REPORT

ON

HUMAN ARTIFICIAL REPRODUCTION AND RELATED MATTERS

ONTARIO LAW REFORM COMMISSION

VOLUME II

Ministry of the Attorney General

1985

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The Ontario Law Reform Commission was established by the *Ontario Law Reform Commission Act* for the purpose of reforming the law, legal procedures, and legal institutions. The Commissioners are:

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During the course of the Reference on Human Artificial Reproduction and Related Matters, the Chairman, Dr. Derek Mendes da Costa, QC, left the Commission to take up an appointment as Judge of the Unified Family Court. Accordingly, while the Commission benefited greatly from Dr. Mendes da Costa's knowledge and experience and wishes to express its indebtedness to him, the recommendations contained in this Report do not necessarily reflect his views and cannot be attributed to him.

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VOLUME II

GLOSSARY OF TERMS AS USED IN THIS REPORT

Amniocentesis	Withdrawal from the amniotic sac of a small sample of the fluid surrounding the growing fetus in order to detect certain fetal abnormalities.
Conceptus	Product of conception, that is, the embryo and membranes.
Embryo	An organism in the the early stages of development before recognizable human features have been formed.
Fallopian tubes	Tubes through which ovulated ova, which have been released from the ovaries, are transmitted into the uterus.
Fertilized ovum	Used interchangeably with "embryo".
Fetoscopy	Visual inspection of a fetus in the uterus.
Fetus	The developing embryo which has achieved recognizable human features (from the end of the eighth week to the moment of birth).
Gamete	An ovum or sperm.
Gene	A unit of heredity.
Implantation	The attachment of the fertilized ovum to the uterine wall.
Laparoscopy	Visual examination of organs by insertion of a light guide through a small incision in the abdominal wall. In this Report, "laparoscopy" is used to refer to the entire procedure by which ova are first visualized, and then recovered by a special needle fitted with a suction apparatus.
Lavage	The technique of "washing out" a fertilized ovum from a woman's uterus before implantation.
Ovum (pl. ova)	The female sex cell.
Semen	Fluid secretion containing sperm emitted during ejaculation.
Sperm	The male sex cell.
Ultrasound	Visualization of internal bodily structures by reflection of ultrasound waves.

CHAPTER 6

PROPOSALS FOR REFORM

1. INTRODUCTION

In earlier chapters of this Report, the Commission examined the incidence and causes of infertility and considered the medical and legal milieu in which infertile men and women, gamete donors, doctors, lawyers, and others attempt to resolve this substantial, and apparently growing, problem. We need not repeat here the case for a fundamental re-examination and reform of a legal framework that basically ignores or deals only inadvertently with continuing advances in medical reproductive technology. It is enough to reiterate our conclusion that clear legal rules must be formulated to deal with artificial conception — rules that, as we said in chapter 4, are in concert with both normative standards generally acceptable to the community and sound, progressive law reform.

In this chapter, the Commission will discuss various issues that have been identified during the course of this Project, and offer recommendations for reform. In this connection, it bears repeating that the Letter of Reference from the Attorney General for Ontario requires that we report on the range of alternative solutions to *legal* issues. However, as we stated in the Introduction to this Report, legal questions inevitably have non-legal dimensions and cannot be divorced from moral, ethical, social, and psychological questions, particularly where, as in the case of artificial reproduction, the non-legal component is so vitally important. But, in the end, after examining these matters, our proposals for reform deal essentially with the legal environment within which the new reproductive technologies should function.

The approach adopted in this chapter is, first, to address, on a functional basis, the matters that are common to the three reproductive technologies in issue, that is, artificial insemination, *in vitro* fertilization, and ovum donation by means of *in vivo* fertilization and lavage. We shall then consider several issues that relate exclusively to the human embryo outside the body. Finally, in a separate section, the Commission will set forth its recommendations concerning the special case of surrogate motherhood.

We begin our discussion with a consideration of the propriety of the various artificial conception technologies, excluding surrogate motherhood, which simply makes use of one of the technologies. Clearly, the examination of the different issues pertaining to the technologies depends upon a determination that each one is ethically and socially acceptable.

2. THE PROPRIETY OF ARTIFICIAL CONCEPTION TECHNOLOGIES

The reports summarized by the Commission in the Appendix to this Report make manifest the centrality of the question concerning the social and ethical propriety of artificial insemination, I.V.F., and gamete donation (including *in vivo* fertilization and lavage). While the reports, emanating from diverse sources and responding to different terms of reference, are not entirely uniform in their treatment of this vital issue, we are struck by the general endorsement of the new reproductive technologies by medical and legal organizations and by committees composed of medical and legal experts, social workers, psychologists, and others. Their acceptance, while not necessarily enthusiastic, ordinarily goes beyond mere resignation to what is perceived to be the inevitable. The general acceptance of the technologies is founded ultimately on their use as a beneficial — indeed, as emphasized in several cases, a necessary — medical procedure to circumvent the problem of male and female infertility.[1] However, notwithstanding this general predisposition in favour of artificial conception, it is noteworthy that a few committees have sought in some cases to preclude, or, what is more usual, to impose special restrictions on, the use of one or more of the procedures.[2]

Differing attitudes to artificial insemination, I.V.F., and *in vivo* fertilization and lavage, and to the use of donor gametes, reflect a great variety of social, ethical, and practical factors. Such factors include the simplicity or complexity of the procedure (and, therefore, the extent of medical intervention and the medical risks involved), the corresponding ability of laypersons to use a particular procedure without medical instruction or supervision, and the extent to which a procedure is regarded as an unacceptable deviation from the "natural" process of human reproduction or from the "normal" concomitants of marriage. A perusal of the relevant, now voluminous, literature reveals the pervasive notion that scientific possibility cannot, and should not, determine ethical or social acceptability: the mere fact that advances in medicine are now able to remedy the

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[1] See, for example, Medical Research Council, "Research related to human fertilisation and embryology" (1982), 285 Brit. Med. J. 1480 (hereinafter referred to as "M.R.C. Statement"), at 1480; Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Report on Donor Gametes in IVF* (1983) (hereinafter referred to as "Victoria Report on Donor Gametes"), para. 6.32, at 47; and Canada, Health and Welfare Canada, *Report of the Advisory Committee on the Storage and Utilization of Human Sperm* (1981) (hereinafter referred to as "Health and Welfare Canada Report"), at xi.

[2] See, for example, the special rules recommended for ovum donation in Queensland, *Report of the Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters* (1984) (hereinafter referred to as "Queensland Report"), at 138-41. In a recent report by a committee in the United Kingdom, it was recommended that "the technique of embryo donation by lavage should not be used at the present time" or until the risks of donation by this method have been overcome: United Kingdom, Department of Health and Social Security, *Report of the Committee of Inquiry into Human Fertilisation and Embryology* (Cmnd. 9314, 1984) (hereinafter referred to as "Warnock Report"), para. 7.5, at 40.

effects of infertility is not perceived to be a conclusive argument in favour of any practice considered to be unacceptable by the community. We concur in this view of science and public policy.

While we do not believe that the question respecting the ethical and social propriety of the new reproductive technologies must necessarily be answered in the same way for each procedure, we are of the view that there are arguments, both for and against, that may be marshalled generally in respect of all means of artificial conception. It is to these common features that we now turn, after which we shall direct our attention to any unique aspects of individual technologies that may affect our conclusions.[3]

For some, the question of the propriety of the new procedures cannot be divorced from the issue of eligibility, dealing, *inter alia*, with whether otherwise ethically acceptable artificial conception procedures ought to be made available only to legally married couples, or whether "common law" couples and single women should also be eligible for participation. For the most part, however, we shall leave eligibility for subsequent discussion.[4] In a sense, this issue, while clearly of critical importance, forms but one aspect of the central question concerning the propriety of the new reproductive technologies themselves.

We begin first with what may now appear to be several rather trite, but nonetheless necessary, observations respecting the rationale for artificial conception: the bearing of children is regarded generally as vitally important, both at an individual and at a societal level; infertility is a disease affecting a very sizeable proportion of the child-bearing population; the treatment of infertility by surgery, drugs, or other traditional medical means cannot alleviate the plight of all infertile persons; fertile people may risk dysgenic reproduction by natural means; the number of infants available for adoption cannot meet the demand of infertile persons for children; and the new artificial conception technologies now offer hope for those who wish to have children but whose medical problems are not amenable to a solution by any other means.

That there are considerable public anxieties — based on ethical, moral, social, medical, and legal concerns — and, therefore, substantial controversy respecting the new techniques, does not, of course, detract from the very simplicity of the fundamental argument in favour of artificial conception. This ought not to come as a surprise. The unadorned nature of the argument reflects the basic goal and function of medical science, that is, to cure disease or alleviate its effects. To suggest that childlessness or dysgenic reproduction must simply be accepted as a necessary, albeit unfortunate, physical evil, and accordingly to prohibit treatment by means of artificial conception, would, in one sense, place infertility in a rather special category of affliction. It would do so because, under

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[3] A very useful examination of the arguments for and against the various technologies and procedures appears in the Warnock Report, *supra*, note 2, paras. 4.2-4.3, at 17-18 (A.I.H.); paras. 4.6-4.15, at 18-23 (A.I.D.); paras. 5.6-5.9, at 31-32 (I.V.F.); paras. 6.4-6.5, at 36 (egg donation); and paras. 7.2-7.3, at 39-40 (embryo donation).

[4] See *infra*, this ch., sec. 3(b)(i).

such a regime, it would be a disease for which treatment is possible, relatively safe, and often uncomplicated, but simply not permissible.

To preclude the use of a practicable and safe medical treatment clearly demands the existence of very compelling ethical, moral, and social arguments, for such prohibitory action runs counter not merely to the basic purpose of medicine, accepted by the community at large, but also to the goal of modern Western societies to provide for the welfare and betterment of their members.

It would seem that at the core of the argument espoused by many persons against the use of artificial conception lies the view that such conception is somehow "unnatural", that it violates the "natural" means of procreation: families should be founded and children conceived only by means of sexual intercourse. Allied to this view is the notion that marriage itself — the "bedrock" of the family — demands a coincidence between sexual intercourse and procreation. Many who hold these opinions have translated them into an absolute moral code that governs their reaction (that is, their fundamental antipathy) to all forms of artificial conception, whether or not performed within a marital union and whether or not donor gametes are used.

As we have said in other portions of this Report, the Commission acknowledges and respects the views of those persons who, for moral, ethical, social, or other reasons, reject the propriety of the new reproductive techniques *en masse*. However, the sincerity or tenacity with which they hold this opinion does not alter the simple fact that they espouse a view of *public* policy, as opposed to individual morality, that the Commission and, we believe, a majority of the community, do not share.

In the first place, we are greatly concerned about the plight of persons with genetically transmissible diseases and of infertile men and women who wish to found a family and, for medical reasons, cannot do so. Their frustration and lack of physical and emotional well-being are very real, and often threaten their stability and their relations with others. The welfare of such persons should not be denigrated by the suggestion, frequently voiced, that the time and effort expended on their incapacity would be better spent on the treatment of life-threatening or more debilitating diseases. As the Warnock Report stated, it is now accepted that the goal of medicine goes well beyond the preservation of human life.[5]

But, beyond any practical or utilitarian rationale for accepting the place of artificial conception in our society, we reject the contention that the treatment of infertility in this manner is "unnatural". If the proposition is merely meant to imply that the use of the new techniques constitutes an interference with nature, we vigorously question the import of this criticism: surely the medical treatment of any ailment by drugs, surgery, or other means must equally come under

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[5] Warnock Report, *supra*, note 2, para. 2.4, at 9. This viewpoint is exemplified in Ontario, for example, in the extent to which public funds are available under the Ontario Health Insurance Plan.

similar attack. As we have said, the role of medicine is precisely that — to interfere with the natural deterioration or malfunctioning of the body.

If, to probe deeper, it is suggested that artificial conception is "unnatural" essentially because it is an *unwarranted* interference with nature, we must respond, in part, as the Warnock Committee did, by noting "the ambiguity of the concepts 'natural' and 'unnatural' ".[6] The history of medicine and science bears witness to the constant tension between man's view of the "natural" (and, therefore, putatively correct) ordering of things and the attempts by doctors and scientists to dispel superstition and beliefs in the righteousness and immutability of the *status quo*. The "naturalness" of any particular thing or act is very much bound up with time and space. For an individual to eschew the new reproductive technologies because their existence and use violate his or her own moral or ethical code is one thing; to reject them on behalf of the larger community because they are somehow "unnatural" offers little, if anything, in the way of an argument founded on public policy considerations.

We also do not accept the arguments against artificial conception that, we have said, are allied to the fundamental one described above. For example, like several other committees before us,[7] we do not believe that separating intercourse from procreation violates the sanctity of marriage or of the family or evinces a breakdown in these relationships. Indeed, it has been contended that, given the frustrations of infertility or genetic risk and childlessness, the continuing desire to participate in an artificial conception programme manifests a deep commitment to the marriage and to the anticipated child.[8] There is, of course, no mathematical or other precise formula by which to measure the nature or level of such commitment, but we see no reason to accept the proposition that artificial conception *per se* is the forerunner of marital or family disharmony and dislocation.

The preceding views expressed by the Commission concerning the general propriety of artificial conception have not distinguished between the various technologies. We have focused essentially on basic principles rather than on any unique characteristics of the procedures.

But, clearly, there are certain differences that have given rise to particular concerns and sometimes, as a consequence, opposition, even where artificial conception has not been rejected generally on broader moral, ethical, or social grounds. For example, with respect to I.V.F., a major criticism of the use of the procedure centres around the disposition of any "surplus" embryos, that is, ova fertilized *in vitro*, originally intended to be used if necessary, but, as it happens,

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6 *Ibid.*

7 See, for example, *ibid.*, para. 4.10, at 21, and paras. 4.14-4.15, at 22; Health and Welfare Canada Report, *supra*, note 1, at xi-xii, 1-2, 37, and 42-44; and Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Issues Paper on Donor Gametes in IVF* (1983), para. 3.2.6, at 14, and para. 3.2.7, at 16 (but see *ibid.*, para. 3.2.7, at 15, and para. 3.3.4, at 19).

8 See *supra*, note 7.

not actually transferred to the uterus of the woman. Many would found their rejection of I.V.F. on the basis that the implications or consequences of this fact — the wastage of the embryos or, perhaps, their use for the purpose of experimentation — inevitably render the whole procedure morally unacceptable, or at least render it so where the guidelines of the hospital or clinic in question do not require the implantation of all fertilized ova.

Another argument that focuses attention on the consequences of the technique, rather than on fundamental ethical principles, relates to the donation of an ovum by means of *in vivo* fertilization and lavage. Leaving aside for the moment the argument based on a general rejection of gamete donation itself, it has been said that the risk of a resulting, unintended pregnancy in the ovum donor, because the embryo may not be washed out, is sufficient to warrant prohibition of this form of donation.[9]

Unquestionably, one of the arguments most strenuously advanced by opponents of artificial conception concerns the use of donor gametes. For some, a distinction is drawn between artificial conception without donor gametes and artificial conception with such gametes; for others, the fact of donation adds further emphasis to a more deep-seated moral antipathy to any type of artificial reproduction.

The arguments against such reproduction, based on the donation of gametes, may take several forms, for example, focusing on the effect of donation on the marriage, or focusing on its effect on the future child.

Whereas A.I.H. is the simplest and least controversial[10] of the technologies and, to most persons, is the closest to natural insemination (since, in both cases, the gametes of the spouses are brought together *in vivo*), A.I.D. and I.V.F. involving donor gametes are regarded by some as representing "the introduction of a third party into what ought to be an exclusive relationship".[11] As the Warnock Committee pointed out, this action is often seen as morally repugnant in itself and a threat to both the marriage and the family.[12] This, in turn, frequently leads to the conclusion that artificial conception with donor gametes is fundamentally harmful to society, which is based, it is said, on the twin social pillars of marriage and the family.

Not only is the use of donor gametes seen by some as a violation of the exclusivity inherent in a marital union and of the sanctity of the family, but it is also seen as harmful to the artificially conceived child. Again, there are several

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[9] See Warnock Report, *supra*, note 2, para. 7.2, at 39, and para. 7.5, at 40. One study indicated that 8-10% of ovum donors by this method become pregnant: see Bustillo *et al.*, "Nonsurgical Ovum Transfer as a Treatment in Infertile Women: Preliminary Experience" (1984), 251 J. Am. Med. Ass'n 1171.

[10] See the views expressed in the various reports summarized in the Appendix to this Report.

[11] Warnock Report, *supra*, note 2, para. 4.10, at 20.

[12] *Ibid.*

facets to this argument. For example, it is said that the wish of many parents to shroud the nature of the child's biological origins in secrecy is essentially a form of deception, which must be regarded as undesirable in itself, and which may detrimentally affect the emotional stability of the child and the parents.

However, at the same time it is also contended that openness and disclosure may be dangerous. Clearly, this may be so where the child's origins are divulged by accident, in the heat of a family quarrel, or in a custody or child maintenance dispute. But it has been suggested that children artificially conceived with donor gametes "may feel obscurely that they are being deceived by their parents, that they are in some way different from their peers, and that the men [or women] whom they regard as their fathers [or mothers] are not their real" parents.[13] Since certain persons are of the view that disclosure of origins is both inevitable and morally right in principle, but that only psychological harm can result from such disclosure, they are driven to the conclusion that artificial conception itself is the evil to be prohibited.

The Commission acknowledges the force of the arguments relating to the implications of gamete donation, particularly insofar as they deal with the likely or potential effects on the child. With respect to the consequences for a marriage, we recognize that pre-conception strains on an infertile or genetically diseased couple, and stress produced by undergoing artificial reproduction treatment, may be substantial and, in some instances, irremediable.

However, we wish to echo the conclusion of the Warnock Committee that "the donor is [not] *necessarily* a threat to the stability of the relationship" between husband and wife.[14] It is not possible to state categorically that all married persons will react adversely to gamete donation. Some clearly will react in this manner; others will not. But we are of the view that this possibility does not warrant the wholesale prohibition of artificial conception services involving donor gametes, a prohibition that would affect both stable and potentially unstable (and, therefore, unsuitable) couples. Rather, we believe that the guidelines that we shall subsequently recommend concerning eligibility to participate in an artificial conception programme will be sufficient to eliminate unsatisfactory participants.[15] Personal moral codes will serve to reduce further the candidates for the new reproductive techniques. But for many other persons, the social and psychological effects of infertility or the genetic hazards of natural reproduction are simply too great to warrant outright prohibition.

In a similar vein, the Commission has also come to the conclusion that the possible consequences of donation *vis-à-vis* the child are not such as to warrant prohibition merely because gametes are donated. As the Warnock Report stated, "[a]n AID child is a child very much wanted: a couple may have had to endure years of waiting and will consequently cherish the child".[16] We believe that this

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[13] *Ibid.*, para. 4.12, at 21.

[14] *Ibid.*, para. 4.11, at 21 (emphasis in original).

[15] See *infra*, this ch., secs. 3(b)(i) and (ii).

[16] Warnock Report, *supra*, note 2, para. 4.15, at 22.

view is equally appropriate with respect to all the technologies. Obviously, no one can guarantee that the parents and the child will be able to deal with the fact of gamete donation in a satisfactory manner, no more than a similar guarantee is possible in the case of adoption. Once again, however, we wish to emphasize that our subsequent recommendations regarding eligibility for participation in an artificial conception programme are designed to ensure, as much as possible, that the child will be reared in a healthy home environment. As a society, we do far less for naturally conceived children.[17]

The preceding consideration of the arguments for and against artificial conception reflects, for the most part, the main currents of thought on the subject. That is not to suggest that opponents of the new technologies have not focused attention on other aspects, such as, for example, the frequency of individual donor use, possible accidental incest or marriage involving a donor's children, and research and experimentation on embryos.

