (AI)  | —           | —                                    | Fixed amount or reimbursement of expenses (sperm)                          | —       | Prohibited | —          |
| NEW SOUTH WALES 3 (AI)  | —           | —                                    | Fixed amount and reimbursement of necessary or reasonable expenses (sperm) | —       | —          | —          |
| NEW SOUTH WALES 4 (IVF) | —           | 10 years                             | —  | —       | —          | —          |
| SOUTH AUSTRALIA 2       | —           | 10 years, with annual review (donor) | —  | —       | —          | —          |
| VICTORIA 1              | —           | —                                    | Travel costs, medical expenses, and other costs                            | —       | Prohibited | Prohibited |
| BRITISH COLUMBIA 1 (AI) | —           | —                                    | Expenses, time, lost wages (sperm)   | —       | —          | —          |
| CANADA 1                | —           | —                                    | —  | —       | Forbidden  | Forbidden  |
| CANADA 2                | —           | 5 years                              | —  | —       | —          | —          |
| CANADA 3                | —           | —                                    | Inconvenience, time, travel costs (sperm)                                  | —       | —          | —          |

\*See List of Texts Cited, *infra* at 214-20.

\*\*For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.

TABLE 3: Time Limits Applicable to the Storage and Commercial Use of Gametes and Embryos (Continued)

| Text*         | Time Limits      |  | Authorized Payments  |         | Trade**  |   |
|---------------|------------------|--|--|---------|--|---|
|               | Gametes          | Embryos  | Gametes  | Embryos | Gametes  | Embryos   |
| CANADA 4 (AI) | —                | —  | Expenses and inconvenience (sperm)   | —       | —  | —   |
| CANADA 5      | —                | —  | Expenses and inconvenience   | —       | If public funding is inadequate, possibility of establishment of profit-oriented banks | —   |
| ONTARIO 1     | —                | 10 years   | Reasonable expenses, time and inconvenience; excludes discomfort; may be higher for ovum | —       | Commercial banks permitted (according to regulations)                                  | Commercial banks permitted (according to regulations) |
| QUEBEC 1      | To be determined | To be determined                                   | Actual expenses  | —       | Forbidden  | Forbidden   |
| QUEBEC 4      | —                | —  | No payment (sperm)   | —       | —  | —   |
| QUEBEC 5      | —                | 2 years (may be extended in special circumstances) | Reasonable costs, to be borne by recipient (sperm)                                       | —       | Forbidden  | Forbidden   |
| QUEBEC 6      | —                | —  | —  | —       | —  | Forbidden   |

\*See List of Texts Cited, *infra* at 214-20.

\*\*For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.

TABLE 3: Time Limits Applicable to the Storage and Commercial Use of Gametes and Embryos (Continued)

| Text*                           | Time Limits          |                                     | Authorized Payments                |                                    | Trade**   |   |
|---------------------------------|----------------------|-------------------------------------|------------------------------------|------------------------------------|---|---|
|                                 | Gametes              | Embryos                             | Gametes                            | Embryos                            | Gametes   | Embryos   |
| COUNCIL OF EUROPE 1             | To be determined     | To be determined                    | Expenses, travel costs, lost wages | Expenses, travel costs, lost wages | Forbidden   | Forbidden   |
| DENMARK 1                       | —                    | 1 year                              | —                                  | —                                  | —   | Forbidden   |
| FRANCE 5                        | To be determined     | 5 years                             | Expenses, excludes lost wages      | —                                  | Profit forbidden                                      | —   |
| NORWAY 1                        | —                    | 1 year                              | —                                  | —                                  | —   | —   |
| SPAIN 1                         | 5 years              | 5 years                             | —                                  | —                                  | —   | Forbidden   |
| SWEDEN 1 (AI)<br>SWEDEN 2 (IVF) | —                    | —                                   | —                                  | —                                  | Profit forbidden                                      | —   |
| UNITED KINGDOM 2                | 10 years             | 5 years                             | —                                  | —                                  | Forbidden   | Forbidden   |
| UNITED KINGDOM 4                | —                    | 10 years, with review every 2 years | —                                  | —                                  | Forbidden (ovum)                                      | —   |
| UNITED KINGDOM 5                | Review every 5 years | 10 years, with review every 5 years | Expenses (sperm)                   | —                                  | Authorized with the approval of the regulatory agency | Authorized with the approval of the regulatory agency |
| UNITED KINGDOM 6                | 10 years             | 5 years                             | Reasonable costs                   | Reasonable costs                   | Authorized with the approval of the regulatory agency | Authorized with the approval of the regulatory agency |

\*See List of Texts Cited, *infra* at 214-20.