Insofar as these and other matters are concerned, the Commission has expressed its view that the proposals made in subsequent sections of this chapter are designed to meet these criticisms within a framework that is socially and ethically acceptable to the majority of the community. However, there is one procedure, alluded to earlier, that caused the Warnock Committee, and causes us, some particular concern. We pointed out that, where an egg is fertilized *in vivo* and then lavage is used, there is a relatively high risk of pregnancy in the embryo donor where the procedure does not succeed in washing out the embryo. This risk prompted the Warnock Committee to recommend that "the technique of embryo donation by lavage should not be used at the present time".[18]

As we have said, the nature and extent of the risk involved in the use of lavage is significant and of concern to us. However, there are factors that favour accepting this form of treatment. First, ovum donation by *in vivo* fertilization and lavage may be the only means by which a woman may be able to bear a child. In this connection, it should be mentioned that, in order to produce a donated egg where fertilization is to take place *in vitro*, the donated egg must be removed by surgery, with all its attendant risks. As the Warnock Committee stated, "[e]mbryo donation by lavage is, according to its advocates, much safer for the donor as it does not require general anaesthesia, and a simple and safer procedure is involved; moreover, for the embryo, there is the advantage of a shorter interval *in vitro* during which time it might deteriorate".[19]

Secondly, the risk of an unwanted pregnancy in the donor would be a matter to which the attending physician is required to direct the donor's attention, since she must give her free and informed consent to the procedure. Since, as we shall

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[17] See, generally, *supra*, ch. 4, at text accompanying notes 1-4.

[18] Warnock Report, *supra*, note 2, para. 7.5, at 40. With respect to resulting pregnancies, see *supra*, note 9. The Warnock Committee was not enthusiastic about any form of embryo donation, but accepted the procedure where donated ova and sperm are brought together *in vitro*: *ibid.*, para. 7.4, at 40.

[19] *Ibid.*, para. 7.1, at 39.

see,[20] our proposals would preclude minors from donating embryos in this fashion, the fear that the risk of pregnancy would not be completely understood or appreciated, or that the consent would somehow be suspect, should be dispelled. Accordingly, we see no reason to treat donation by lavage in a manner different from the manner in which we treat the other reproductive technology procedures. It bears mentioning that even the Warnock Committee did not reject the procedure as a matter of principle; its objection was basically that the technology has not yet developed to the point where the risk of pregnancy is acceptable.

Our conclusion in respect of the propriety of the artificial reproductive technologies should now be clear. We began this section with the simple argument in favour of their use and acceptability: for some persons, artificial conception — whether it is artificial insemination or I.V.F., and whether or not gametes or embryos are donated — offers the only opportunity of having a child.

Having rejected the notion that the new techniques are morally repugnant because they are "unnatural" procedures violating the sanctity of marriage and of the family, we believe that the fundamental arguments against artificial conception, whether ethical, moral or social, cannot prevail in the case of A.I.H. And we take this view not essentially because, as has been suggested by some, A.I.H. is, as an ethical matter, the closest artificial technique to natural reproduction. As we have indicated, we endorse the use of artificial conception technologies as legitimate and ethically acceptable advances in medicine, designed to alleviate the effects of infertility or genetic hazards and, therefore, to further the welfare of a relatively substantial segment of society. For this reason, then, we do not distinguish I.V.F. without donor gametes from A.I.H., insofar as the propriety of the procedure is concerned. While the greater complexity and far more substantial intervention by the medical profession in the case of I.V.F. may appear to represent a more significant departure from natural reproduction, the Commission would prefer not to view the question of its legitimacy in this way. It, too, is ultimately justified by its purpose, its use by persons committed to becoming parents, and its results.[21]

We have also rejected the argument that the use of donor gametes should fundamentally alter our view of the new technologies. Unlike adoption — which has become increasingly difficult in the case of infants — the use of donated sperm or donated ova permits a couple to have a child biologically related to one of them. Given this intimate connection and, as we shall see in a subsequent section,[22] given our recommendation that artificial conception procedures should

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20 See *infra*, this ch., sec. 3(c)(ii).

21 See The Society of Obstetricians and Gynaecologists of Canada, "Statement on In-Vitro Fertilization and Embryo-Transfer", published in the Bulletin of the Society, Vol. VI, No. 3, May/June, 1984, at 4 (hereinafter referred to as "SOGC Statement"). The Society stated (at 4): "The Committee [on Endocrinology and Fertility] feels that In-Vitro Fertilization (IVF) is a recognized and acceptable form of treatment for infertility, not treatable by other means".

22 See *infra*, this ch., sec. 3(b)(i).

be available, in the case of a couple, only where both parties, and the union, are stable, we believe that the prospects for the child are favourable indeed.

Finally, we have concluded that embryo donation ought not to be treated differently from gamete donation. For a small group of people, the former type of donation offers the only chance to have a child. This group should not be denied the advantages offered to those whose desire for a child can be accommodated simply by the donation of sperm or ova. The fact that both the man and woman are infertile or genetically impaired is, from a moral, ethical, and social perspective, an entirely fortuitous event.

Accordingly, the Commission recommends that, as a matter of general principle, artificial conception technologies, that is, artificial insemination, I.V.F., and *in vivo* fertilization followed by lavage, should continue to be available and accepted as legitimate techniques to be used (except where a fertile and genetically healthy single woman receives treatment) where medically necessary to circumvent the effects of infertility or genetic impairment.

The mere endorsement of the new reproductive technologies does not, of course, ensure their continued use on a stable, legal foundation. As we have seen in chapter 3, the present law deals only inadvertently, if at all, with the many novel issues raised by artificial conception. We stated there that the law must respond positively and unambiguously to the new technologies if they are to flourish on a solid legal footing. Accordingly, the Commission further recommends that the use of the new artificial conception technologies should be subject to the recommendations proposed in subsequent sections of this chapter. These recommendations deal with the critical component parts of a regulatory scheme, from eligibility to participate in an artificial conception programme, to parentage and the status of artificially conceived children, consents, record-keeping, gamete banks, experimentation, and several other vital issues.

As we indicated in chapter 4, the nature of our response to the method of regulation need not necessarily be uniform from issue to issue. Legislation, judicial determination, and the rules and practices of the medical profession may, and will, be used in various ways to deal with particular problems. Nor have we attempted to establish a scheme that would codify all facets of the relatively new, and rapidly developing, medical technologies. We agree in principle with the Warnock Committee's view that there may well be "real dangers in the law intervening too fast and too extensively in areas where there is no clear public consensus".[23]

However, the Commission believes that, in some instances, judgments, based on our perception of sound public policy and law reform, may have to be made even where "there is no clear public consensus". The public may be more or less evenly divided in its views; yet the present law may be unsatisfactory to all parties. To await a consensus may be a luxury that we can ill afford; in the meantime, the uncertain and unsatisfactory state of the law may prejudicially affect all participants in artificial conception services, and particularly their

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[23] Warnock Report, *supra*, note 2, para. 1.9, at 7.

children. In such circumstances, while we must be guided in part by our view of community values, decisions must be taken even though they may not necessarily reflect a clear consensus.

The recommendations that follow reflect, then, our attempt to marry our perception of community values with our perception of sound public policy and progressive law reform. For the most part, the regulatory scheme proposed by the Commission virtually ignores artificial insemination by a husband or by a partner in a nonmarital relationship (A.I.H.). Indeed, unless expressly stated otherwise, we do not deal with artificial insemination where the sperm used is that of the recipient's husband or partner, since generally we do not believe that A.I.H. should be the subject of regulation. Of all the technologies, A.I.H. has the widest acceptance and poses the fewest legal and other problems.

Moreover, unlike I.V.F., A.I.H. does not involve a great expenditure of public funds; nor does it unduly strain the time and resourses of hospitals, physicians, and other scientists. This relatively limited investment of time and money in the case of A.I.H. helps to explain why we believe that, by and large, A.I.H. may be left alone, to be governed by the present law and practice, as amended by those few proposals that we make.

The format of the remaining sections is as follows. First, we shall deal with those issues that are common to all the technologies (again, bearing in mind that A.I.H. is not included unless expressly provided). Secondly, additional issues relating to the fertilized ovum outside the body will be considered. Finally, we shall set forth our proposals for reform in respect of surrogate motherhood.

3. GENERAL RECOMMENDATIONS FOR REFORM

(a) ARTIFICIAL CONCEPTION SERVICES AS THE "PRACTICE OF MEDICINE"

In chapter 3 of this Report,[24] the Commission sought to determine whether the provision of artificial conception services constitutes the "practice of medicine", thereby bringing the procedures under the regulatory purview of the *Health Disciplines Act*[25] and restricting them to persons licensed to practice medicine under Part III of that statute. Although, as we noted, others may be authorized "to perform specified acts in the practice of medicine under the supervision or direction" of a licensed doctor,[26] apart from this exception, engaging in the practice of medicine by unlicensed persons is an offence under the Act.[27]

We need not recanvass the question whether artificial insemination or

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[24] *Supra*, ch. 3, sec. 2.

[25] R.S.O. 1980, c. 196.

[26] *Ibid.*, s. 50(k).

[27] *Ibid.*, ss. 52 and 67.

I.V.F., or any of the allied procedures, is the practice of medicine under existing law.[28] Rather, our concern here is with the merits and demerits of statutorily declaring artificial conception procedures to be the practice of medicine. Clearly, the attempt to preclude unlicensed persons from performing certain procedures having an obvious medical component serves to promote public health and welfare. The designation of a procedure to be the practice of medicine does not merely permit only licensed doctors to undertake it; it also obliges the College of Physicians and Surgeons of Ontario to regulate the practice[29] and therefore, for example, to "establish, maintain and develop standards of qualification and practice"[30] and of "professional ethics",[31] all in the public interest.[32]

The senior councils of the College have lay representation[33] and, through the regulatory control of the Minister of Health,[34] the College is at least indirectly accountable to the general public. Furthermore, it functions under legislation that can be amended by the provincial Legislature, and regulations passed under the the *Health Disciplines Act* are made by the Council of the College with the approval of the Lieutenant Governor in Council and with prior review by the Minister of Health,[35] in order to reflect public perceptions on questions of health. The College has the professional expertise to regulate matters of technical medical detail and, under the Act and regulations, individual medical practitioners may be monitored and disciplined for professional misconduct, and complaints may be made by the public to the College.[36]

But a declaration that a certain procedure is the practice of medicine also has another dimension to it, not related to the quest to promote public health and safety. Such a declaration, by concentrating the provision of the applicable services in the hands of licensed doctors alone, may well result in the inaccessibility of these services to persons who cannot pay for them, particularly where public health insurance funds are unavailable, or who are geographically too distant from a licensed doctor. Accordingly, the matter of designating artificial conception services as the practice of medicine may be somewhat more complicated than would appear at first blush. This issue may be seen to be even more complicated if one adds to the equation the view that the principle of "individual

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28 While the complexity of I.V.F. and its dependence on the exercise of medical skills and judgment make it more likely to be considered a medical procedure, the relative simplicity of artificial insemination renders its legal characterization less obvious.

29 *Health Disciplines Act, supra*, note 25, s. 46(2)(a).

30 *Ibid.*, s. 46(2)(c).

31 *Ibid.*, s. 46(2)(d).

32 But see the view of Garrow J.A. in *In re Ontario Medical Act* (1906), 13 O.L.R. 501 (C.A.), at 511-12.

33 See *Health Disciplines Act, supra,* note 25, s. 48(2)(b), respecting the Council of the College. See, also, *ibid.*, s. 54(1)(c) (Executive Committee), s. 55(1)(c) (Registration Committee), s. 57(1)(c) (Complaints Committee), and s. 59(1) (Discipline Committee).

34 See, for example, *ibid.*, s. 49.

35 *Ibid.*, s. 50.

36 See, generally, *supra*, ch. 3, sec. 3(d).

autonomy" mandates an absence of state interference in the process, particularly where A.I.H. is involved.

The necessary balancing of interests implicit in the preceding discussion requires us to weigh the need for medical care and supervision against the desire of people to make their own arrangements.

Insofar as the techniques involved in I.V.F. are concerned, the acquisition of ova and the subsequent placement of a fertilized ovum into an appropriately prepared uterus are dependent upon medical skills. The same conclusion applies to the acquisition, by lavage, of ova fertilized *in vivo*. In some cases, where, for example, an ovum is acquired by a surgical procedure and under a general anesthetic, the risks to the patient are clear.

As we have seen in chapter 3, artificial insemination is a simpler procedure than I.V.F. Nevertheless, in the case of artificial insemination, infection and penetration of the cervix by instruments, and injections of semen into the cervix, potentially causing severe shock or death, are very real risks, however infrequently they may arise.

Where donor gametes are considered for use in an artificial conception procedure, different factors weigh in the balance. First, there is the question whether the use of donor gametes is advisable. Before a woman considers the use of donor semen, for example, she should be counselled concerning the prospects, risks, and advantages of conceiving the genetic child of her partner. If he has failed to make her pregnant naturally, due to a low sperm count, for instance, means may be applied to treat him or to accumulate his sperm before insemination in order to increase the chance of pregnancy. Accordingly, unnecessary recourse to donor gametes may be avoided through medical care.

Where the use of donor gametes appears appropriate, the woman or couple involved should be assured of the donor's suitability to serve as such, determined by reference to the donor's genetic fitness and to individual physical characteristics matched to the woman or woman's partner, or both. These matters require competent medical history-taking and assessment.

Therefore, while, for example, the physical application of donated sperm is a relatively simple matter, the range of counselling, donor selection, and instruction of patients that should precede the procedure, and the subsequent follow-up care to ascertain its effectiveness, depend upon medical knowledge and skills. And where donated ova are required, the case for medical management of the procedure is obviously much more clear and convincing.

A review of reports from other jurisdictions reveals a general belief that the treatment of infertility by means of the new reproductive technologies ought to be undertaken only by or under the supervision or direction of a licensed physician.[37] The express or implicit justification for this view relates to the need to

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[37] See, for example, Warnock Report, *supra*, note 2, para. 3.1, at 15; Queensland Report, *supra*, note 2, at 105 *et seq.*; Law Society of Scotland, *Draft Submission on Government*

protect the public from the risks and dangers that may arise where unqualified persons engage in procedures that only licensed medical doctors have the expertise to practise.

The Commission endorses this view, not only insofar as it deals with the prevention, detection, and treatment of health hazards relating to the patient herself, but also insofar as it deals with the prevention of avoidable harm to children artificially conceived with donor gametes.

We believe that, because of the nature of the procedures, the case for declaring I.V.F. and the procedures respecting ovum or embryo donation to be the practice of medicine is very compelling. Admittedly, it is not impossible for properly trained scientists who are not medical doctors to master the techniques involved. Yet, on balance, the Commission does not wish to see such persons engaging in the practice of artificial conception, at least when they have not been authorized to act under the supervision or direction of a licensed physician; however qualified they might be in their own particular field, they may be ill-equipped to prevent, detect, or treat medical complications that may arise during or after the procedure.

The case for declaring artificial insemination to be the practice of medicine is, we recognize, more controversial, given its relative simplicity and its successful performance by laypersons to date. However, we are of the view that the risks to the woman and to the child are significant enough to warrant intervention as a matter of public policy.

For the reasons advanced above, the Commission recommends the enactment of legislation expressly providing that artificial conception procedures, that is, artificial insemination (including A.I.H.), I.V.F., and *in vivo* fertilization followed by lavage, constitute the "practice of medicine" under the *Health Disciplines Act.* Under such legislation, artificial conception procedures could be performed only by licensed members of the College of Physicians and Surgeons of Ontario or by other persons specifically and legally authorized to perform such services under the supervision or direction of a member.[38]

The Commission has also considered the question whether legislation should go further and require physicians to obtain a special licence or to practise in a

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Inquiry into Human Fertilisation and Embryology (1983) (hereinafter referred to as "Law Society of Scotland Report"), at 6; and Law Reform Commission of Saskatchewan, *Tentative Proposals for a Human Artificial Insemination Act* (1981) (hereinafter called "Law Reform Commission of Saskatchewan Report"), at 1-12, recommendation (3), and Draft Act, ss. 3 and 24.

38 We have been advised that, in September, 1982, the Advisory Committee on Special Procedures of the College approved the performance of artificial insemination by specially trained registered nurses. However, while nurses are, in fact, performing artificial insemination, discussions apparently are continuing between the College of Physicians and Surgeons of Ontario and the College of Nurses of Ontario concerning whether the practice must be specifically authorized by the Council of the College of Physicians and Surgeons of Ontario, or whether it is a nursing skill that may be regulated by the College of Nurses of Ontario.

specially licensed health facility in order to perform artificial conception procedures, a view espoused in several reports from other jurisdictions.[39] The purpose of this requirement, like the purpose of statutorily declaring artificial conception services to be the practice of medicine, is fundamentally to exercise control and supervision in order to protect the public health and welfare.

Given our preceding recommendation respecting the role of the medical profession in artificial conception, it should be clear that the Commission fully supports the attempt to promote community health standards and to protect recipients and children involved in artificial conception. However, not every measure of control is necessarily in the public interest; there must be a perceived goal that cannot otherwise be realized without such intervention. We do not believe that a further overlay of licensing, involving a new or expanded bureaucratic involvement in health care, is required to protect the community or its constituents. As we have said earlier in this section and in chapter 3, the nature and scope of the *Health Disciplines Act* and the regulations made under it, the monitoring, disciplinary control, and public accountability of the College of Physicians and Surgeons of Ontario, the jurisdiction of the College to establish binding rules or standards in respect of artificial conception practices, the ultimate control by the Ministry of Health, and the professional expertise and ethics of the medical profession itself, offer, along with the further proposals made in this chapter, a sufficient measure of supervision and regulation of artificial conception services in this Province. Accordingly, we are of the view that physicians should not be required to obtain a special licence or to practise in a specially licensed health facility in order to perform artificial conception procedures.

(b) Eligibility for Participation in an Artificial Conception Programme

(i) Criteria for Assessment: Marital Status and Other Matters

One of the most controversial issues respecting the new reproductive technologies concerns eligibility to participate in an artificial insemination or I.V.F. programme, and, more specifically, the question of marital status. In the reports canvassed by the Commission, in the submissions made to us, and in the literature, this critical, threshold issue has been hotly and inconclusively debated. The debate has centred on matters of ethics, religion, private morality, public good, and social policy; it has focused on the importance of the family and

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[39] See, for example, Warnock Report, *supra*, note 2, para. 13.7, at 77; Victoria Report on Donor Gametes, *supra*, note 1, paras. 3.40-3.41, at 30, and, from the same Committee, *Interim Report* (1982) (hereinafter referred to as "Victoria Interim Report"), para. 5.8.1, at 21-22; British Medical Association, Working Group on Human In Vitro Fertilisation, "Appendix VI: Interim report on human in vitro fertilisation and embryo replacement and transfer" (1983), 286 Brit. Med. J. 1594 (hereinafter referred to as "B.M.A. Working Group Report"), para. (4), at 1594. However, a system of licensing A.I.D. doctors was rejected in British Medical Association, Board of Science and Education, "Appendix V: Report of Panel on Human Artificial Insemination", Brit. Med. J. Supplement 3, Vol. II, April 7, 1973, para. 24, at 4.

marriage as the bedrock of society; and it has ultimately concerned itself, as we believe it must, with different perceptions of what constitutes the best interests of children conceived by artificial means.

Much of the public discussion of, and antipathy to, artificial reproduction is based on the apprehension that "unsuitable" persons may use the new technologies to become parents. Many who, reluctantly or otherwise, accept or acknowledge that virtually no legal controls can be applied to curb reproduction among "unsuitable" persons who are fertile[40] argue that artificial conception services should not be made available to such persons: in a sense, since the means of control are available in the latter case, such means should therefore be used. Others have rejected this type of intervention in the context of eligibility, stressing the alleged right of individual reproductive autonomy and the conceptual anomaly of controlling parents using artificial conception while ignoring parents who conceive naturally.

The paramountcy of the interests of the artificially conceived child helps us to put the issue of eligibility in what we believe to be its proper, child-oriented perspective, a perspective reinforced by the Terms of Reference of this Report and by the obvious public interest in the welfare of children. Since we are firmly of the opinion that our proposals for reform must be animated by our perception of the best interests of artificially conceived children, it follows that we do not view the matter of eligibility as predominantly or essentially applicant-oriented, pertaining primarily to the gratification of the potential participants. While we have endorsed the role of artificial conception in order to alleviate the effects of infertility or genetic impairment in such persons, this is not tantamount to an unrestricted acceptance of the right of *all* infertile or genetically impaired persons to participate in an artificial conception programme. Artificially conceived children, and the public, would not be well served by such an unfettered right.

The Commission has canvassed this matter generally in chapter 4, rejecting what it called the "private ordering" approach to artificial conception in favour of a modified state regulatory approach. We noted that some persons are emotionally ill-equipped to understand or cope with the unique problems of engaging in an artificial conception programme and of bearing and rearing the resulting child, especially where donor gametes are involved. Our general conclusion that the law must impose a degree of regulation in the unique case of artificial conception — regulation that is neither desirable nor practicable in the case of natural reproduction — is particularly apposite when considering the specific issue of eligibility for participation in an artificial conception programme. It is at this initial juncture that the state is able to intervene in a manner that will ensure, as much as possible, that the future child will be born into, and reared in, a satisfactory home environment. Any subsequent state intervention that might take place — if, for example, the child is declared to be "in need of

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[40] See Somerville, "Birth Technology, Parenting and 'Deviance' " (1982), 5 Int. J. Law and Psychiatry 123.

protection"[41] — is clearly not unimportant, but operates only at a later stage, on an *ad hoc* basis, and in rather extreme cases.

Having concluded, then, that the matter of eligibility must not be left simply to the dictates of persons seeking artificial conception services, it remains for us to set forth the range of alternatives and, finally, the standards or criteria to which we subscribe, bearing in mind that our analysis of the options and our final decision must be viewed from the perspective of the best interests of artificially conceived children.

The Commission recognizes, of course, that what may be called "suitability for parenthood" is an amorphous social and psychological concept, fluctuating from time to time. Yet, notwithstanding the fluidity and ambiguity of the concept, it is noteworthy that most of the reports canvassed by the Commission deal expressly or implicitly with the subject and offer (or, frequently, assume) certain conclusions.[42] The critical issue in respect of "suitability for parenthood" relates to the question whether a participant in an artificial conception procedure must be legally married, or at least living in some sort of stable relationship, or whether she may be single and not involved in any type of union. The question whether marriage ought to be a precondition to eligibility

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41 See *Child Welfare Act,* R.S.O. 1980, c. 66, Part II. See, also, Part III of the new *Child and Family Services Act, 1984,* S.O. 1984, c. 55. During the final editing of this Report, the *Child and Family Services Act, 1984,* was enacted, to come into force on a day to be named by proclamation of the Lieutenant Governor. While the Report will continue to refer to the *Child Welfare Act,* reference will also be made to the *Child and Family Services Act, 1984.*

42 In some cases, the discussion involves a more or less general consideration of suitability, drawing on several factors as illustrative of what is meant. For example, a Royal Commission in British Columbia put the issue in this way:

> Who, then, should be eligible for AID? One approach to a decision might be the development of a test of 'ability to nurture', which would involve guidelines describing generally the types of emotional and social variables which seem essential to success in parenting a child. The potential recipient would be evaluated on her ability to meet these guidelines and would not be eliminated from consideration just because of her marital status. This 'ability to nurture' test would include the concepts of guidance and a stable home environment as well as the recipient's ability to provide for the child's needs....
>
> The guidelines, moreover, would also involve an evaluation of the physical and mental health of the potential recipient. It is suggested that an attempt to judge the recipient in terms of her conformity to prevailing mores about marriage and lifestyle should be made in the context of their current state of flux and, more importantly, should concentrate on the conduct of the individual which can be shown to relate quite directly to her ability to nurture. As suggested above, the central concern in evaluating the prospective AID recipient should focus directly (and singularly) on her ability to be a successful parent. It is the potential child's interest which must be paramount in this situation.

British Columbia, Royal Commission on Family and Children's Law, *Ninth Report of the Royal Commission on Family and Children's Law: Artificial Insemination* (1975) (hereinafter referred to as "British Columbia Royal Commission Report"), at 10-11.

raises, in turn, a further question, dealt with in chapter 3 of this Report, namely, whether legislation imposing such a requirement would, for example, violate the provisions of the *Canadian Charter of Rights and Freedoms*[43] or the Ontario *Human Rights Code, 1981.*[44] We do not intend to review the contending arguments here, except to note that discrimination based on marital status is prohibited. Indeed, it was precisely for this reason — the perceived conflict with provincial human rights legislation if all but married women were precluded from undergoing artificial insemination — that the majority of the Law Reform Commission of Saskatchewan recommended that, for the time being at least, the law should not prescribe criteria for the selection of recipients.[45]

Most of the other bodies that have turned their attention to the question of marital status have either emphasized that a two parent family is preferable[46] or have ignored the standing of single women, although the British Columbia Royal Commission on Family and Children's Law would not eliminate anyone from consideration "just because of her marital status",[47] and the Royal College of Obstetricians and Gynaecologists in the United Kingdom would not rule out I.V.F. for single women, notwithstanding its "grave reservations".[48]

With respect to the status of unmarried, cohabiting, couples, most of the legislation described in the Appendix to this Report implicitly countenances access by such persons to artificial conception services, but almost all the legislation actually deals with the question only in the context of the status of the child;[49] access to services is, therefore, assumed. Only the Victoria *Interim Report* appears to have suggested that unmarried couples should be precluded from participation, although, even here, the Report did leave the door open for possible participation in the future.[50] Unfortunately, this critical issue was not canvassed in the later Report.[51] However, it bears mentioning that the Victoria *Infertility (Medical Procedures) Act* 1984, provides, with respect to eligibility,

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43 *Canadian Charter of Rights and Freedoms*, being Part I of the *Constitution Act, 1982*, which is itself Schedule B of the *Canada Act 1982*, c. 11 (U.K.).

44 *Human Rights Code, 1981*, S.O. 1981, c. 53.

45 Law Reform Commission of Saskatchewan Report, *supra*, note 37, at 1-4.

46 See, for example, Warnock Report, *supra*, note 2, para. 2.11, at 11-12: "... as a general rule it is better for children to be born into a two-parent family, with both father and mother, although we recognize that it is impossible to predict with any certainty how lasting such a relationship will be".

47 British Columbia Royal Commission Report, *supra*, note 42, at 10.

48 United Kingdom, Royal College of Obstetricians and Gynaecologists, *Report of the RCOG Ethics Committee on In Vitro Fertilisation and Embryo Replacement or Transfer* (1983) (hereinafter referred to as "RCOG Report"), para. 6.1, at 6. It should also be noted that, under the Victoria *Infertility (Medical Procedures) Act* 1984, No. 10163, I.V.F. may not be performed on single women: see ss. 10(3)(a), 11(3)(a), 12(3)(a), and 13(3)(a). See, also, text accompanying note 53, *infra*.

49 To be considered *infra*, this ch., sec. 3(d), esp. sec. 3(d)(i).

50 Victoria Interim Report, *supra*, note 39, para. 5.8.5, at 24.

51 Victoria Report on Donor Gametes, *supra*, note 1.

that a married woman includes a woman who is "living with a man as his wife on a *bona fide* domestic basis although not married to him".[52] In addition, it is made clear that a single woman is not eligible for treatment.[53]

With respect to whether existing Ontario law might have a bearing on the policy issue whether single women ought to be at least eligible for consideration in an artificial conception programme, one may look, by way of rough analogy, to adoption legislation. Under the *Child Welfare Act*,[54] single persons cannot be considered as adoptive parents except in "special circumstances",[55] such as arise when an orphaned or abandoned child has an unmarried relative who wishes to adopt the child and is otherwise qualified to do so. However, some movement away from this position is reflected in Part VII of the new *Child and Family Services Act, 1984*.[56] This new policy is explained in the background paper prepared by the Ministry of Community and Social Services:[57]

> Aside from a recognition of the changing concepts of marriage and the family, requirements imposed by Ontario's Human Rights Code have contributed to the elimination of the 'special circumstances' qualification for unmarried adoptive applicants. *Hence, single applicants will be eligible for consideration as adoptive parents.* It is, however, anticipated that in most cases adoption practice would continue to reflect a strong preference for a two-parent family based on considerations of the child's best interests.

It should be noted that, in addition to the perceived or possible effect of human rights legislation, the Ministry mentioned "the changing concepts of marriage and the family". While consideration of the best interests of existing children eligible for adoption may not be completely congruent with consideration of the best interests of artificially conceived children, the factors noted in the Ministry statement quoted above are germane to both cases: in adoption and artificial conception, the issue is who should be eligible for consideration as prospective parents.

The Commission is acutely aware of the controversy that surrounds the vital question of eligibility. Indeed, the absence of a clear public consensus on this issue is reflected in the views expressed by individual members of the Commission. However, 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.

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52 *Supra*, note 48, s. 3(2)(a)(i).

53 *Ibid.*, ss. 10(3)(a), 11(3)(a), 12(3)(a), and 13(3)(a).

54 *Supra*, note 41.

55 *Ibid.*, s. 74.

56 *Supra*, note 41.

57 Ontario, Ministry of Community and Social Services, *The Child and Family Services Act: Draft legislation and background paper* (1983), at 136 (emphasis added).

As we have said, such a restriction would appear to contravene human rights legislation applicable in this Province. Moreover, any *a priori* exclusions based simply on membership in a particular group (such as married persons) would automatically eliminate from consideration single persons or unmarried couples who, by any standard, would make suitable parents.

A majority of the Commission believes that there are many variables that must be considered, including the home environment, the physical and mental health of the prospective parent or parents, their emotional reaction to artificial conception and its real or potential frustrations, the marital status of the parties and, where married or in a *de facto* relationship, the stability of the union.

Accordingly, a majority of the Commission[58] recommends that stable single women and stable men and women in stable marital or nonmarital unions should be eligible to participate in an artificial conception programme.[59] We wish to emphasize that implementation of this proposal would not entitle any person, whether married or not, to artificial conception services. Rather, the proposal deals first with eligibility, affording equal opportunity to all persons to apply for consideration for services, and, secondly, with their stability, focusing on the human factors involved, and not on the matter of status.

Our proposal is intended, therefore, to permit participation in an artificial conception programme only by those persons who, we believe, are likely to offer a proper home environment for the child. While we have left the door open to single women to apply, we do not envisage either a rash of applications by such women, nor a substantial change in the number of single women artificially inseminated.[60] Indeed, it is our view that, as a general rule, the welfare of children is better served when they are reared in a two parent family. We expect that this belief, which mirrors the perception of most child pyschiatrists, social workers, and other knowledgeable professionals, as well as that of the general community, will continue to be reflected in the practice of most artificial conception practitioners.

In order to ensure that the gravity of the eligibility criteria to be addressed by artificial conception practitioners will be fully appreciated by them, we wish to offer a further proposal. In chapter 4, we considered various institutional means that are available to regulate a particular activity, such as legislation, the courts, or the medical profession itself. In the case of the criteria for determining participation in an artificial conception programme, we have already stated our view that the matter ought not to be left to individual physicians. Accordingly, we recommend that the proposed criteria for participation in an artificial conception

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58 Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, dissents from this recommendation: see Vice Chairman's Dissent, at page 287 of this Report.

59 It bears repeating that most of our proposals, including the one just made, do not apply to artificial insemination where the sperm of the recipient woman's husband or partner is used (A.I.H.): see the discussion near the end of sec. 2 of this chapter.

60 See *supra*, ch. 2, sec. 3(b)(i).

programme should be set out in regulations made under the *Health Disciplines Act*.[61]

(ii) The Refusal of Artificial Conception Services: Complaints and Appeals

In a previous section, the Commission recommended that artificial conception services should be confirmed statutorily to be the "practice of medicine". We also recommended that prospective applicants for artificial conception be screened to determine, *inter alia*, their general stability and, where relevant, the stability of their marital or nonmarital union, with a view to assessing the likely home environment of any future child. Accordingly, under our recommendations, the question of access to the new reproductive technologies would have more than a purely medical or clinical dimension; our proposals envisage a type of social and psychological screening of applicants.

The kind of pre-treatment assessment contemplated by the Commission would require physicians, perhaps with assistance from other health care and related professionals, to cover a broad range of issues. While there may be no legally established right to artificially assisted procreation,[62] there is at least a social and moral obligation and, perhaps, a legal right to have an application for reproductive assistance respectfully received, fairly assessed, and equitably resolved. This raises the question whether applicants who have been refused access to services should be afforded special rights of review of, or appeal from, the unfavourable decision. Since, as we have said, the determination will be based upon more than a clinical diagnosis and prognosis, and will include, for example, a social and psychological component, it may be appropriate to provide a second forum where the disappointed applicant may challenge an adverse ruling.

As we have seen, several means already exist to challenge and seek review of decisions made in the practice of medicine.[63] Courts of law tend to be respectful of medical and clinical judgments,[64] but not where negligently made. Where persons or agencies bound by the provisions of the *Canadian Charter of Rights and Freedoms*[65] make decisions that violate its principles, the courts are available to afford appropriate remedies. Moreover, the Ontario Human Rights Commission monitors observance of the *Human Rights Code, 1981*,[66] and, in some cases, recourse may be had to the office of the Ombudsman.[67] Administrative law remedies also may be available in the courts against public health

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61 *Supra*, note 25.

62 See *supra*, ch. 3, sec. 3.

63 See *supra*, ch. 3, sec. 3(d).

64 See, generally, *Whitehouse v. Jordan*, [1981] 1 All E.R. 267 (H.L.).

65 *Supra*, note 43.

66 *Supra*, note 44.

67 However, there are limits upon the Ombudsman pursuing issues that may be taken or appealed to the regular courts: see *Ombudsman Act*, R.S.O. 1980, c. 325.

authorities, including hospitals. Furthermore, under the *Health Disciplines Act*,[68] the College of Physicians and Surgeons of Ontario has established a Complaints Committee and a Discipline Committee, and beyond the former exists the Health Disciplines Board to review its decisions. Recourse beyond the Discipline Committee lies to the Divisional Court. The Registrar of the College of Physicians and Surgeons may also investigate a member's conduct with the approval of the Executive Committee. Finally, complaints may be made to the hospital, to its own institutional ombudsman, and to the Ministry of Health.

The options open to this rich variety of tribunals, once they have accepted a case and have determined that a complaint of improper conduct is well-founded, will depend upon the jurisdiction specifically given to each of them. However, where a practitioner decides upon ethical or conscientious grounds not to provide artificial conception services, ordinarily it is virtually impossible to compel the practitioner to do so.[69]

The present variety of means for the redress of grievances may, of course, fail to satisfy an individual complainant or may not offer a conveniently available forum or remedy. Nevertheless, the range of accessible paths is extensive and appears to the Commission to be adequate in light of existing experience and what can be anticipated in the foreseeable future. Accordingly, the Commission recommends that no additional or different means of challenge or appeal should be made available to a person who is denied access to artificial conception services.[70]

(c) THE DONATION OF GAMETES

(i) Criteria for Selection of Donors

Where donation is required to produce a pregnancy, the selection of gamete donors is of critical importance to the prospective social parent or parents and to the resulting child. Selection is vital not simply from the perspective of the donor's reproductive history, but also from the standpoint of his or her genetic and general medical status. It is self-evident that a donor who has an infertility problem or who has a harmful transmissible disease should not be used to overcome the infertility problems of others.

At present, the medical profession in Ontario has not developed formal guidelines respecting the selection of gamete donors. Indeed, somewhat different

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68 *Supra*, note 25.

69 In this connection, see the text following note 63, *supra*, ch. 3, respecting the relevant portion of the Canadian Medical Association's *Code of Ethics*, to which the College of Physicians and Surgeons of Ontario subscribes.

70 Of the reports canvassed by the Commission, only the British Columbia Royal Commission Report appears to have dealt directly with this question. The Royal Commission recommended that an appeal should lie to a specially constituted tribunal "representative of medicine, social sciences and appropriate agencies of government": *supra*, note 42, at 12, recommendation 5.

methods appear to be used by different physicians to screen donors.[71] Notwithstanding this variation in practice, however, it must be borne in mind that normal medical procedure clearly necessitates extreme care in the selection process. Moreover, the general law concerning the provision of health care services by physicians and others operates in the same way in the present context as it does in respect of any other facet of medical practice.[72]

Most of the relevant reports that the Commission has reviewed deal with the issue of gamete donor selection in a reasonably predictable manner. For example, concern for the patient and the artificially conceived child is general and has resulted frequently in proposals that would impose quite strict screening procedures on doctors and clinics. Some of the reports mention social and psychological, as well as medical, factors,[73] and some deal with the matching of a donor's physical characteristics with those of the prospective parent or parents.[74]

A recent manifestation of concern respecting the proper screening of donations was the report, in July 1984, that the federal government of Canada was planning to license sperm banks and establish criteria for donors.[75] The nature and scope of such initiatives remain to be seen; they appear not to deal, for example, with ovum donation.

Leaving aside for the moment the issue of any federal standards in the future, there is an obvious temptation to define formally the criteria for donation, for example, by statute or regulation, in order to exclude certain harmful qualities. But, as we indicated in chapter 3,[76] there is another side to the matter that may well invite caution respecting a full codification of standards. It may be impossible or impracticable to legislate specifically what must constitute required medical procedure, particularly since knowledge of genetically transmissible conditions is constantly evolving. Legislative standards that are too detailed may inhibit or limit the sound development of medical criteria and legal responses.

Bearing these matters in mind, the Commission recommends that, subject to the further proposal made below, legislation should remain silent on criteria for the selection of donors. Questions of reproductive history, marital status, and

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71 See discussion *supra*, ch. 2, sec. 3(b)(i).

72 We shall return to the question of artificial conception and legal liability at a later juncture: see *infra*, this ch., sec. 3(f).

73 See Health and Welfare Canada Report, *supra*, note 1, at 5 *et seq.*; Victoria Report on Donor Gametes, *supra*, note 1, para. 3.13, at 19; and Queensland Report, *supra*, note 2, at 86, para. (xii).

74 See Law Reform Commission of Saskatchewan Report, *supra*, note 37, at 1-13, recommendation (5), and British Columbia Royal Commission Report, *supra*, note 42, at 14, recommendation 7.