\*\*For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.

TABLE 3: Time Limits Applicable to the Storage and Commercial Use of Gametes and Embryos (*Concluded*)

| Text*           | Time Limits |         | Authorized Payments   |                            | Trade** |         |
|-----------------|-------------|---------|---|----------------------------|---------|---------|
|                 | Gametes     | Embryos | Gametes   | Embryos                    | Gametes | Embryos |
| UNITED STATES 1 | —           | —       | Expenses and time (sperm)   | —                          | —       | —       |
| UNITED STATES 2 | —           | —       | Expenses and time (sperm)<br>Expenses, time, risks and inconvenience (ovum) | Expenses and inconvenience | —       | —       |

\*See List of Texts Cited, *infra* at 214-20.

\*\*For the purposes of this table, the term “prohibited” implies the intervention of the criminal law, while the term “forbidden” implies any other type of unspecified sanction.



TABLE 4: Surrogacy\*

| Text**                      | General Position  | Involvement of Intermediaries                    | Advertising | Payment  | Contract                                   |
|-----------------------------|---|--|-------------|--|--|
| AUSTRALIA 1                 | Commercialization prohibited  | Prohibited                                       | Prohibited  | Prohibited   | Null                                       |
| COMMONWEALTH OF AUSTRALIA 3 | Permitted under strict control  | Controlled                                       | Controlled  | —  | Null                                       |
| NEW SOUTH WALES 5           | Surrogacy discouraged<br>Commercialization prohibited                   | Prohibited (including professional and attorney) | Prohibited  | Prohibited   | Null                                       |
| QUEENSLAND 2                | Surrogate motherhood prohibited   | Prohibited                                       | Prohibited  | Prohibited   | Null                                       |
| SOUTH AUSTRALIA 1           | Commercialization prohibited  | Prohibited if payment                            | Prohibited  | Prohibited for intermediaries                                | Null                                       |
| VICTORIA 1                  | Commercialization prohibited  | Prohibited if payment                            | Prohibited  | Prohibited   | Null                                       |
| CANADA 2                    | Opposed to the prohibition of surrogacy<br>Commercialization prohibited | —  | —           | Prohibited   | Legal, but null vis-à-vis surrogate mother |
| CANADA 5                    | Permitted for medical reasons on experimental basis                     | —  | —           | Permitted for surrogate mother for direct and indirect costs | —  |
| ONTARIO 1                   | Regulation of contracts   | Regulated  | —           | Permitted for surrogate mother if approved by court          | Enforceable if approved by court           |

\*For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.

\*\*See List of Texts Cited, *infra* at 214-20.

TABLE 4: Surrogacy\* (Continued)

| Text**               | General Position  | Involvement of Intermediaries   | Advertising                        | Payment                             | Contract |
|----------------------|---|---|------------------------------------|-------------------------------------|----------|
| QUEBEC 1             | Surrogacy strictly forbidden  | Prohibited  | —                                  | —                                   | Null     |
| QUEBEC 4             | Prevent surrogacy agreements<br>Commercialization prohibited                  | Prohibited  | Forbidden                          | —                                   | —        |
| QUEBEC 5             | Generally opposed to surrogacy<br>Commercialization prohibited                | Prohibited  | Forbidden vis-à-vis intermediaries | —                                   | —        |
| QUEBEC 6             | Surrogacy forbidden   | Forbidden   | Forbidden                          | —                                   | —        |
| COUNCIL OF EUROPE 1  | Commercialization forbidden<br>Member states may permit altruistic agreements | Forbidden (except medical services by physician in exceptional cases) | Forbidden                          | Forbidden                           | Null     |
| FRANCE 5<br>FRANCE 4 | Surrogacy prohibited  | Prohibited  | —                                  | —                                   | Null     |
| GERMANY 1            | Surrogacy prohibited  | Prohibited  | —                                  | —                                   | —        |
| SPAIN 1              | Surrogacy discouraged   | —   | —                                  | —                                   | —        |
| UNITED KINGDOM 1     | Commercialization prohibited  | Prohibited if payment   | Prohibited                         | Prohibited vis-à-vis intermediaries | Null     |

\*For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.

\*\*See List of Texts Cited, *infra* at 214-20.