75 *The Globe and Mail,* Toronto (July 5, 1984), at 1. This initiative was the result of the Health and Welfare Canada Report, *supra*, note 1.

76 See *supra*, ch. 3, sec. 4(a).

genetic and other medical status should be left to professional standards to be set by the medical profession itself.

However, we said that our recommendation is subject to a further proposal. Having regard to federal initiatives respecting the setting of standards for donor selection, at least in the context of licensed sperm banks, and given our belief that such standards should be uniform across Canada, we recommend that there should be consultation between the provincial governments and the federal government so that such uniformity may be furthered.

(ii) Minors as Gamete Donors

In chapter 3 of this Report, the Commission reviewed existing legislation dealing with the donation of gametes by minors.[77] We saw that section 3(1) of the *Human Tissue Gift Act*[78] precludes a minor from serving as a donor of "tissue" for "implantation in the body of another living person". We also concluded that the definition of "tissue" in section 1(c) of the Act likely excludes sperm, but not ova: while sperm are "replaceable by natural processes of repair", ova are finite in number.

We have also seen[79] that section 10 of the *Human Tissue Gift Act* prohibits the buying, selling, or dealing in any "tissue" for a transplant or in any body part "for therapeutic purposes, medical education or scientific research" where valuable consideration passes. However, even assuming that sperm and ova are body parts, the Act does not cover an *inter vivos* gift by any person, arguably even a minor,[80] of sperm or ova for research or experimentation purposes.

The question whether minors should be permitted or, in the case of sperm donors, continue to be permitted, to donate gametes has both a medical and what one might call a broader public policy component, although the two are not unrelated. In terms of the procedure, the donation of sperm raises no medical problems and is not subject to medical risks. However, one of the procedures used for ovum donation, which involves a general anesthetic and surgical laparoscopy, represents the very resort to the bodies of minors that the *Human Tissue Gift Act* is presumably intended to prevent. The other procedure for ovum donation involves the *in vivo* fertilization of a woman's single ovum, after which she is subjected to a lavage or flushing procedure, which is intended to remove the embryo before implantation. While not a surgical operation, this procedure has a different risk factor, since an embryo that is not recovered by flushing may become implanted in the ovum donor's uterus, making her pregnant.[81]

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77 See *ibid.*

78 R.S.O. 1980, c. 210.

79 *Supra*, ch. 3, sec. 7.

80 But see Dickens, "Contractual Aspects of Human Medical Experimentation" (1975), 25 U. Toronto L.J. 406, at 416. See, also, s. 4(1) of the *Human Tissue Gift Act* (reproduced *supra*, ch. 3, sec. 7) respecting *post mortem* gifts "for therapeutic purposes, medical education or scientific research".

81 See *supra*, note 9.

On the other hand, an argument may be made that ovum donation is justifiable where an older, mature minor, aged sixteen or seventeen, is willing to serve, and where her decision is ratified upon independent investigation, for instance, in a family court proceeding, upon a showing of good cause. In special circumstances — where, for example, ethnic matching is desired — a mature minor may be willing and appropriate to serve as a donor.

A more compelling case for a minor consenting to donation of her ovum may arise where her ovum is acquired indirectly as a result of therapeutic surgery, such as a hysterectomy, and she is willing for her ovum to be used in another woman's treatment for infertility rather than be wasted. Of course, it may be that therapeutic removal in the latter case would not constitute the "removal forthwith from [her] body" contemplated by section 3(1) of the *Human Tissue Gift Act,* so that she may be legally able to consent to the use of her ovum in an artificial conception procedure. However, donation even under these conditions may have psychological consequences, which a minor may not anticipate or appreciate.

Surprisingly little attention has been given to the issue of minors as gamete donors. One report in Victoria recommended legislation providing that "it shall be unlawful to recover, or receive, any gametes from a child", that is, an unmarried person under eighteen years of age.[82] This recommendation was followed by legislation to the same effect.[83] In addition, the Queensland Report opposed the use of gametes from minors.[84]

As a matter of public policy, and insofar as ethical or social considerations are concerned, the Commission does not have a general antipathy toward gamete donations by minors. However, we are cognizant of the medical and nonmedical rationale for the proscriptions in the *Human Tissue Gift Act.* The nature of the procedure in the case of sperm donation is not such as to warrant the prohibition of this kind of donation. Whether minors may be suitable as sperm donors is, we believe, a matter of clinical judgment, to be determined according to the standards and principles of professional medical practice. Accordingly, we are of the view that the issue of sperm donation by a minor may be left to the general law, which, as we have seen, permits such donation.

The more critical question, then, is that dealing with ovum donation by minors. In this regard, the Commission is unanimous in respect of the general principle, but divided in respect of whether any exceptions to this principle are justifiable.

The majority of the Commission is of the view, and accordingly recommends, that minors should be prohibited from undergoing any procedure undertaken deliberately to donate ova. The majority believes that the medical and surgical risks involved in a laparoscopy, or, in the case of *in vivo* fertilization and

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82 See Victoria Report on Donor Gametes, *supra*, note 1, para. 3.12, at 18.

83 See the Victoria *Infertility (Medical Procedures) Act* 1984, *supra*, note 48, s. 25(1).

84 Queensland Report, *supra*, note 2, at 86, para. (xi).

lavage, the risk of pregnancy, are, on balance, sufficient to outweigh any perceived merit or advantage in acquiring such ova. A legally required intervention by a family court judge could, of course, screen unwarranted invasive procedures, but the majority of the Commission stresses that such intervention cannot remove or reduce the risks to the donor. A minority of the Commission, while not taking exception to the prohibition recommended above *as a general rule*, would, however, permit a family court judge to approve a minor's donation, and her consent, where good cause has been shown.

Notwithstanding the above views, we do not believe that, so long as they have given their valid and informed consent,[85] minors should be prohibited from donating ova acquired indirectly as a result of therapeutic surgery, such as a hysterectomy. Since the surgery in question must be medically indicated in any event, and since at this stage the extraction of the ovum is not in itself harmful or risky, the medical rationale for precluding donation would not apply. Having regard to this fact and to the purpose served by ovum donation, we do not believe that there is a compelling reason why another woman should not receive the benefit of an ovum donated under these circumstances. We see no value being served by wastage of the ovum.[86]

(iii) Consent of Gamete Donors

The consent issue touched on at the end of the preceding section, in the context of the donation of ova by minors after therapeutic surgery, requires separate treatment in a more general context.

We have seen that the *Human Tissue Gift Act*[87] provisions relating to *inter vivos* gifts apply only to the removal of "tissue", which likely excludes semen but includes ova. Furthermore, the provisions appear to be limited to material that is deliberately removed for the purpose of transplantation. Finally, our earlier discussion respecting whether a person has a claim to ownership of, or control over, severed body parts indicates that this area of the law is unclear and unsatisfactory.[88]

Having regard to the state of the law in this area, the Commission is not disposed to leave matters as they are. In addition to the alternative of requiring a person's express consent to act as a gamete donor, we have considered the

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85 See *infra*, the following section.

86 The question of withdrawal of donations will be dealt with *infra*, this ch., sec. 3(c)(iv).

87 *Supra*, note 78.

88 See *supra*, ch. 3, sec. 7. Some courts, however, have recognized the concept of abandonment of the products of conception, such as early stillborn fetuses, where no express directions concerning any disposition have been given. See, generally, Dickens, "The Control of Living Body Materials" (1977), 27 U. Toronto L.J. 142, at 183 *et seq.*, and *Hembree v. Hospital Board of Morgan County*, 300 So. 2d 823 (Ala. Sup. Ct. 1974), where it was held that there is no implied term of a hospital-patient contract that prevents the disposal of the patient's body products without the patient's prior permission.

alternative of legislation that would provide that an acquired ovum is available for donation unless the "donor" is known to object.[89]

When considering the use of ova or sperm for artificial conception purposes, we believe it is important to bear in mind that we are not dealing simply with a part of the body, like a bone, the use of which has no, or virtually no, ethical or moral dimension to it. Ova and sperm bear the genetic code of their source; their use involves the perpetuation of a particular person's genetic line. Consequently, while a person's psychological or emotional well-being may well be affected by the uses to which other severed body parts may be put, the nature and extent of a person's reaction is likely to be quantitatively and qualitatively different where gamete donation is involved.

As we indicated in the preceding section, an ovum may be acquired during, for example, a hysterectomy. In this case, and in other analogous cases, the woman might be unaware of the acquisition and future use of the gamete. The option of permitting her ovum to be used in an artificial conception programme, notwithstanding the possible ignorance of the "donor", is, to us, unpalatable. Such a regime places too much store in the actions of the physicians involved, the knowledge of the woman, and her timely intervention. It may even encourage subterfuge, precisely to avoid such intervention.

Given the nature of the material in question — whether it be sperm or ova — and given the emotions involved in its donation, the Commission recommends that legislation should expressly require a donor's free and adequately informed consent as a precondition to the donation or use of his or her gametes.[90] Moreover, for the same reasons, we recommend that, at the time of donation, a donor should be entitled to restrict the use of the donated gamete to a specified purpose. Such a restriction should continue in effect even after the gamete has been used in a fertilization procedure, unless, prior to fertilization, the donor has altered the specified purpose or has indicated that the restriction is no longer to apply.

The proposal concerning the restriction on the use of a donated gamete would, for example, permit one sibling to donate a gamete to another sibling without fear that an embryo produced with the donated gamete may be used by a stranger if not transferred to the recipient for whom it was originally intended. It would also allow a donor with ethical or other qualms respecting a particular use to restrict his donation accordingly.

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89 This option would clearly favour potential recipients of the ova of others, and, in one sense, would accord generally with the philosophy evinced in the *Human Tissue Gift Act* respecting *post mortem* gifts for transplantation and other uses of body parts where the deceased has made no express gift. Section 5(2) of the Act provides that "[n]o person shall give a consent ... if he has reason to believe that the person who died or whose death is imminent would have objected thereto".

90 Few committees have canvassed the matter in any detail. It appears that the requirement of consent may have been taken for granted. See, however, Victoria Report on Donor Gametes, *supra*, note 1, para. 3.25, at 24, and Queensland Report, *supra*, note 2, at 79, para. (c).

We envisage that, where restricted donations are possible, the storage facility will have to devise some method of indicating whether the donation in question is subject to some limitation and, if so, what the limitation entails. As a result, for example, sperm donated exclusively for research purposes[91] could not be used to fertilize an ovum donated exclusively for artificial conception purposes. Or, where an ovum donated exclusively for artificial conception purposes is fertilized by sperm donated generally, for any purpose, the use of the fertilized ovum would have to be governed by the more restrictive use; accordingly, if not used for artificial conception purposes, it could not be used for research.

It is not thought that the matter will, in practice, become particularly complicated; it should be emphasized that the vast majority of donations will be general, without restriction. Moreover, some storage facilities may even preclude any problem from arising by accepting only unrestricted donations.

(iv) Revocation of a Donor's Consent

As we have seen, an adult may consent to the donation of ova, and any person may consent to the donation of semen, for transplantation purposes. In addition, an adult, and perhaps even a minor, may give (but not sell) semen or ova for therapeutic, medical education, or research purposes. Intimately related to the issue of consent to donation is the question whether, and to what extent, a donor may change his mind respecting the donation or the use of the gametes.

By way of analogy, it is clear that, in medical treatment and research, patients and subjects are free, without prejudice and without having to give reasons, to withdraw their consents at any time.[92] Of course, a danger of withdrawal after the donation of gametes for artificial conception purposes is that such action may well inconvenience the practitioner and, particularly, the potential recipient.

There appear to be several alternative approaches to the issue. One option is to provide that, upon donation, donors are deemed to have abandoned control over their donation, as though the donation were a sale of a commodity, with title passing immediately to the purchaser. For example, the Royal College of Obstetricians and Gynaecologists in the United Kingdom has recently recommended that, "[w]hen sperm, ova or embryos are donated the donor should surrender all rights to interest or ownership".[93]

The Commission does not favour this option. We believe that, under such a

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91 See *infra*, this ch., sec. 4(e)(i).

92 See Annas *et al.*, *Informed Consent to Human Experimentation: The Subject's Dilemma* (1977).

93 RCOG Report, *supra*, note 48, para. 14.4.1., at 16. See, also, *ibid.*, para. 5.3, at 5. However, the Report also proposed that "[s]tored semen (other than that produced for donor purposes) remains the property of the man until he requests its destruction": *ibid.*, para. 14.4.3, at 16.

regime, persons might be dissuaded from making a donation because of the total loss of control that such action would entail. Moreover, we are of the view that, given the nature of the material donated, donors are significant moral actors in a critically important facet of human life. Consequently, we believe that their conscientious concern with the use of their genetic material ought to be fostered, not discouraged by deeming donated gametes to have been abandoned.

Indeed, the Commission rejects in principle any alternative that precludes donors from exercising a reasonable degree of control over their gametes. Accordingly, we recommend that, after donation, but prior to the use of their gametes in a fertilization procedure, donors should be entitled to require their donation either to be wasted or returned to them, so that the gametes may not be used for artificial conception, research, or any other purpose. As we indicated in the preceding section of this chapter, it would also be possible for a donor, prior to fertilization, to exercise his or her right to restrict the use of the donation to a specified purpose or to indicate that a previously imposed restriction is no longer to apply.[94] We further recommend that a donor's consent given at the time of donation should remain of legal effect until withdrawn or otherwise altered, as proposed above and in the preceding section, so that a fresh consent should not be required each time the gametes are used. Consequently, it is for the donor to take the initiative to express and give effect to any subsequently formed different intention. To provide otherwise would be to create, as a matter of practice, an unworkable scheme. So long as the consent is free and adequately informed, no prejudice will result to donors.

(v) Payments to Donors

We noted earlier in this chapter that section 10 of the *Human Tissue Gift Act*[95] prohibits the buying, selling, or dealing in tissue or body parts for valuable consideration. The obvious purpose of this provision is to prevent a commercial market in human body materials, except "blood or a blood constituent".[96] However, it bears noting that sperm donors are, in fact, routinely paid, presumably for the personal service of supplying sperm, rather than for the sperm itself, as though it were a commodity. Given this presumed legal basis of payment, sale of goods and consumer protection questions concerning, for

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94 While the topic has been considered expressly in few cases, where it has been dealt with the donor's option appears to be limited to withdrawal of donations. See, for example, Victoria Report on Donor Gametes, *supra*, note 1, para. 3.17, at 21, and Queensland Report, *supra*, note 2, at 86, para. (xv). In the Victoria *Infertility (Medical Procedures) Act* 1984, *supra*, note 48, s. 15(1), upon a withdrawal of consent the gametes must be destroyed unless the donor has consented to the use of the gametes in another I.V.F. procedure.

95 *Supra*, note 78.

96 We leave aside here the question whether providing A.I.D. to a healthy woman is "for therapeutic purposes", within the meaning of s. 10, since only her husband may have a medical or genetic obstacle to achieving natural insemination: see Dickens, *Medico-Legal Aspects of Family Law* (1979), at 16-17.

example, whether the donor gives implied undertakings of quality and fitness for purpose, tend not to arise.[97]

The concept of a payment is divisible into compensation for inconvenience and expenses incurred — which, regarding sperm banks run on a noncommercial basis, might represent operating costs — and reward beyond such compensation, representing a profit margin. An analogy between donation of sperm and donation of blood for transfusion is not exact for a number of reasons, but experience indicates that inducing blood donation by the offering of a reward may cause donors to suppress information and disguise their reasons for donation, thus rendering them undesirable as donors.[98]

Despite evidence that encouraging blood donations by the offer of a reward may be undesirable, we have seen that the *Human Tissue Gift Act* does permit payment of those who donate blood or a blood constituent. Although reliance is placed overwhelmingly upon voluntary donation, it is recognized that it may be proper to pay donors of, for example, a particularly rare blood type, and to allow commercial plasmapheresis centres to operate. Payments are permitted because of the public interest in the availability of adequate supplies of transfusible blood. The question is, then, whether the same public interest exists with respect to the availability of gametes for artificial conception.

Reports and legislation from other jurisdictions manifest a general antipathy to payments for the gametes themselves (that is, payments representing a profit), but would countenance payments for expenses, such as travel, medical, and other costs.[99] In some cases, reports have gone further to recommend payment for "time"[100] or "inconvenience",[101] a rather different category than out-of-pocket expenses. Other reports have gone even further, and have proposed that payments be made to compensate for lost wages or revenue.[102] Finally, one report recommended generally that only reasonable expenses should be given.[103]

In light of the Commission's general views on the ethical, moral, and social acceptability of artificial conception, it should be evident that we believe that there is a public interest in the availability of suitably screened gametes for such

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97 This matter is considered *infra*, this ch., sec. 3(f)(ii).

98 See Titmuss, *The Gift Relationship* (1970).

99 See, for example, Victoria Report on Donor Gametes, *supra*, note 1, para. 3.11, at 18; British Columbia Royal Commission Report, *supra*, note 42, at 23; Queensland Report, *supra*, note 2, at 110-11; The American Fertility Society, *Report of the Ad Hoc Committee on Artificial Insemination* (1980) (hereinafter referred to as "American Fertility Society Report"), para. 12, at 5; and Warnock Report, *supra,* note 2, para. 4.27, at 28. See, also, the Victoria *Infertility (Medical Procedures) Act* 1984, *supra*, note 48, ss. 11(6), 12(6), and 13(7).

100 See British Columbia Royal Commission Report, *supra*, note 42, at 23.

101 See American Fertility Society Report, *supra*, note 99, para. 12, at 5.

102 See British Columbia Royal Commission Report, *supra*, note 42, at 23.

103 See RCOG Report, *supra*, note 48, para. 14.4.1, at 16.

a purpose. However, we 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. These should be based roughly upon the time and inconvenience involved in the initial screening with a view to recruitment into donor programmes, and the periodic follow-up checking of those who remain active donors. However, payment for "discomfort" should not be available. The sum paid should not be so great as to be an incentive to deceive, nor so great as unduly to burden a clinic having to pay for the time of applicants it rejects. In Ontario, existing payments tend to fall within the $25-$50 range which, without proposing a definite tariff, the Commission considers acceptable.

It is considered that the same principles should be applied to ovum donors, although payments may prove to be greater where ovum recovery involves invasive procedures, such as laparoscopy, or where a woman's naturally released ovum is recovered nonsurgically, by means of *in vivo* fertilization and lavage. Similarly, long term treatment for the multiple acquisition of ova, induced by superovulation, may justify higher payment, which would be acceptable provided that it conformed to the principle of payment only for reasonably incurred expenses.

(vi) Frequency of Use of Donors

Some A.I.D. practitioners impose limits upon how frequently donations from an individual donor may be employed. Either the number of successful pregnancies or the number of donations may be used to measure and limit frequency of use. The reason for this restriction is to reduce the possibility that resultant offspring of different sexes, unaware of their common genetic origin, might meet, marry, and have children in a relationship that would be biologically, although not legally,[104] incestuous. Although the statistical likelihood of inadvertent incestuous unions is low in large population centres and ought, therefore, not to be exaggerated, limiting the use of individual donors may be a sensible precaution where, for example, a doctor practises in a small community or within a relatively small and cohesive ethnic group. An advantage of acquiring sperm from a sperm bank is that the gametes from an individual donor can be distributed over a wide geographical area in order to reduce the possibility of subsequent incestuous unions.[105]

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[104] Under the *Criminal Code,* R.S.C. 1970, c. C-34, s. 150, the crime of incest is committed only where voluntary sexual intercourse is performed with a person known to be within a prohibited relationship.

[105] Gamete banks are dealt with *infra*, this ch., sec. 3(c)(vii).

In order to prevent the possibility of incest, several reports on artificial conception have recommended limiting the frequency of use of donors. The British Columbia Royal Commission Report, the Health and Welfare Canada Report, the American Fertility Society Report, and the Warnock Report all focus on restricting the number of successful pregnancies.[106]

Notwithstanding the rationale for these proposals, there are certain practical difficulties with them. Legislating against the use of a donor beyond a specified number of occasions would necessitate extensive monitoring and checking, not only of records, but also of the identities of named donors. Furthermore, it would require comparisons of the records of donors of individual practitioners and clinics with those of other practitioners and clinics, since a donor who had exhausted his utility with one practitioner might apply to donate to another.[107]

Legislation also may not be appropriate in that it would interfere unduly with clinical judgment respecting the use of an appropriate available donor. Legislation might limit the means of a woman, successfully inseminated and bearing a child through an individual donor, to seek further resort to him so that she may have a family of children who are full siblings.

Practical limits on the use of donors may arise as a result of our proposal to restrict financial payments to reasonable expenses, thereby precluding donation for a profit.[108] Moreover, experience shows that donors tend to serve as such for only limited times in their lives and that most donors are aware, or have been warned, of the potential problems associated with multiple donations and act accordingly. Finally, doctors, as well, are conscientious in attempting to preclude the scenarios described above.

As we stated earlier in passing, while we recognize the rationale for limiting donations from individual donors, we do not believe that the actual or potential magnitude of the problem warrants intervention. In those cases where caution is appropriate, we are of the view that practitioners are, and will continue to be, assiduous in avoiding the multiple use of the same donor.

Sound law reform in this area must reflect not only theoretical problems that might arise, but also the likely extent of such problems and the practicalities of remedying them. Having regard to these factors, the Commission recommends, on balance, that the frequency of employment of individual gamete donors is a matter that should properly be left to the professional judgment and ethics of

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106 British Columbia Royal Commission Report, *supra*, note 42, at 19, recommendation 12 (6 pregnancies); Health and Welfare Canada Report, *supra*, note 1, at xiv, recommendation 2.4 (no number proposed); American Fertility Society Report, *supra,* note 99, para. 9A, at 5 (15 pregnancies); and Warnock Report, *supra,* note 2, para. 4.26, at 26-27 (10 children).

107 With respect to the maintenance of a "central" register in the context of artificial conception services, see, for example, Victoria Report on Donor Gametes, *supra*, note 1, para. 3.32, at 27, and the Victoria *Infertility (Medical Procedures) Act* 1984, *supra,* note 48, s. 22.

108 See *supra*, this ch., sec. 3(c)(v).

medical practitioners and to the preference of participants in artificial conception programmes.

(vii) Sperm, Ova, and Embryo Banks

As we have seen, section 10 of the *Human Tissue Gift Act*[109] prohibits the buying, selling, or dealing in any tissue or body part for valuable consideration. Consequently, gamete banks cannot operate in Ontario on a commercial basis, whether for profit or not. At present, sperm banks exist in some Ontario hospitals, and commercial sperm banks operate, for example, in the United States. While ova, unlike sperm, cannot now be stored for future use,[110] it is not unreasonable to expect that technological advances will overcome present difficulties. Embryos, however, may be preserved for subsequent transfer.[111]

The question arises, then, whether commercial gamete banks — that is, banks that buy and sell gametes and embryos — should be permitted to operate in the Province and, if so, on what basis. We should mention here that recent federal proposals to license sperm banks[112] would deal, at least in part, with standards of operation, but would not extend to the actual authorization of commercial operation as such.

While the characterization of a gamete bank as "commercial" does not necessarily involve an element of profit — it could simply refer to the receipt of payments in order to recover reasonable operating expenses, for example — the buying and selling of gametes or, one might say, the commercialization of this aspect of human reproduction, may appear rather offensive at first blush. On reflection, however, it may be less unorthodox than it seems and may, in fact, be an ethically and socially acceptable outgrowth of the acceptance of artificial conception itself.

In the first place, the purchase and sale of health care services and medical necessities is hardly novel. As we have seen, section 10 of the *Human Tissue Gift Act* expressly legitimizes the purchase and sale of "blood or a blood constituent", presumably because it is in the public interest to stockpile supplies of blood and to encourage people to contribute to them. Moreover, many means of achieving natural reproduction — the surgical treatment of reproductive impairments, for example — depend upon the existence of paid services, where profit is involved. Finally, once it is accepted that individual gamete donors may receive payment for their reasonable expenses where there is a direct donation,[113] it may

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109 *Supra*, note 78.

110 See Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Report on the Disposition of Embryos Produced by In Vitro Fertilization* (1984) (hereinafter referred to as "Victoria Report on Embryos"), paras. 1.6.3-1.6.5, at 9-10.

111 See *ibid.*, paras. 1.7-1.8, at 10-11.

112 See *supra*, this ch., note 75 and accompanying text.

113 See *supra*, this ch., sec. 3(c)(v).

be anomalous to proscribe similar payment to agencies that recruit and screen donors and preserve sperm by freezing.

We do not wish to labour the point. Suffice it to recognize that socially useful (indeed necessary) and ethically acceptable health care services and products have always been provided at a cost, and frequently at a profit.

Secondly, it must be borne in mind that the Commission finds artificial conception ethically, morally, and socially acceptable in principle. Accordingly, any suggested restriction on the availability of the necessary elements of an artificial conception programme must be scrutinized very carefully; it would be futile and frustrating to give with one hand, only to take with the other. It is from this perspective that we view the question of so-called commercial gamete banks.

Certain A.I.D. practitioners in Ontario now use commercial sperm banks operating in the United States. Presumably, they find their recruiting and screening services reliable; moreover, they enjoy the advantage of ordering sperm according to fairly detailed specifications. Commercial banks also aid anonymity where sperm is sought from an ethnically identified donor not commonly found in a community from which fresh sperm would come. They also have the advantage of distributing an individual donor's sperm over a wide geographical area, thereby reducing the possibility of the donor's offspring of different sexes meeting and marrying.

In the main, there seems to be general, although not unanimous, agreement that gamete banks serve a useful purpose and should be allowed to operate under licence from the appropriate public authority.[114] We have come to the conclusion that, given the need for both gametes and public accountability, an appropriately operated licensing system would provide for the reasonable availability of gametes of assured quality, while at the same time precluding offensively aggressive marketing enterprises seeking only profits by means of the recruitment of donors and the supply of gametes.

Accordingly, we recommend that gamete banks, that is, banks that buy and sell sperm, ova,[115] and embryos, should be permitted to operate on a commercial basis. However, they should be allowed to operate only under licence and under stringent regulations setting standards of operation, with respect, for example, to payment by users to defray reasonable costs and, perhaps, to provide a reasonable profit. Gamete banks should operate subject to public accountability

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114 See British Columbia Royal Commission Report, *supra*, note 42, at 32-33; Queensland Report, *supra*, note 2, at 110-11; and Warnock Report, *supra*, note 2, para. 13.13, at 79. One Report canvassed by the Commission would put a moratorium on the establishment of banks outside the jurisdiction of a university or other publicly owned agency: Health and Welfare Canada Report, *supra*, note 1, at 16 and xiv, recommendation 2.5. Another Report recommended that "no hospital authorised to conduct a cryopreservation programme [should] maintain a bank or store of large numbers of frozen embryos from which embryos may be disposed of as the hospital thinks fit": Victoria Report on Embryos, *supra*, note 110, para. 2.3, at 24-25.

115 We include ova here in anticipation of the future possibility of storing such gametes.

or under the auspices of a public organization, preferably on the model of the Canadian Red Cross Society blood donor clinics.

Earlier, we noted the recent federal initiatives respecting the licensing of sperm banks. Having regard to these initiatives, and to the proposal we have already made in this connection,[116] we recommend further that there should be consultation between the provincial governments and the federal government so that the goal of uniformity of standards across Canada may be furthered.

One final matter bears on the topic of gamete banks. The Commission has endorsed the operation and licensing of gamete banks because it is of the view that their existence is ethically and socially acceptable and that they facilitate the provision of necessary and desirable services to the infertile and the genetically impaired. However, we have also made recommendations that would, in effect, place artificial conception services under the supervision of licensed doctors.[117] Accordingly, we wish to restrict access to gamete banks. To this end, we recommend that licensed gamete banks should be prohibited from supplying gametes or embryos to any person or agency other than a licensed physician, a hospital or other approved health care facility, or another licensed sperm bank.

(viii) Importation of Gametes and Embryos from Outside Ontario

Related to the issue of commercial gamete banks is the question of the importation of gametes (including embryos) into Ontario from outside the Province. As we said in chapter 3,[118] there may well be a constitutional prohibition against any attempt to bar, or even restrict, such importation, given the jurisdiction of the federal Parliament over the "regulation of trade and commerce".[119] In addition, the *Canadian Charter of Rights and Freedoms*[120] may affect any attempted prohibition of transactions within Canada.

However, these real or potential constitutional limitations may not imperil provincial legislation dealing with the use and quality of imported gametes. Just as in the case of gamete banks, the Commission is concerned about the danger of offensive commercialization of the gamete market and the loss of quality control over gametes used in Ontario. Recourse to out-of-Province suppliers should not become a means of escaping quality standards prevailing in Ontario.

Having regard to our earlier proposal respecting the establishment and regulation of gamete banks, and its underlying rationale, we do not believe that a compelling case can be made out for the prohibition of the importation of gametes from outside Ontario. Aside from any constitutional impediment to such

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116 See *supra*, this ch., sec. 3(c)(ii).

117 See *supra*, this ch., sec. 3(a).

118 See *supra*, ch. 3, sec. 4(b).

119 *Constitution Act, 1867,* 30-31 Vic., c. 3 (U.K.), s. 91.2.

120 *Supra*, note 43.

action, we believe that there are sound reasons why prohibition is not a satisfactory option. In some cases, members of a distinctive ethnic or other group may not be able to find suitable donors in the Province. In other cases, the matching of a donor's characteristics to those of the recipient and his or her spouse or partner may be facilitated if Ontario physicians were able to import gametes from the United States or elsewhere. We see no reason to preclude such flexibility, so long as quality control is not sacrificed in the process. The critical question should always be the quality of the gametes, tested mainly by the medical suitability of the donor rather than by the geographic source of the gametes.

Accordingly, the Commission recommends that the use of gametes and embryos imported from outside Ontario should be permitted but should conform to the standards set in respect of gamete banks operating in the Province. Having regard to the previously described federal initiatives in this general area, we further recommend that, with regard to importation, there should be consultation between the provincial governments and the federal government to ensure that uniform standards are established for the whole of Canada.

(d) STATUS OF ARTIFICIALLY CONCEIVED CHILDREN: PARENTAGE, BIRTH REGISTRATION, AND INHERITANCE RIGHTS

As we have emphasized on numerous occasions throughout this Report, the Terms of Reference of the Commission's study direct us to pay particular attention to the best interests of the artificially conceived child. Central to the welfare of such a child and to its "identity" is the child's secure legal, social, and emotional status within its family and in the wider community. We shall examine these matters, and offer recommendations for reform, in the sections that follow.

(i) Parentage of Artificially Conceived Children

a. Legal Status of Social Parents and Gamete Donors

In chapter 3, we considered the question of the legal status of the artificially conceived child.[121] We need not repeat that discussion here, beyond providing briefly some background to our proposals for reform. We indicated earlier that the two major pieces of legislation in the area — the *Children's Law Reform Act*[122] and the *Vital Statistics Act*[123] — frequently accommodate neither the reasonable expectations of the parties nor the welfare of artificially conceived children. For example, while legislation does permit a married, cohabiting couple to make use of a presumption that the husband is the father of a child

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121 *Supra*, ch. 3, sec. 5.

122 R.S.O. 1980, c. 68.

123 R.S.O. 1980, c. 524.

conceived with donor sperm,[124] and requires the child to be registered accordingly,[125] the presumption of paternity is rebuttable by "[a]ny person having an interest",[126] including, for example, the sperm donor. Moreover, an infertile husband seeking to regularize his relationship with the child would have to found his application for a declaration of paternity under the *Children's Law Reform Act* on a lie, since he is not, in fact, the natural father. Finally, where the recipient woman is in an unmarried relationship, the legislation cannot be used to regularize the birth of an A.I.D. child: her male partner could not be recorded as the child's father unless he were to declare falsely that he was the father.

The question of status and parentage bears directly on a wide spectrum of legal rights and obligations respecting all parties involved, including support rights under the *Family Law Reform Act*[127] and succession rights under the *Succession Law Reform Act.*[128] And, in turn, these legal consequences affect the social and psychological stability of the child, both in its family and in society.

The potential for legal assaults on the relationship between the social parents and the artificially conceived child, and the need to conceal the biological truth in order to regularize such a relationship are, we have said, both unwholesome and unacceptable, for they run counter to the best interests of all concerned, and particularly the child. We are reinforced in this strongly held conclusion by the unanimous support for it in the reports canvassed by the Commission. With only minor deviations, the committees and bodies that have examined the question of parentage and status have recommended in principle that, where artificial conception using donor sperm has taken place with the consent of the woman and her spouse, the latter should be deemed in law to be the father for all purposes, and the donor should have no legal connection to the resulting child. Legislation has followed suit in several jurisdictions as well.[129]

Our conclusion, and the conclusions of others just noted, that the present state of affairs is not satisfactory has not been arrived at simply on the basis of legal theory. We are well aware that, despite manifold legal problems in this area, the practical results in the majority of cases (certainly of A.I.D.) do reflect the intentions of the parties and do manage, more or less, to accommodate the best interests of the children. At least where the participants are a married, cohabiting man and woman, and where, as is the usual case, the donor is

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124 *Children's Law Reform Act, supra*, note 122, s. 8(1)1.

125 *Vital Statistics Act, supra*, note 123, s. 6(4).

126 *Children's Law Reform Act, supra*, note 122, s. 4(1).

127 R.S.O. 1980, c. 152.

128 R.S.O. 1970, c. 488.

129 See, for example, legislation based on the United States Uniform Parentage Act: National Conference of Commissioners on Uniform State Laws, Uniform Parentage Act, Uniform Laws Annotated, Vol. 9A, §5. See, also, Part II of the Victoria *Status of Children (Amendment) Act* 1984, No. 10069. This legislation is discussed in sec. 3 of the Appendix to this Report.

anonymous, the social fact is more telling than the potentially unstable legal situation might indicate.

However, as we have said, existing law achieves the parties' reasonable and justifiable intentions on a very fragile basis. We believe that the challenge and role of the law in this area is to remove what uncertainty now exists, to regularize family relationships that the law does not now, but should, expressly recognize, and to exclude gamete donors who are otherwise strangers to the new relationship. Accordingly, the Commission recommends that, for all purposes, a woman bearing a child through artificial conception in order to rear it[130] should be conclusively deemed to be the child's legal mother, and that the woman's husband or male partner[131] who consents to the initiation of the artificial conception procedure or procedures should be conclusively deemed to be the child's legal father. A donor of sperm or an ovum should have no legal relationship to the child arising from the fact of donation; in other words, a donor should have no parental rights or duties regarding the artificially conceived child.

It will be noted that, under our proposals, only a consenting husband or partner would be deemed to be the natural father of a child conceived artificially with donor gametes. We recognize that this means that, where no consent is given to the artificial conception procedure, but where the woman undergoes the procedure in any event, the resulting child would not have a legal father: in these relatively rare cases, our previous proposals would preclude the non-consenting spouse or partner from being deemed to be the legal father, and would also eliminate the donor. However, we believe that, in such a case, it would be exceedingly unfair to place on the spouse or partner the legal burdens that he clearly did not wish to assume.[132]

b. The Nature and Form of a Husband's or Partner's Consent

The issue of the nature and form of a husband's or partner's consent in the context of the child's status and paternity has been dealt with by several bodies outside Ontario, where a determination had to be made concerning the circumstances in which a husband or partner would be deemed in law to be the father of a child with which he had no biological connection. The most comprehensive

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130 With respect to surrogate motherhood arrangements, where the birth mother does not intend to rear the child, see *infra*, this ch., sec. 5.

131 With respect to the eligibility of unmarried couples for artificial conception services, see *supra*, this ch., sec. 3(b)(i).

132 It does bear mentioning here that, while a non-consenting husband or partner would not be deemed to be the legal father of the artificially conceived child, he would owe the child a support obligation under s. 16 of the *Family Law Reform Act, supra*, note 127, where he "has demonstrated a settled intention to treat [the] ... child [as a child] of his ... family". (See the definition of "child", *ibid.*, s. 1(a).) Moreover, such a child may apply for a support order under the dependants' relief provisions of the *Succession Law Reform Act, supra*, note 128, where the deceased husband or partner has not made adequate provision for the proper support of the child.

discussion of the consent question appears in the working paper[133] and report[134] on illegitimacy published by the English Law Commission. The Law Commission canvassed two approaches, one requiring a writing in a prescribed form and perhaps formally witnessed,[135] the second involving a presumption of consent.[136] The first alternative was said to give rise to timing problems. The Law Commission preferred that consent should be given before the treatment in question was commenced, but stated that, while this last option "is clearly desirable in the interests of fairness to the husband ... we doubt if it is sufficiently important in the interests of society as a whole to justify elevating it into a positive rule of law".[137]

Instead, the second approach was taken, an approach subsequently endorsed by the Law Society of Scotland.[138] The Law Commission said that, for the purpose of status and paternity, "[i]t would be presumed that the husband had consented unless he (or anyone else with a sufficient interest) satisfied the court that he had not done so".[139]

The Commission believes that, if some manifestation of prior consent were required in order to deem the husband or partner to be the child's natural father, the failure to comply with such a requirement would clearly be highly prejudicial to the resulting child: the child would be rendered legally fatherless, notwithstanding the fact that, while not following the requirements to the letter, the husband or partner might, in fact, have agreed to the procedure. The potential for injustice would be even greater where a more formal, written consent requirement was in place. Such a requirement might be impossible to fulfil where, for example, the husband or partner might be reached in time only by telephone or telegraph.

We cannot think of a more unpalatable regime than one in which the child's legal status is made dependent upon some affirmative, mandatory manifestation of consent by the mother's spouse or partner, and particularly upon a formal,

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133 The Law Commission, *Family Law — Illegitimacy,* Working Paper No. 74 (1979) (hereinafter referred to as "Law Comm. W.P.").

134 The Law Commission, *Family Law — Illegitimacy,* Law Com. No. 118 (1982) (hereinafter referred to as "Law Comm. Report").

135 *Ibid.*, para. 12.14, at 174.

136 *Ibid.*, para. 12.16, at 175. See, also, Law Comm. W.P., *supra*, note 133, para. 10.16, at 140.

137 Law Comm. Report, *supra*, note 134, para. 12.15, at 175.

138 Law Society of Scotland Report, *supra*, note 37, at 7. See, also, *Children's Act,* S.Y.T. 1984, c. 2, s. 14 ("consents in advance"); United States Uniform Parentage Act, *supra*, note 129, §5(a) (consent in writing and signed by husband and wife); Victoria *Status of Children Act* 1974, No. 8602, ss. 10C-10E, enacted by *Status of Children (Amendment) Act* 1984, *supra*, note 129 (consent rebuttably presumed); the proposed South Australia *Family Relationships Act Amendment Act, 1984* (Bill No. 4), s. 6, adding (*inter alia*) s. 10d(2) to the *Family Relationships Act, 1975,* No. 115; and the American legislation discussed in sec. 3(c)(i)b(2) of the Appendix to this Report.