TABLE 4: Surrogacy\* (Continued)

| Text**           | General Position                                      | Involvement of Intermediaries  | Advertising | Payment  | Contract |
|------------------|---|--|-------------|--|----------|
| UNITED KINGDOM 5 | Commercialization prohibited                          | Prohibited for both profit and non-profit agencies (including professionals) | —           | —  | Null     |
| UNITED KINGDOM 6 | Surrogacy discouraged<br>Commercialization prohibited | Prohibited vis-à-vis commercial agencies                                     | —           | —  | Null     |
| MICHIGAN 1       | Commercialization prohibited                          | Prohibited if payment  | —           | Prohibited except reasonable expenses incurred by surrogate mother   | Null     |
| NEW YORK 2       | Commercialization prohibited                          | Prohibited if payment (excludes physician's costs for AI and IVF)            | —           | Prohibited except reasonable expenses incurred by surrogate mother (affidavit setting out all payments received must be submitted to court), excluding loss of wages | Null     |

\*For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.

\*\*See List of Texts Cited, *infra* at 214-20.

TABLE 4: Surrogacy\* (Concluded)

| Text**          | General Position   | Involvement of Intermediaries                               | Advertising | Payment  | Contract |
|-----------------|--|---|-------------|--|----------|
| UNITED STATES 2 | Opposed to legal prohibition<br>Authorized for medical reason<br>as clinical experimentation | Permitted if costs<br>limited or pro-<br>fessional services | --          | Compensation for<br>surrogate expenses<br>and inconveni-<br>ences, at least,<br>is authorized;<br>costs to<br>intermediaries | --       |

\*For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.

\*\*See List of Texts Cited, *infra* at 214-20.

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## APPENDIX B

### Proposed Contents of a Medically Assisted Procreation Act

#### Note

The following text is not intended to represent draft legislation on medically assisted procreation. It was put together in order to provide a comprehensive legislative approach to the control of most aspects of medically assisted procreation. In order to achieve such a goal we did not take into consideration the division of powers between the various levels of government. It is obvious that, within our constitutional framework, co-operative agreements between the federal, provincial and territorial governments would be necessary to put such control mechanisms in place. However, the details of such agreements would take us beyond the scope of this working paper. In order to provide as complete a text as possible, we had to be more affirmative than some of our recommendations, and we took the position that agreements between the different levels of government would be worked out.

Along with such agreements and legislation, provincial legislation would be necessary to deal with such issues as parentage and succession.

**PROPOSED CONTENTS OF A  
MEDICALLY ASSISTED PROCREATION ACT**

**SHORT TITLE**

**1.**

**INTERPRETATION**

**2.** In this Act,

“central registry”  
“certification”  
“certified clinic”  
“counselling services”  
“deposit”  
“donation”  
“embryos”  
“gamete”  
“genetic predisposition”  
“genetic trait”  
“import”  
“inspector”  
“medically assisted procreation”  
“national agency”  
etc.

**DECLARATION OF PRINCIPLES**

**3.** It is hereby recognized and declared that

- (a) medically assisted procreation technologies should be developed and used in accordance with the fundamental principles of equality and justice and in a manner that respects the sanctity of life and the dignity and inviolability of the person;
- (b) the use of medically assisted procreation technologies to select or avoid the transmission of genetic predispositions or traits is unacceptable except where specifically provided for;

- (c) commercialization of medically assisted procreation is unacceptable;
- (d) access to medically assisted procreation should not be limited on the basis of any criterion that relates to the family status, marital status or sexual orientation of the candidate;
- (e) a person should have the opportunity through counselling services to be fully informed prior to making a decision to use a medically assisted procreation technology; and
- (f) the establishment of standards for public safety in relation to the use of medically assisted procreation technologies is essential.

#### ACCESS TO MEDICALLY ASSISTED PROCREATION SERVICES

#### **4. Limitation on Access**

No one should be denied access to medically assisted procreation services, unless cost or scarcity of resources requires that candidates undergo a selection process. If a selection process is required, the family status, marital status or sexual orientation of the candidate should not be used as selection criteria.

#### GAMETES AND EMBRYOS

#### **5. Possible Uses of Gametes and Embryos**

**(1) Gametes.** The possible uses of gametes should be limited to fertilization, experimentation and destruction; however, fertilization should be prohibited beyond the time limit on freezing prescribed by regulation [recommendations 6(4) and 12(2)] and donated sperm should not be used for fertilization until the donor has been properly tested for evidence of the AIDS virus [recommendation 11].

**(2) Embryos.** The possible uses of embryos should be limited to implantation, experimentation and destruction; however, implantation should be prohibited beyond the time limit on freezing [recommendations 5(3) and 12(1)].