139 Law Comm. Report, *supra*, note 134, para. 12.16, at 175 (footnote reference deleted).

written consent procedure, prior to the commencement of treatment. Accordingly, we recommend that the consent of the husband or partner should be presumed as a matter of law. However, this presumption should be rebuttable at his instance or at the instance of another person with a legitimate interest. In the latter connection, for example, a beneficiary under the will of the husband or partner may wish to adduce evidence that the husband or partner did not consent to the artificial conception procedure, where a successful rebuttal of the presumption would augment the beneficiary's share of the deceased's estate.

As a result of our proposal, the onus of proof would be on the person attempting to rebut the presumption. The court hearing the matter would be able to draw appropriate inferences from the man's conduct, for example, without being constrained by particular forms of expression of consent or dissent.

(ii) Retroactive Recognition of Parentage

The critical legal, social, and psychological importance of the issue of status and parentage has been underscored in the preceding section. Indeed, the Commission is so firmly committed to its proposal to regularize the status of artificially conceived children that it believes that it is justifiable and desirable to extend it to existing children.

Accordingly, having regard to the recommendations made above, and in conformity with at least the *de facto* status of many existing artificially conceived children, we recommend that the proposed legislation respecting the status and legal parentage of such children should be retroactive in effect. Such a provision would relieve past gamete donors of parental rights and duties, and would regularize the status of husbands and male partners who hitherto have treated the children as if they had been conceived naturally within marital or nonmarital unions.

(iii) Registration of Birth

a. Where Donor Gametes are Used

Intimately related to the preceding issue of status and parentage is the question of birth registration, the documentary manifestation of these two legal concepts. In chapter 3, the Commission considered in some detail the law and practice respecting the registration of births under the *Vital Statistics Act.*[140] The system of birth registration contained in this Act serves as a record of the circumstances of birth and, as well, provides one means by which the parentage of children is presumptively established.

It will be recalled that, in the case of married, cohabiting persons, the child must be given the surname of the husband and the particulars of the husband must be given as those of the father;[141] but, as we have seen, the presumption that the child is a child of the couple is rebuttable. Where an unmarried woman

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[140] *Supra*, note 123.

[141] *Ibid.*, s. 6(4).

gives birth to a child, no particulars of the father must be given unless she and a male who acknowledges himself to be the father jointly request that his particulars and surname be given.[142]

We have noted already that, in the context of artificial conception, the continuing efficacy of these presumptions is dependent, in one sense, on the provision of false information and on the anonymity of the gamete donor. These factors help to preserve the register of births as a social, rather than a true biological, record of parentage, frequently conforming to the reasonable intentions of the parties and furthering the well-being of the artificially conceived child.

As we have said before, this haphazardly effective system does not conform to modern perceptions of status and paternity. Consistent with our views on these two matters, the Commission recommends that, in the case of artificial conception with donor gametes, the woman who bears and intends to rear[143] the child should be registered as the child's mother, and the mother's spouse or partner who, under our previous proposals,[144] is deemed to be the legal father, should be registered as the child's father.[145] The gamete donor should not be named in the register of births, nor should the fact of artificial conception appear in the register.

b. Posthumous Artificial Conception, Where No Donor Gametes are Used

Section 6(4) of the *Vital Statistics Act* is, as we have seen, a provision that requires the registration of the husband's surname, and the giving of the husband's particulars as those of the father, where a child is born to a "married woman". Consequently, where a widow gives birth to a child conceived posthumously by means of her deceased husband's preserved sperm, the widow would not be able, at least as a matter of law, to use section 6(4) of the Act. However, where the child is born within 300 days of the husband's death, the widow may ultimately gain registration showing her deceased husband's surname and particulars by utilizing the rather circuitous path of applying for, and obtaining, a declaration that her husband is the legal father[146] (having regard to the statutory presumption[147]), and then seeking the desired registration from the Registrar General.[148]

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142 *Ibid.*, s. 6(7) and (8).

143 The case of surrogate motherhood is examined elsewhere: see *infra*, this ch., sec. 5.

144 See *supra*, this ch., sec. 3(d)(i).

145 Accordingly, having regard to our earlier proposals (see *ibid.*), the husband or partner may contest the registration — indeed, his presumed paternity — by proving that he did not consent to the procedure.

146 *Children's Law Reform Act, supra*, note 122, s. 4(1).

147 *Ibid.*, s. 8(1)2.

148 *Ibid.*, s. 16.

Under the procedure just described, time is obviously of the essence: a delay in posthumous A.I.H. would mean that the child could be born outside the 300 day period, in which case no statutory presumption of paternity would arise; under these circumstances, because the husband has died, no application could be made for a paternity declaration.[149]

The status of a child conceived posthumously by means of the sperm of an unmarried mother's deceased partner is also precarious. Again, there is a limited 300 day statutory presumption of paternity.[150] In addition, the *Children's Law Reform Act* refers, somewhat ambiguously, to a birth occurring within 300 days after the man and woman "ceased to cohabit": there is no express mention of a birth that has occurred within 300 days of the termination of the relationship "by death".[151]

The Commission is of the view that the existing situation is unsatisfactory, the burden of the legislative gaps or inattention falling primarily on the artificially conceived child. We see no reason why the child should not be registered as the child of the mother's deceased husband where his sperm was used to inseminate her artificially. Nor, given the general assimilation of the position of married couples and unmarried couples, do we see any reason for distinguishing the position of the child of the latter from the position of the child of a married couple. Accordingly, the Commission recommends that, where a woman gives birth to a child conceived posthumously by means of her deceased husband's or partner's preserved sperm, the woman should be entitled to register the birth showing the deceased as the father of the child and giving the deceased's particulars as those of the child's father.

(iv) Inheritance Rights of Artificially Conceived Children

a. Where Donor Gametes are Used

In a previous section,[152] the Commission recommended that a child conceived artificially with donor gametes should be recognized in law to be the natural child of the woman giving birth and her consenting husband or partner. However, some have suggested that, notwithstanding this assimilation of the position of artificially and naturally conceived children, an exception should be made in the case of the law of succession. It is argued that fidelity to genealogical lines is an important historical principle of succession[153] and that, as a result, genealogical continuity in family relationships is entitled to respect after death.

In practice, the issue manifests itself where, for example, a testator's will

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149 *Ibid.*, s. 5(2).

150 *Ibid.*, s. 8(1)4.

151 *Ibid.* Termination by death, along with termination by divorce and a judgment of nullity, are referred to in the relevant provision respecting married couples: *ibid.*, s. 8(1)2.

152 *Supra*, this ch., sec. 3(d)(i).

153 See Glendon, *The New Family and the New Property* (1981), at 105 *et seq.*

contains such language as "to John and the heirs of his body", and where, unknown to the testator, John's wife has had a child through A.I.D. Strictly speaking, the child falls outside the language of the will. In such a case, the testator's intention to benefit the artificially conceived child cannot be assumed from the mere fact of testamentary disposition, evidenced by the will itself. His gift may have presupposed a biological connection with John. Moreover, other beneficiaries have an interest in disputing the claim of an artificially conceived child where the strict language of the will would seem to exclude him or her.

There are, then, several values that are important in the community and in testamentary law, and these values may well conflict where an artificially conceived child is involved and specific or unambiguous language has not been used to accommodate the child in a will. Beneficiaries must be given their rightful portions; and the intent of testators must be a paramount consideration in the interpretation of wills. The problem is that, without specific inclusory or exclusory language, it may be impossible to tell what a testator would have wanted had he or she known of the biological origins of the child in question.

But, aside from this practical or evidentiary problem, and subject to one caveat, the Commission sees no reason why, as a matter of public policy, its previous recommendation respecting the status and parentage of artificially conceived children should be restricted so as to exclude inheritance rights. While there are other legal consequences attaching to our proposal — relating, for example, to support and custody — inheritance is a vital concomitant of status and parentage. As a matter of principle, we do not believe that we should provide an artificially conceived child with an assured legal status *vis-à-vis* his social father and then subsequently deny him the legal benefits that flow from such status.

We said, however, that this conclusion is subject to one caveat. Let us assume, for example, that the grandfather of an artificially conceived child knows of the biological origins of that child and does not wish the latter to inherit through him. The grandfather might simply exclude the child by specifically naming the beneficiaries and leaving the child out. Or the testator may leave property to the heirs of the infertile man's body, thereby excluding the child.

In these cases, where it is clear from the language of the will that the testator does not intend to benefit the artificially conceived child, we are of the view that the testator's intentions should prevail. As a general principle, no one should be forced to benefit another by means of a testamentary disposition.[154] We are buttressed in this view by the analogous provisions of the *Child Welfare Act* and the new *Child and Family Services Act, 1984* dealing with the inheritance rights of adopted children. Section 86(3) of the former and section 152(4) of the latter basically provide that such children should be deemed to be the natural children of the adopting parents for the purpose of inheritance, "unless the contrary is expressed" by the testator. A similar principle is evinced insofar as children

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[154] We are aware, of course, of the dependants' relief provisions of the *Succession Law Reform Act, supra*, note 128, which permit dependants to apply for support where adequate provision has not been made for such persons by the deceased.

born out of wedlock are concerned: for the purpose of construing any instrument, Act, or regulation, such children are to be treated in the same way as children born within wedlock, "unless the contrary intention appears".[155] We are of the opinion that this exception to the general rule is reasonable.

Accordingly, consistent with our earlier proposals respecting the status and parentage of children conceived artificially with donor gametes, we recommend that, unless the contrary is expressed by the testator, such children should acquire inheritance rights to the estates of those persons who are legally recognized as their parents, and to the estates of others as if they were the natural children of such parents. It is further recommended that such children should have no inheritance rights through the gamete donors, unless, of course, the donors expressly provide for the children in their wills.

b. Posthumous Artificial Conception, Where No Donor Gametes are Used

It will be recalled that, in respect of the registration of a child posthumously conceived by means of the sperm of a deceased husband or partner, the Commission recommended that the child should be registered naming the deceased man as father.[156] The question arises, then, concerning the inheritance rights of such a child.

We see two issues involved: first, the issue of principle, namely, whether the child should be entitled to inherit through his or her legal father; and secondly, whether the position of the child posthumously conceived with the sperm of the mother's deceased male partner should be assimilated to that of a child posthumously conceived with the sperm of the mother's deceased husband.

Dealing first with the main issue, the Commission clearly favours, in principle, giving the child rights of inheritance as though he or she were the natural child of the man in question, conceived in his lifetime. We believe that this conclusion follows directly from our earlier proposals respecting status and parentage.

However, the implementation of this general conclusion would be impracticable, or unacceptably disruptive, where the estate has already been distributed according to the provisions of the will or the law of intestate succession. If such distribution has occurred, the Commission considers that the dispositions made should not be disturbed. Similarly, distribution should not be postponed simply because sperm is held in cryopreservation. It is recommended, however, that a posthumously conceived child of a husband should be entitled to inheritance rights in respect of any undistributed estate once the child is born or is *en ventre sa mere,* as if the child were conceived while the husband was alive.[157]

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155 *Children's Law Reform Act, supra,* note 122, s. 2(1).

156 See *supra,* this ch., sec. 3(d)(iii)2.

157 We therefore reject the proposals of the Warnock Committee to the effect that a child who was not *in utero* at the date of the death of its father should be disregarded for the

Moreover, such a child should be entitled to inheritance rights where the child is born or is *en ventre sa mere* when the time for the ascertainment of possible beneficiaries arrives. For example, the testator may leave a life estate to X, after which the property would pass to the testator's "children" then alive. If, at the death of X, there exists, or is *en ventre sa mere*, a posthumously conceived child of the testator, that child should be entitled to share.

The second issue to which reference was made concerns the status of a posthumously conceived child of a man who lived in a nonmarital union with the mother. There is an argument that such a child should not be treated in the same way for inheritance purposes as the posthumously conceived child of a woman and her deceased husband. In the latter case, it has been suggested, it may more readily be presumed from the nature of the relationship (marriage) that the man would wish the child to inherit through him, but that no such assumption should be made where the man did not have the same type of formal connection with the mother.

The Commission does not accept these views. We do not believe that one can conclude that a man in a nonmarital union must be presumed to have a different intention than that of a married man with respect to any child conceived posthumously with his sperm. Moreover, it bears mentioning that the *Succession Law Reform Act*[158] does not distinguish between children on the basis of their parents' marital status. Accordingly, we recommend that the position of a child posthumously conceived with the sperm of the mother's deceased partner in a nonmarital union should be the same as that of a child posthumously conceived with the sperm of the mother's deceased husband.

(e) MEDICAL RECORDS

In an earlier section, we recommended that legislation should expressly provide that artificial conception procedures constitute the "practice of medicine" under the *Health Disciplines Act.*[159] As a result of this proposal, such procedures could be undertaken only by licensed physicians[160] or others authorized to act under their supervision or direction.[161] Implementation of this proposal would bring in its train several important legal consequences regarding medical records.

First, the present requirement to keep medical records on patients, expressed in the regulations passed under the *Health Disciplines Act,*[162] would apply to artificial conception procedures. Secondly, the failure to maintain

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purposes of succession to and inheritance from the latter: see Warnock Report, *supra*, note 2, para. 10.9, at 55, and para. 10.15, at 57.

158 *Supra*, note 128, s. 1(2).

159 *Supra*, note 25. See *supra*, this ch., sec. 3(a).

160 *Health Disciplines Act, supra*, note 25, s. 52.

161 *Ibid.*, s. 50(k). See, generally, *supra*, ch. 3, sec. 2.

162 R.R.O. 1980, Reg. 448, s. 29(1).

adequate records would be professional misconduct on the part of the physician.[163] Indeed, it might well be professional misconduct where a physician failed to maintain records required for the conscientious and professional care of persons, other than patients, to whom legal, fiduciary, or ethical duties are owed.[164] These other persons could include artificially conceived children, who, while not patients, have frequently been said to be persons to whom physicians owe at least ethical duties. Thirdly, under traditional negligence law, there would likely be a legal duty of appropriate record keeping owed to patients and others, including children, who foreseeably might be prejudicially affected by the failure to keep such records.

In addition to legal obligations imposed on physicians, we have seen that other legislation governs the retention, ownership, confidentiality, and destruction of medical records in public hospitals.[165] Similarly, the Canadian Medical Association *Code of Ethics,*[166] to which the College of Physicians and Surgeons of Ontario subscribes, contains provisions dealing with confidentiality of medical records and patient information. These provisions may be enforced through the professional misconduct provisions of the *Health Disciplines Act* and the regulations passed thereunder.[167]

The legislation, regulations, and professional ethical guidelines respecting the keeping and confidentiality of medical records have been discussed in some detail in chapter 3.[168] As we indicated there, the questions of confidentiality and anonymity are particularly important in the case of medical records respecting artificial conception services.

The Commission believes that, while the governing legislation and ethical guidelines with respect to the maintaining of medical records are not entirely satisfactory for all purposes,[169] they appear to be quite comprehensive and satisfactory insofar as they relate to the recording of artificial conception services. Physicians are under statutory, regulatory, and ethical obligations to keep records and maintain their confidentiality, and we are of the view that, at this general level — dealing with records of medical care — it would be unnecessarily duplicative to enact specific artificial conception legislation mandating what is already obligatory. There is no indication that a particular abuse

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163 *Ibid.*, s. 27.3.

164 See *ibid.*, s. 27.32, which defines "professional misconduct" to mean, *inter alia,* "conduct or an act relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional".

165 See *Public Hospitals Act,* R.S.O. 1980, c. 410. See, also, *supra*, ch. 3, sec. 6.

166 Canadian Medical Association, *Code of Ethics* (September, 1982).

167 See, generally, *supra*, ch. 3, sec. 6.

168 See *ibid.*

169 See Ontario, *Report of the Commission of Inquiry into the Confidentiality of Health Information* (1980) (hereinafter referred to as "Krever Report"), discussed *supra*, ch. 3, sec. 6.

has occurred in respect of the recording of artificial conception services. To the extent that reform is thought to be necessary in the area of medical records, it should comprehend all health care services and not merely one, relatively small, field of medicine.[170] Accordingly, we recommend that, subject to the recommendations that follow, no specific legislation or rules dealing with medical records relating to the provision of artificial conception services should be enacted or established.

Turning now from the keeping of medical records generally to certain specific matters, we are of the opinion that artificial conception does exhibit several unique characteristics that require attention.

First, we shall consider a matter relating to information concerning gamete donors. As we indicated in chapter 3, it is not clear that donors, particularly sperm donors, are "patients" for the purpose of the record keeping provisions of Ontario legislation. In order to ensure that the legislation and other guidelines respecting medical records are as comprehensive as possible, particularly in light of a proposal to be made subsequently concerning a record of linkage between donors and recipients, we recommend that the relevant statutes, regulations, and professional rules be amended to make it clear that gamete donors are patients for the purposes of record keeping. We now turn to a second issue, dealing with the question of linkage.

In chapter 3, we noted that a system of linkage in medical records — permitting doctors to link donors to recipients and, thereby, to their offspring — may be of critical importance where medical or genetic information is required, either in an emergency or otherwise. An artificially conceived child may be born with some disability directly related to the medical or genetic characteristics of the donor. In such a case, treatment of the child may require access to health information concerning the donor and the donor's family medical history. Or vital medical information — for example, affecting future decisions concerning reproduction — may come to light and should be communicated to the donor or to his or her other children. Only a system of linkage can ensure the provision of the requisite medical information to the appropriate persons.

Many of the bodies that have considered the question of medical records in the context of artificial conception have concerned themselves with matters relating to linkage. Generally, there has been a predisposition in favour of maintaining a system of linkage, in some cases to facilitate the provision of necessary medical information to one party or another, in other cases to facilitate access to basic information concerning a donor's ethnic origin and genetic health.

The Commission understands that, as a matter of practice, most doctors do in fact keep records that link donors to recipients, while at the same time

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[170] Most of the reports surveyed by the Commission specifically recommend the keeping of adequate, confidential records respecting artificial conception. However, most of the discussion in the reports deals with certain specific issues, such as disclosure, that we shall consider in the text immediately following.

preserving their anonymity.[171] We wish to express our endorsement of the present general practice of anonymously linking donors to recipients in medical records. Indeed, we think that the matter ought to be taken one step further. While we do not believe that furtherance of this practice, in an attempt to make it universal, should be promoted by statutory enactment, we do recommend that, pursuant to the power given to the Council of the College of Physicians and Surgeons of Ontario under section 50 of the *Health Disciplines Act*,[172] the Council should make regulations that would establish a system of record keeping permitting doctors to link gamete donors with recipients. However, again in light of our subsequent proposals, we wish to underscore our concern lest the actual identity of the donor be divulged. Accordingly, we recommend that anonymity concerning the identity of all parties involved in artificial conception — the donor, the recipient, her spouse or partner (if any), and the child — should be preserved in the medical records.

The preceding recommendation, it should be emphasized, is concerned exclusively with the preservation of the anonymity of the parties among themselves. However, as we have indicated, it may be necessary for a doctor (but not recipients or children) to trace donors after children have been born using their gametes. To repeat, the most important reason for such tracing would be to discover relevant genetic or other information from the donor in order to treat the artificially conceived child or to convey relevant genetic information to the donor or, perhaps, to his or her other biological children.

The Commission recommends that, where a genetic or transmissible defect or disease in a donor or a donor's child becomes known to a doctor, the doctor should be under a duty, imposed by regulations governing the medical profession,[173] to make all reasonable efforts to report all relevant information to any person whose health and welfare the doctor reasonably believes may be affected by it. Sanctions for the failure to abide by such a regulation should lie in potential civil liability in negligence and in the "professional misconduct" regulations under the *Health Disciplines Act*,[174] rather than in a specific new penalty.

A third matter to which special attention should be given concerns whether practitioners engaged in an artificial conception practice should be legally obligated to follow up the results of any procedure, for example by attempting to ascertain whether conception has taken place and, if so, whether any child who is born suffers from the kinds of genetic or other defect or disease to which reference was made earlier. This issue, then, is intimately related to the

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171 See *supra*, ch. 2, sec. 3(b)(i).

172 *Supra*, note 25. Section 50(g) provides that, "[s]ubject to the approval of the Lieutenant Governor in Council and with prior review by the Minister [of Health], the Council may make regulations ... (g) governing standards of practice for the profession". As we have seen, regulations have been made, dealing, *inter alia*, with medical records: see R.R.O. 1980, Reg. 448, ss. 29 and 27.3.

173 See *supra*, note 172.

174 R.R.O. 1980, Reg. 448, s. 27.

preceding one respecting the doctor's duty to report defects in artificially conceived children to others.

Although a system of follow up is obviously desirable, as a practical matter it is often impossible or impracticable for the artificial conception practitioner to obtain information about any subsequent conception and birth. To ensure secrecy, at least at this stage, the recipient woman who has conceived artificially usually leaves the services of that practitioner for her own doctor, who may be unknown to the artificial conception practitioner. The latter may simply assume that the woman has become pregnant or has given up the attempt, and that, if she has conceived, she will be seeing her own doctor henceforward.

The Commission does not believe that it is feasible to go beyond present practice, which in some, but not all, cases may well involve some follow up after artificial conception procedures have been used.[175] Accordingly, we recommend that there should be no positive duty on artificial conception practitioners to take steps to ascertain whether conception and birth have taken place or to ascertain the medical status of any child. However, should it be thought necessary or desirable to deal more formally with this matter, we recommend that any legal obligation to follow up the outcome of artificial conception treatment should be incorporated in the regulations governing the medical profession under the *Health Disciplines Act.*

A final matter relating to medical records in the context of artificial conception concerns access to such records by recipients, their husbands or partners (if any), donors, and artificially conceived children. A subsidiary, albeit no less critically important, question is, assuming access, whether disclosure should be limited to non-identifying information contained in the records, or whether the identity of the parties should be revealable and, if so, under what circumstances. With respect to the latter question, it bears repeating that earlier we recommended anonymity in the general context of linkage. The issue here is whether an exception should be made for any of the persons involved, particularly the child.

Before we deal specifically with access to medical records, we wish to raise the critical threshold question concerning whether a child should be told of his biological origins.[176] Unfortunately, the answer to this question depends, in part, on interpretations of data that vary significantly and, indeed, on data that has not been gathered to the satisfaction of social scientists, even from the analogous and more accessible field of adoption. The social and psychological ramifications of disclosure are simply not clear; one cannot accurately predict the implications in individual cases.

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175 In some cases, donors and their artificially conceived children may be protected where the mother of an impaired child, needing the information contained in the medical records of the artificial conception practitioner, communicates with that practitioner herself, or gives to her new physician the name of the practitioner, so that the donor may be sought.

176 See, generally, Berger, "Psychological Aspects of Donor Insemination" (1982), 12 Int. J. Psychiatry in Med. 49, and Simanek, "Adoption Records Reform: Impact on Adoptees" (1983), 67 Marq. L. Rev. 110.

With respect to the issue of disclosure, we agree in principle with the view expressed in a Report of the Royal College of Obstetricians and Gynaecologists in the United Kingdom that "the decision to disclose to the child the nature of its parentage should at the present time remain with the 'legal' parents".[177] The decision, we believe, does not lend itself any more to legislative resolution in the artificial conception context than it does in the adoption context, where disclosure of status is not mandated by statute or otherwise, but is left to the legal parents, or, in some cases, others. Each family situation is different, so that a general hypothesis — that, for example, secrecy is deceitful and fundamentally unhealthy — while perhaps reasonable and compelling in the abstract, cannot be translated into a meaningful statutory directive. To counsel common sense, bearing in mind all the circumstances of each case, such as the child's age and temperament, is likely all that can usefully be done concerning this particular matter.

Returning to the separate question of access to medical records, we have seen that the mere existence of medical records does not compel or, indeed, justify disclosure. Confidentiality is the norm. However, recent legislative developments make manifest, at least in some small measure, a movement away from a doctrinaire approach to this issue. Aside from exceptions for essentially medical or related reasons contained in the new *Child and Family Services Act, 1984*,[178] the most obvious example of this movement away from rigid nondisclosure occurs in the adoption context[179] in respect of the "voluntary disclosure register". Without canvassing the matter in detail here, it should be noted that the

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177 See RCOG Report, *supra*, note 48, para. 14.4.12, at 18:

> [T]he identity of donors should not be revealed and indeed the donor arrangements should be such that anonymity is inviolable .... [T]he decision to disclose to the child the nature of its parentage should at the present time remain with the 'legal' parents. This should apply equally to children resulting from AID or from IVF and ER. In the event of the parents making such disclosure the child should have access to the same information regarding the genetic background of the donor as was available to its parents without breaching anonymity. If AID or IVF has been employed to avoid transmission of a genetic defect the parents should consider how this information can be conveyed to the child in the event of their premature deaths.

In the British Columbia Royal Commission Report, *supra*, note 42, it was recommended that "[t]he child should not have the fact of his origin by artificial insemination divulged to him" (*ibid*,, at 14, recommendation 7), except if nonidentifying information must be obtained for medical reasons (*ibid.*, at 27, recommendation 16).

178 *Supra*, note 41, ss. 157(2)(d) and 166(1)(f).

179 But see *Child and Family Services Act, 1984, supra*, note 41, s. 157(1), which provides:

> 157.-(1) Despite the provision of any other Act, no person shall inspect, remove, alter or permit the inspection, removal or alteration of information that relates to an adoption and is kept,
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> (a) by the Ministry;
>
> (b) by a society or licensee; or
>
> (c) in the register maintained under section 158,

Child Welfare Act[180] has established such a register. Where an adopted child, eighteen years of age or older, and a person who was his or her parent at the time of birth, place their names in this register, a procedure is in place for mutual disclosure of identifying information where, *inter alia*, the adopting parent consents.[181]

The reports that have canvassed the issue of disclosure have generally favoured anonymity respecting the identity of the parties, although not respecting medical or other related information. The Warnock Committee recommended a relatively open system, for it was of the view that, "on reaching the age of eighteen the child should have access to the basic information about the donor's ethnic origin and genetic health and that legislation be enacted to provide the right of access to this".[182]

With respect to the question of access to medical records after a child has, in fact, discovered that he or she was artificially conceived, a minority of the Commission considers that specific legislation is justifiable. These Commissioners would recommend that children born of donated gametes and their legal parents[183] should be entitled to access to all but personally identifying information respecting the donors. A single Commissioner would also grant donors access to nonidentifying information concerning the women and children affected by their donations.

The majority of the Commission, however, does not wish to go this far in respect of access to medical records. They do not believe that legislation could be adequately drafted to take into account the very different needs and emotional makeup of the children in question. In some cases, disclosure of all relevant, nonidentifying information contained in the doctor's record may be appropriate and desirable, while, in other situations, disclosure of some of the information may be more harmful than silence. Accordingly, by a majority, the Commission recommends that the decision concerning access to medical records by the parties involved — the woman, her husband or partner (if any), the child, and the donor — should be left to individual members of the medical profession. However,

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or disclose or permit the disclosure of such information that the person obtained from the records of the Ministry, the records of a society or licensee, or the register maintained under section 158.

Section 157(2) contains some exceptions to the rule in s. 157(1). For example, s. 157(2)(a) provides that s.s. (1) does not apply to "the inspection or disclosure of information in accordance with section 158". See text immediately following.

180 *Supra*, note 41.

181 *Ibid.*, s. 81(6)(b). See, also, the new *Child and Family Services Act, 1984, supra*, note 41, s. 158.

182 Warnock Report, *supra*, note 2, para. 4.21, at 24-25. This proposal presupposes, of course, that the child has already been told of, or has otherwise discovered, his biological origins. See, also, Queensland Report, *supra*, note 1, at 56, and RCOG Report, *supra*, note 46, para. 14.4.12, at 18.

183 See *supra*, this ch., sec. 3(d)(i).

under no circumstances should any doctor or other person disclose information that could in any way identify the parties involved.[184]

(f) Artificial Conception and Legal Liability

(i) Concealment and Misrepresentation of Information by Gamete Donors

When considering the criteria for selection of gamete donors, the Commission emphasized the critical importance to the prospective parents, and particularly to the resulting child, of the selection of suitable gamete donors.[185] In order to ensure, as much as possible, that donors with genetic or other transmissible diseases are not used, the Commission recommended that the question of a donor's genetic and medical status should be governed by professional guidelines to be set by the medical profession. Moreover, since, under our proposals, artificial conception services would constitute the "practice of medicine",[186] the whole panoply of professional medical standards would be brought to bear on the process of gamete donor selection.

Proper professional screening of prospective donors, including adequate genetic and related testing, should minimize risks relating to donation. However, medical science remains dependent, at least in part, on information provided directly by the person tested. The acquisition of family histories and other important information from patients requires intelligent and diligent probing. There is room for human error and mistake. In some cases, likely to be rare, donors may even deliberately conceal information or misrepresent facts or events. To the extent that laboratory and other scientific testing cannot act as a sufficient safeguard against such conduct, it may be thought necessary to provide special legal sanctions against donors.

At present, the *Criminal Code*[187] creates offences for criminal negligence causing bodily harm[188] and for obtaining money by false pretenses.[189] The

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184 It bears mentioning that the medical profession's *Code of Ethics, supra*, note 166, Responsibilities to the Patient, para. 6, provides that a physician "will keep in confidence information derived from his patient, or from a colleague, regarding a patient and divulge it only with the permission of the patient except when the law requires him to do so". Arguably, "information ... regarding a patient" is restricted to identifying information.

Mention should also be made of the regulations under the *Public Hospitals Act, supra,* note 165, which substantially limit access to medical records in public hospitals. For example, access by a physician is at the discretion of the hospital board. Indeed, no member of the public, including a patient, has a direct right to remove, inspect, or receive information from a medical record in a public hospital. See R.R.O. 1980, Reg. 865, s. 49.

185 See *supra*, this ch., sec. 3(c)(i).

186 See *supra*, this ch., sec. 3(a).

187 R.S.C. 1970, c. C-34.

188 *Ibid.*, s. 204.

189 *Ibid.*, ss. 319-20.

Commission is of the view that, while the existence of these criminal sanctions may well act as a deterrent in some cases, the Province should, and constitutionally can,[190] go further to create a provincial offence dealing expressly with the conduct described earlier. We believe that the matter is of sufficient importance to warrant such a specific provision in the law of Ontario.

The Commission has considered three alternative types of provincial offence, one rendering it an offence knowingly to conceal or misrepresent information in offering or agreeing to donate gametes for artificial conception purposes, another rendering it an offence negligently to conceal or misrepresent information in such circumstances, and, finally, one rendering it an offence simply to provide false or misleading information, whether innocently, negligently, or fraudulently.[191]

We believe that the last mentioned option, creating a provincial offence in the absence of demonstrable fault, is unjustifiably excessive. Such a Draconian measure might even serve to discourage donations by honest persons, fearful of providing incorrect information despite their best intentions.

A regime founded on negligent conduct, while less severe, is also, we believe, unwarranted. We are of the view that the potential for civil liability at the suit of those persons to whom the donor has a legal duty to take reasonable care, and who have been injured by the donor's negligent conduct, is a sufficient response to this type of conduct.

We are left, then, with the more traditional type of offence, requiring the prosecution to prove the donor's wrongful intent to conceal or misrepresent information. To the extent that the existence of such a sanction can act as a deterrent to unacceptable conduct, this regime, in our view, would best serve to protect the interests of the parties. Accordingly, the Commission recommends that it should be made a provincial offence knowingly to conceal or misrepresent information in offering or agreeing to donate gametes for artificial conception purposes. Knowledge by prospective donors that such an offence exists should help to emphasize the significance and seriousness of donation.

(ii) Products Liability and the Supply of Gametes and Embryos

The possibility that the federal government will regulate the supply of sperm, at least for the purpose of licensing sperm banks,[192] gives added point to the question of liability for the direct and indirect supply of gametes, including embryos, that lack the genetic or other attributes claimed for them by their suppliers, that is, gamete donors, gamete banks, and artificial conception practitioners. While the implementation of our proposals respecting donor

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190 See *Constitution Act, 1867,* 30-31 Vic., c. 3 (U.K.), s. 92.15.

191 See *R. v. City of Sault Ste. Marie,* [1978] 2 S.C.R. 1299, 85 D.L.R. (3d) 161, for the distinction between traditional, strict, and absolute liability offences.

192 See *supra*, ch. 3, sec. 4(b).

selection and donor liability under a new provincial offence provision would certainly help to reduce risks to those involved, the use of gametes does carry irreducible minimum risks that may lead to untoward consequences.

Liability for the supply of gametes may be imposed under both contract law and tort law. Leaving aside the application of negligence law and, at this juncture, focusing exclusively on strict liability in the law of torts, it has been said that "no general principle of strict liability for defective products has been announced by any court".[193]

Indeed, in our *Report on Products Liability,* the Commission stated that it was "of the firm view that the most rational basis for dealing with the rights of a person injured by a defective product is to create a direct right of action, not dependent on contract, against the supplier of the defective product".[194] The Commission's draft *Products Liability Act*[195] would provide a right of action to an injured person "[w]here in the course of his business a person supplies a product of a kind that it is his business to supply ..." and where the product in question was defective and caused the injury.[196] A "product" was defined to mean "any tangible goods", and "to supply" was defined to mean "to make available or accessible by sale, gift, bailment or in any other way ...".[197] It is not unreasonable to suggest that the supply of gametes, at least by gamete banks, would fall within these provisions. Consequently, if the proposals in our earlier Report were implemented, principles of strict liability would apply to the supply of gametes and embryos.

However, the area in which these principles make their greatest mark is that of contract law. At present, there is uncertainty in the legal literature and case law concerning whether the supply of biological products attracts liability as a sale of goods or as the rendering of a service, and whether this distinction is applicable in provincial law to lead to different results. In Canada, if the supply of gametes is characterized as a sale of goods, the implied warranties of merchantable quality and fitness for a specified purpose would apply;[198] indeed, analogous warranties may apply if the supply of gametes is characterized as the offering of a service.[199] Consequently, any failure of result would leave both donor and practitioner liable even in the absence of negligence.[200]

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193 Ontario Law Reform Commission, *Report on Products Liability* (1979), at 21. However, strict liability principles have been invoked in a small number of tort cases: see *ibid.*, at 20-21.

194 *Ibid.*, at 64.

195 *Ibid.*, Appendix 1, at 135.

196 Draft Bill, s. 3(1), in part.

197 *Ibid.*, s. 1(1)(c) and (d), respectively.

198 See *Sale of Goods Act,* R.S.O. 1980, c. 462, s. 15.

199 Waddams, "Implied Warranties and Products Liability", in Law Society of Upper Canada, *New Developments in the Law of Torts* (1973) 159, at 162-64.

200 See, generally, *ibid.*, esp. at 163 *et seq.*

In the United States, several courts have held that implied warranties are confined to sale of goods transactions.[201] Blood donation has regularly been held to be a service, rather than a sale of goods, transaction. Accordingly, suppliers of blood, whether individual donors, philanthropic agencies, or commercial blood banks, are not held to the implied warranties of merchantable quality and fitness for purpose, although they do bear ordinary civil liability where a plaintiff proves negligence, for instance, in the case of inadequate screening of donors.[202] This position would appear to result from a recognition of the critical need for blood donation services, and of the likelihood that the application of strict liability principles would discourage individuals and agencies from undertaking the supply of blood.

The question is, then, whether the need to ensure a supply of gametes for artificial reproduction is comparable to the need to ensure a supply of blood for transfusion. If it is considered that the needs of those whose reproduction is dependent upon donated gametes are sufficiently meritorious or pressing, a regime under which strict liability principles, and particularly the implied warranties of quality and fitness for purpose, would apply would have to be rejected as having an inhibiting, counter-productive effect, by tending to lessen the availability of such services. The fact that the provincial health insurance plan covers A.I.D. and diagnostic services leading to I.V.F. may indicate that the practice of gamete donation does, in fact, respond to a call for services considered worthy of protection.

The Law Reform Commission of Saskatchewan has stated that, "while categorization of the transaction in this way [as a sale of goods, bringing in train the implied warranties] should cause few problems, it is generally undesirable to have law designed for commercial transactions involving chattels applied to the relationship between a donor and a collector of semen",[203] or, presumably, between a doctor and recipient. Accordingly, it was proposed that the transaction in question should not be treated as a sale of goods and that no implied warranties should apply.[204]

The Commission agrees in principle with this conclusion. Indeed, we would go further and reject the application of strict liability generally, whether arising in the context of contract or tort. We believe that compensation and deterrence are satisfactorily ensured by the ordinary law of negligence. Finally, we are of the view that imposing strict liability on the donation or supply of gametes, even by commercial gamete banks, would substantially reduce the number of gametes available to treat infertile or genetically impaired persons. Our conclusion in this matter does not ignore the fact that gametes may be defective. However, our earlier proposals respecting the screening of gamete donors, as well as normal

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201 See *ibid.*, at 163, *n.* 17.

202 See, for example, *Perlmutter v. Beth David Hospital,* 123 N.E. 2d 792 (N.Y. Ct. App. 1954).

203 Law Reform Commission of Saskatchewan Report, *supra*, note 37, at 3-14.

204 *Ibid.*, at 3-16, recommendation (9).

medical practice, will serve to eliminate gametes that should not be used in an artificial conception programme.[205] Moreover, standards of screening sperm donors will be influenced by the criteria that may be proposed by the federal government through its announced scheme to license sperm banks. Accordingly, the Commission recommends the enactment of legislation that would provide that principles of strict liability, and particularly the implied warranties of merchantable quality and fitness for purpose, should not be applied to the direct or indirect donation or supply of gametes or embryos;[206] rather, recovery in such a transaction should be dependent upon general principles of the law of negligence.

(iii) Wrongful Conception, Wrongful Birth, Wrongful Life, and Dissatisfied Life Claims

When discussing, in previous sections, the potential liability of practitioners and donors for conduct in the context of artificial conception, it was stated that the ordinary principles of tort law, including the law of negligence, would and should continue to apply to this branch of medical practice. We need not review here the applicability of that law in the context of artificial conception in those cases where the courts can utilize well-known concepts in a traditional way. For example, the law respecting liability for prenatal injuries ordinarily follows orthodox tort principles and, therefore, warrants no special treatment.[207]

There is, however, a set of claims that is both contentious and widely surveyed in modern United States medicolegal jurisprudence and literature. These claims are represented by a substantial and growing number of difficult cases, in which vigorous dissents are commonplace, and have been addressed by

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205 See *supra*, this ch., secs. 3(c)(i), (vii), and (viii).