**(3) Offence.**

#### **6. Selection of Gametes and Embryos**

**(1) Limits.** To eliminate the possibility of eugenic practices, the selection of gametes and embryos with specific qualities should be prohibited [recommendation 2].

**(2) Exception.** However, such selection should be permitted when the objective is to prevent the transmission of serious genetic diseases [recommendation 2].

**(3) Offence.**

## **7. Commercialization**

**(1) Gamete and Embryo Donation.** All commercialization of the donation of gametes and embryos should be prohibited [recommendation 3(1)].

**(2) Exception.** Only reimbursement of reasonable expenses incurred by donors should be permitted [recommendation 3(1)].

**(3) Gamete and Embryo Banks.** Gamete and embryo banks should not be permitted to operate on a profit basis [recommendation 3(2)].

**(4) Exception.** Banks should be allowed to be reimbursed for reasonable costs related to their operations [recommendation 3(2)].

**(5) Offence.**

## **8. Control over Gametes and Embryos in Case of Deposit and Donation**

**(1) Control over Gametes.** Control over gametes should be vested in the person from whom the gametes are derived [recommendation 6(1)].

**(2) Control over Embryos.**

*(a)* Control over embryos should be vested in both partners, if each partner contributed gametes used to conceive the embryos;

*(b)* control over embryos should be vested in the partner genetically linked to the embryos, if only one partner contributed gametes used to conceive the embryos; and

*(c)* control over embryos should be vested in the bank or clinic in possession of the embryos, if the gametes used to create the embryos were both donated. [recommendation 5(2)].

**(3) Deposit of Gametes.**

*(a)* The person with control who wishes to deposit his or her gametes for future personal use should be required, before the deposit, to make a written statement expressing his or her intentions as to the fate of the gametes;

(b) the statement must include provisions for the fate of the gametes in such circumstances as death of the person with control, abandonment of the parental project or expiry of the time limit on freezing; and

(c) the depositor should be able to change his or her stated intentions regarding the fate of the gametes by making a written statement to that effect before the gametes are used to create an embryo or used for any other intended purpose. [Recommendation 6(2)].

#### **(4) Deposit of Embryos.**

(a) Before conceiving an embryo for future personal use, the person with control should be required to make a written statement expressing his or her intentions as to the fate of the embryos. If control over the embryos is vested in both partners, their joint intentions are to be expressed in one written statement.

(b) The statement must include provisions for the fate of the embryo in such circumstances as death of the person or persons with control, abandonment of the parental project, expiry of the time limit on freezing, or divorce or other dispute between the persons with control.

(c) The person with control should be able to change his or her stated intentions regarding the fate of the embryo by making a written statement to that effect before the embryo is used for its intended purpose. If control over the embryo is vested in both partners, both must agree to any changes. [Recommendations 5(1) and (2)].

#### **(5) Donation of Gametes.**

(a) The person with control who wishes to donate his or her gametes should be required, before the donation is made, to make a written statement consenting to the donation and stating the conditions attached to his or her donation respecting the use of the gametes; and

(b) the donor should be able to withdraw his or her consent to the donation or change the conditions by making a written statement to that effect before the gametes are used to create an embryo or are used for another intended purpose. [Recommendation 6(3)].

#### **(6) Donation of Embryo.**

(a) The person with control who wishes to donate an embryo should be required, before the donation is made, to make a written statement consenting to the donation and should be able to attach to the statement conditions as to the use of the embryo. If control over the embryo is vested in both partners, their joint consent and conditions are to be expressed in one written statement.

(b) The donor should be able to withdraw his or her consent to the donation or change the conditions by making a written statement to that effect before the embryo is used for its intended purpose. If control over the embryo is vested in both partners, both must agree to the withdrawal of consent or any other changes. [Recommendation 5(4)].



**(7) Offence.**

**9. Import of Gametes and Embryos**

**(1) Restriction.** Importation of gametes and embryos should be restricted to certified banks. Imported gametes and embryos should also meet established national standards [recommendation 14].

**(2) Offence.**

**CLINICS AND BANKS**

**10. Restriction of Services**

**(1) Clinics.** The application of medically assisted procreation technologies should be restricted to certified clinics [recommendation 21(2)].

**(2) Banks.** Only certified banks should be permitted to store gametes and embryos [recommendation 21(2)].

**(3) Offence.**

**11. Counselling Services**

Every clinic offering medically assisted procreation services should be required to provide counselling services whereby persons using these services may obtain information and assistance from psychologists, physicians or other experts, either before, during or after the technology is applied [recommendation 16].

**12. Maintenance and Use of Records**

**(1) Obligation to Keep Records.** Clinics should be required to keep records (on the donor, the mother and the child) that allow physicians to link the donor to the recipient while protecting the anonymity of the parties [recommendation 17(1)].

**(2) Limit on the Information to Be Kept.** Only the information needed to attain the following objectives should be collected: to permit access to medical and genetic information that may be needed to obtain optimum medical care for the child; to meet the psychological needs of the child; to ensure proper clinical reports and to permit studies on the long-term effects of the various technologies used in medically assisted procreation [recommendation 17(2)].

**(3) Protection of Confidentiality.** Clinics should be responsible for protecting the confidentiality of the information they hold [recommendation 17(3)].

**(4) Access to Information/Anonymity.** The legal parents or the child should be able to request disclosure of non-identifying information such as social information (about the ethnic origin, profession, education, religious affiliation and interests of the donor, for example). However, identifying information should be disclosed only with the donor's consent [recommendation 18].

**(5) Exception.** It should be possible to reveal to the prosecuting authorities the identity of any donor who fails to provide information or who provides false information about his or her medical or genetic history, for the purpose of a criminal prosecution related to such failure or false information [recommendation 19].

**(6) Offence.**

### **13. Annual Reports from Clinics**

**(1) Obligation to File Annual Reports.** Clinics offering medically assisted procreation services should be required to submit written annual reports to a central registry [recommendation 9].

**(2) Content of Reports.** The minimum content of the reports should be set by regulation and the data should be presented in the prescribed form [recommendation 9]. The clinics should also be required to document and justify the number of embryos implanted in each treatment cycle [recommendation 15].

**(3) Offence.**

### **NATIONAL AGENCY**

### **14. Establishment of a National Agency**

The federal, provincial and territorial governments, in conjunction with the professionals involved, should establish a national regulatory agency on medically assisted procreation [recommendation 22(1)].

### **15. Powers and Duties of Agency**

**(1) Establishment of Certification System.** The national agency should establish a system of certification for clinics offering medically assisted procreation services and gamete and embryo banks [recommendation 21(1)].

**(2) Regulations.** The national agency should be empowered to make regulations [recommendation 22(2)(b)]

- (a) prescribing the criteria for granting certification to a bank or clinic;
- (b) establishing standards for the selection and screening of gamete and embryo donors [recommendation 10], and prescribing the maximum number of gametes that may be used from one donor [recommendation 13];
- (c) establishing standards for the screening, storage [recommendation 10] and importation of gametes and embryos [s. 9];
- (d) prescribing time limits respecting the freezing of gametes and embryos [[s. 5];
- (e) respecting the prohibitions pertaining to the selection of gametes and embryos [s. 6] and to the commercialization of gamete and embryo donation [s. 7];
- (f) respecting the reimbursement of costs incurred by donors and costs incurred by banks [s. 7];
- (g) respecting the exercise of control over gametes and embryos, including the attachment of conditions to donation and the expression of intentions in the case of deposit [s. 8];
- (h) respecting the composition and duties of counselling services established by clinics [s. 11];
- (i) respecting the maintenance of records by clinics and the contents of the records [s. 12(1) and (2)];
- (j) respecting the procedure for the release by clinics of identifying and non-identifying information about donors [s. 12(3) and (4)]; and
- (k) respecting the content of annual reports submitted by clinics to the central registry [s. 13(1) and (2)].

**(3) Additional Powers and Duties.** The national agency should be given the following powers and duties:

- (a) to take steps necessary to ensure compliance with the Act and regulations;
- (b) to grant certification to a clinic or bank;
- (c) to inspect certified clinics and banks [recommendation 22(2)];
- (d) to amend, suspend or revoke the certification of a clinic or bank that fails to comply with the Act or regulations or with the terms of its certification [recommendation 22(2)];
- (e) to establish a central registry which would collect annual reports from clinics and make available to the public the statistics derived from it;
- (f) to analyse medically assisted procreation success rates and other information collected from the annual reports of clinics and compile statistics;

(g) to take steps necessary to prevent exploitation and commercialization in the area of medically assisted procreation;

(h) to promote research and studies in relation to medically assisted procreation technology, including research and studies aimed at reducing the number of multiple pregnancies, at developing technologies that follow the normal cycle of ovulation [recommendation 15] and at determining the long-term effects (medical and psychological) of medically assisted procreation technology on children born as a result of the technology [recommendation 20];

(i) to identify problems arising from medically assisted procreation on the basis of national data; and

(j) to advise governments on matters related to medically assisted procreation.

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