206 Legislation implementing this proposal would be an exception to s. 3(1) of the Commission's draft *Products Liability Act,* reproduced *supra*, this sec., at least insofar as commercial gamete banks, in the "business" of supplying gametes, are concerned.

With respect the application of the implied warranties to the supply of defective medical products by physicians, see Waddams, *supra*, note 199, at 164, where the author stated that "there may be considerations of social policy that would justify the exemption of medical practitioners from the scope of strict liability ...". For the reasons advanced in this Report, we agree, at least insofar as the supply of gametes and embryos is concerned.

207 Aside from a small number of cases and one statutory provision, there have been very few developments in Canadian jurisprudence respecting prenatal injuries. See, for example, *Duval v. Seguin,* [1972] 2 O.R. 686 (H.C.J.), aff'd (1974), 1 O.R. (2d) 482 (C.A.), and *Steeves v. Fitzsimmons* (1975), 11 O.R. (2d) 387 (H.C.J.). See, also, s. 67 of the Ontario *Family Law Reform Act, supra*, note 127, which provides that "[n]o person shall be disentitled from recovering damages in respect of injuries incurred for the reason only that the injuries were incurred before his birth".

While claims in respect of postconception injuries appear to be fully accepted, and are commonplace in the United States, a debate still rages in respect of preconception injuries. See, for example, *Albala v. City of New York,* 445 N.Y.S. 2d 108, 429 N.E. 2d 786 (1981), where the Court rejected a claim for such injuries.

a few state enactments generally hostile to the claimants.[208] The different claims may be characterized as follows:

1. *wrongful conception,* brought by a woman and, perhaps, her spouse or male partner, where she conceives and a child is born after a negligently performed sterilization or abortion, or after having been given negligent contraceptive advice, whether or not the child is defective;
2. *wrongful birth,* brought by a woman and, perhaps, her spouse or male partner, where she conceives and a child is born after the negligent failure of another person, before or after conception, to advise, counsel, or test the child's parents concerning genetic risks or other related matters, so that the parents are precluded from making an informed decision whether to avoid the conception or to avoid the child's birth, as the case may be;
3. *wrongful life,* brought by the child or the child's estate, on the ground that the child should not have been conceived or born, but was so, due to negligence of the type described in paragraph 2, as a result of which the child is forced to bear pain and suffering because of a predictable defect;[209] and
4. *dissatisfied life,* brought by a child, where, through the negligence of another person, a child is born medically "normal", but into conditions of social, psychological, economic, or other nonmedical "disadvantage", such as illegitimacy.

These claims have received increased attention as a result of greater recourse to preconception genetic diagnosis and counselling, and improved means of undertaking prenatal diagnosis by means of, for example, amniocentesis, fetoscopy, and fetal imaging by ultrasound. Claims may also relate, however, to negligent screening of gamete donors for artificial reproduction, negligent handling of gametes and embryos, and the negligent cryopreservation, thawing, or transfer of a gamete or embryo.

While, therefore, claims may clearly arise in the context of artificial reproduction, the relatively small extent of artificial conception services in the practice of medicine as a whole makes it easy to understand why the above claims do not, and will not, represent a very substantial proportion of the wrongful birth and other related claims advanced. The major resort to these claims in litigation in the United States has come, and will likely continue to come, from allegations of negligent sterilization, negligent contraceptive advice, and negligent genetic and prenatal diagnosis and counselling.

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208 See, for example, legislation in South Dakota: S.D.C.L., c. 21-55 (1982 Supp.), enacted by S.L. 1981, c. 172, §§1-4.

209 Accordingly, the claim is not that, without the negligence in question, the child would have been born without the defect, which would constitute an orthodox prenatal injury claim for negligence. Rather the claim is that, in the absence of negligence, the particular child would not have been born at all.

After initial derision and rejection of claims by parents for wrongful conception and wrongful birth in United States jurisdictions, many courts have gradually come to accept these claims as falling within more or less orthodox negligence principles. More recent legal literature addresses not so much the claims themselves, but the heads of damages that should properly be allowed.[210] On the other hand, wrongful life claims by children or their estates, which are by far the most controversial of the claims, have been admitted only in some rather isolated cases;[211] most jurisdictions continue to reject them. And no court has admitted or awarded damages upon a dissatisfied life claim.[212]

A number of American jurisdictions have enacted or have received proposals for legislation designed to disallow wrongful birth and wrongful life claims as a matter of public policy, in part because of their relationship to abortion.[213] A physician facing the prospect of such claims, it is argued, may have an incentive to advise and perform an abortion in order to escape liability. Those opposed to abortion consider that a judicial allowance of these claims would render abortion a medically favoured option, and therefore they are sympathetic to a legislative proscription of such claims. Others accept that individuals are legally free to control their reproduction through recourse to contraception and should not be barred from seeking remedies for a denial of that legal freedom resulting from medical negligence; that is, they believe that medical negligence should not be protected simply because it results in childbirth. However, many would still prohibit wrongful life and wrongful birth claims on the basis that their acceptance would involve an endorsement of what they believe to be the morally indefensible notion that some births are wrongful.

The view that the birth of a child is never a wrong, but (in the words of some judges) is always a "blessing", no matter how great the child's disability or physical or emotional suffering, and that it should therefore not entitle a parent to succeed in a wrongful birth claim or the child to succeed in a wrongful life or dissatisfied life claim, has a bearing upon this Project and its Terms of Reference. The latter direct that special attention be paid to the best interests of the child. This raises the issue whether it can be said in a particular case that it is in a child's best interests not to be conceived, or not to be born into an unsatisfactory social setting.

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210 See, for example, Nicholson, "Damages: Recovery of Damages in Actions for Wrongful Birth, Wrongful Life and Wrongful Conception" (1984), 23 Washburn L.J. 309.

211 See, in particular, *Curlender v. Bio-Science Laboratories,* 106 Cal. App. 3d 811, 165 Cal. Rptr. 477 (Ct. App. 1980); *Turpin v. Sortini,* 182 Cal. Rptr. 337, 643 P.2d 954 (Sup. Ct. 1982), vacating 119 Cal. App. 3d 690, 174 Cal. Rptr. 128 (Ct. App. 1981); and *Harbeson v. Parke-Davis, Inc.,* 656 P.2d 483 (Wash. Sup. Ct. 1983). See, also, Kennedy, "The Trend Toward Judicial Recognition of Wrongful Life: A Dissenting View" (1983), 31 U.C.L.A. L. Rev. 473.

212 See *Zepeda v. Zepeda,* 190 N.E. 2d 849 (Ill. Ct. App. 1963), *cert.* denied 379 U.S. 945 (1964), dealing with the claim of an illegitimate child.

213 See Donovan, "Wrongful Birth and Wrongful Conception: The Legal and Moral Issues" (1984), 16 Fam. Planning Perspectives 64, and the South Dakota legislation *supra*, note 208.

The contention that it can be in a child's best interests not to be born underlies the wrongful life and dissatisfied life claims. But all jurisdictions reject the latter and most jurisdictions reject wrongful life claims on the public policy ground that, in principle, life is always to be preferred to the absence or denial of life. It bears mentioning, however, that in another context courts have recognized that severely impaired newborn or older children may be denied "extraordinary" treatment, thereby allowing them to die, because that is, in fact, in their best interests.[214]

This brief discussion is designed simply to illustrate the profound and complex issues involved in the determination of liability for negligence resulting in human conception and birth, particularly where the claim involves the notion that, but for the defendant's negligence, the child in question would not have been born. Difficulties are amplified when considering the heads of damages that may be allowed for successful claims, including whether a negligent professional should be required to pay for the upbringing, to majority, of a healthy child living as a normal member of its parents' family, or for the lifelong special nursing needs of a severely handicapped child. Further issues of public policy concern whether actions may be brought by handicapped children not only against negligent physicians who were responsible for their parents' care and counselling, but also against the parents themselves for their negligent or wilful decisions to have or to risk having children with handicaps.[215]

As we indicated earlier, wrongful life and related claims that arise in the context of artificial conception constitute a relatively small proportion of all such claims. These claims exist, and are troubling, within a much broader context encompassing not just medicine, but other health sciences. Accordingly, we believe that the challenges presented by wrongful life and related claims cannot and should not be resolved within the four corners of a report on human artificial reproduction. We therefore recommend that these claims should be the subject of a separate study, so that they may be considered carefully in the context of tort law generally. In this way, proposals for an integrated jurisprudence in the area may be adequately developed.

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214 See *Re Superintendent of Family and Child Service and Dawson* (1983), 42 B.C.L.R. 173, 145 D.L.R. (3d) 610 (S.C.), discussed in Dickens, "Withholding Pediatric Medical Care" (1984), 62 Can. Bar Rev. 196, and Sneideman, "The Stephen Dawson Case: Whose Decision is it Anyway?" (1984), 14 Man. L.J. 165.

215 In Ontario, the law does not now prohibit actions by children against their parents: see *Family Law Reform Act, supra*, note 127, s. 66.

4. PROPOSALS RELATING TO THE FERTILIZED OVUM OUTSIDE THE BODY

(a) INTRODUCTION

In chapter 2 of this Report, the Commission described the I.V.F. procedure.[216] We noted that, since laparoscopy — the removal of a mature ovum from the ovary — is a surgical procedure that involves a certain risk, many I.V.F. clinics stimulate menstrual cycles in order to produce superovulation in the woman, so that multiple eggs may be extracted at one time. Another reason for this practice relates to the likely success of fertilization and implantation: there is a greater likelihood of successful fertilization where several ova are exposed to sperm *in vitro,* and the probability of successful pregnancy is increased by transferring more than one fertilized ovum to the recipient's uterus.

To the extent that I.V.F. clinics fertilize more than one ovum at a time and that more ova will be fertilized than will ultimately be transferred to the recipient, vital questions arise concerning the ethical acceptability of this practice and the status and control of a fertilized ovum outside the body. With respect at least to the first question, concerning the ethical acceptability of implanting multiple ova, the absence in Ontario of any formal I.V.F. guidelines concerning this particular matter has forced physicians and clinics to develop their own rules. With respect to the second question, it has been said that the issue of status and control is "[t]he most ethically and politically controversial aspect of I.V.F.".[217]

While the issue of the status of a fertilized ovum outside the body arises mainly in the context of I.V.F., where "surplus" fertilized ova may be produced, it will also be relevant in the context of *in vivo* fertilization and lavage.[218] It should be noted that, given the fact that the failure of lavage may result in the pregnancy of the donor, superovulation is not used in this process, for it would significantly increase the risk of pregnancy.

Although the obvious purpose of donation by *in vivo* fertilization and lavage is to transfer the fertilized ovum very quickly to the uterus of another woman, for various reasons the transfer may never take place. In such a case, the fertilized ovum will not be used by its intended recipient, and its status will become a matter of concern, particularly to the person or facility in possession of it.

In the sections that follow, the Commission will consider the issues described above and other related matters. We turn first to deal with the propriety of the simultaneous transfer of multiple ova to one recipient.

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216 *Supra*, ch. 2, sec. 3(b)(ii).

217 Annas and Elias, "*In Vitro* Fertilization and Embryo Transfer: Medicolegal Aspects of a New Technique to Create a Family" (1983), 17 Family L.Q. 199, at 208.

218 The process is described *supra*, ch. 2, sec. 3(b)(ii).

(b) THE SIMULTANEOUS TRANSFER OF MULTIPLE OVA

The question whether the practice of transferring multiple fertilized ova to a woman is ethically acceptable involves two considerations. First, there is risk to the recipient that a multiple pregnancy will occur. However, so long as the woman has been fully informed of, and accepts, this risk, we see no reason why it should act as a bar to the procedure.

The second consideration concerns the source of the ova to be transferred. In the case where the recipient can produce her own ova, the Commission is of the view that superovulation and the transfer of multiple fertilized ova ought to be an option open to the recipient and her physician. As a matter of principle, we see no essential difference between this procedure and I.V.F. involving a single ovum from the recipient.

More controversial is the question of multiple transfer where donor ova are involved. Since objection has been taken to the confusion of genetic background of artificially conceived children,[219] it may be argued that only a single donor — who would have to undergo superovulation — should be found. Others, however, have rejected this argument; for them, single or multiple ova could be donated by different donors for transfer together to the recipient.

Given the professional duty of doctors to keep appropriate records, and modern means of genetic identification of parentage, it may be doubted whether prohibitory legislation is required to minimize the risk of uncertainty of genetic origin. No objection has been taken in the reports canvassed by the Commission to the practice of sperm from different donors being used at different inseminations within an individual woman's menstrual cycle. We believe that this principle appears no less acceptable regarding ova.

Accordingly, the Commission recommends that there should be no prohibition of the practice of transferring multiple fertilized ova to a woman, regardless of whether the ova are her own or are donated, and, where the ova are donated, regardless of whether a single donor or different donors are used. The use of such a procedure appears to fall within the legitimate discretion of the medical profession, bearing in mind the nature and extent of a physician's general accountability in respect of his practice.

(c) CONTROL OF A FERTILIZED OVUM OUTSIDE THE BODY

(i) General

We now turn to deal with the critical issue concerning the locus of legal control of a fertilized ovum outside the body,[220] that is, who has the lawful right to determine the use to which the ovum may be put.

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219 See Victoria Report on Donor Gametes, *supra*, note 1, para. 6.26, at 46, and para. 6.35, at 48.

220 We wish to emphasize that the issues raised in this section pertain exclusively to the control of a fertilized ovum, not a gamete. Insofar as the latter is concerned, reference

In chapter 3, when dealing with research and experimentation on human genetic material, the Commission discussed the uncertain state of the law respecting the status and control of human body parts, including embryos.[221] We indicated first that the law does not seem to give the same status to a fertilized ovum as it does to a living child or, perhaps, even a fully differentiated fetus. We also stated that, whether or not body parts, including a fertilized ovum, may be the subject of "ownership",[222] the concept of legal control of the fertilized ovum is a useful one for our purposes. The question therefore arises: how does one determine who has legal control?

We have already stated that the law is not free from serious doubt in this area. Indeed, existing legal doctrine applied to the question of control, the legal and practical consequences of actual possession of the fertilized ovum, and formal preconditions for treatment or donation, involving, on the one hand, physicians, clinics or gamete banks, and, on the other, patients and donors, all bear on this matter.

The Commission's consideration of the locus of legal control will focus on two main candidates, that is, the gamete producers and the person in actual possession of the genetic material. As a practical matter, the two will seldom be the same, since donated gametes and embryos are held by artificial conception physicians, clinics, gamete banks, or research facilities. Consequently, to the extent that the law does not impose a clear solution, there may well be a substantial degree of disagreement between these parties concerning who has control.

We turn first to consider the claim of the gamete producer to legal control. In this connection, it has been suggested that "[t]he person producing the substance has the first right to it, subject to statute".[223]

The notion that the producer of the genetic material has a right, superior to others, to control its destiny, hardly seems radical, particularly in view of the nature of the material in question. Yet, the principle that legal control resides in the gamete producer may be difficult to apply in the case of a fertilized ovum, where sperm and ovum have been inextricably mixed to create new genetic material. For example, what if those with the power of control, that is, the two

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should be made to an earlier recommendation of the Commission, namely, that after donation donors should be entitled to require that their donations be wasted or returned to them and not used for artificial conception or any other purpose: see *supra*, this ch., sec. 3(c)(iv). Consequently, the donor would have some measure of control over his or her gamete after donation. However, since he or she obviously could not sever the gamete after it has been used in a fertilization process, the preceding right to withdraw the donation would no longer be operative.

221 See *supra*, ch. 3, sec. 7.

222 See Matthews, "Whose Body? People as Property", in Lloyd *et al.* (eds.), *Current Legal Problems 1983* (1983) 193, at 224, and Victoria Report on Embryos, *supra*, note 110, para. 2.8, at 27-28.

223 Matthews, *supra*, note 222, at 224.

gamete producers, disagree with respect to transfer, donation, wastage, or experimentation? Clearly, a sperm donor cannot prevail in insisting upon a transfer of a fertilized ovum to his wife if the latter refuses. Such difficulties may be aggravated if a couple, who are the gamete producers, separate. On the other hand, few problems may arise upon the actual or presumed death of one spouse, since the survivor presumably will gain sole legal and actual control. Not all the permutations of granting and denying consent to different uses or dispositions of a fertilized ovum need to be reviewed, however, in order to make the point that, in the ordinary case, unless both gamete producers agree upon an alternative, wastage will be the ovum's fate, postponable, perhaps, by cryopreservation.[224]

In some instances, the gamete producers may agree to transfer voluntarily their interests in the fertilized ovum to which they have both contributed. In other cases, the general law relating to the abandonment of property may be applicable to give legal control to only one of the producers or to some third party, such as a gamete bank. For example, a couple who have contributed gametes to a fertilized ovum *in vitro*, but who no longer need it to achieve a pregnancy, may leave it in the custody of the physician, without intending to have anything more to do with the ovum. And, in another context, it should be noted that the very purpose of *in vivo* fertilization and lavage is to donate the fertilized ovum to another person; consequently, no thought is ordinarily given to the retention of some control over the donation.

Related to the issue of voluntary transfer or abandonment is the attitude of artificial conception practitioners, clinics, and gamete storage facilities. These persons and institutions need not necessarily be passive agents, leaving the issue of control of donated material to be determined by the general law or, as a practical matter, by the donors themselves. In order to operate free of any possible legal uncertainty, they may impose on gamete donors and potential parents certain conditions respecting the future use or disposition of their gametes. For example, gamete producers may be required to agree that, upon donation, legal control respecting the use and disposition of the donated material should pass exclusively to the practitioner, clinic, or gamete bank. Under these circumstances, where there is a refusal to accept such conditions, the latter will presumably decline to accept the intended donation.

We have seen, therefore, that, even assuming that the gamete producer has legal control over the use and disposition of his gamete, he may transfer or lose this right to another party. However, it may be suggested that legal control of a gamete or fertilized ovum cannot, in fact, be found in the producer where he no longer has actual possession of the genetic material. It may be argued that, whatever the intentions of the producer, legal control automatically passes where

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224 In a sense, this result reflects the natural order. In nature, the vast majority of human gametes are wasted: some fail to result in conception; many fertilized ova fail to implant successfully (see Hurtig *et al.*, "Thirty-four fertilized ova ... recovered from 210 women of known fertility" (1952), 23 Pediatrics 202); and 62% of concepti are lost prior to 12 weeks of gestation (see Edmonds *et al.*, "Early Embryonic Mortality in Women" (1982), 38 Fertility and Sterility 447).

possession changes hands, so that legal control always and necessarily resides in the person in possession.

On the basis of this argument, the presence or absence of a voluntary transfer, and, indeed, the general law of abandonment, would be irrelevant. A contract ceding legal control of a gamete to a hospital would be functionless, since the mere giving up of possession would lead to the same legal result. An examination of the state of mind of the producer-donor, concerning whether he actually abandoned his interest in the genetic material upon donation, would be equally unnecessary, since, by hypothesis, the loss of possession itself would be determinative of the legal rights of the parties.

The question whether the source of the genetic material or the simple fact of possession is the critical factor in assessing the locus of legal control of a fertilized ovum cannot be resolved here. What is clear to the Commission, however, is the need for the law to be more certain in this area. Existing legal concepts of ownership, property, and control are elusive; decisions made on the basis of *de facto* control alone may not be valid in law; and not all practitioners, clinics, or storage facilities may have the foresight or sophistication to draft comprehensive rules governing their services. The nature and importance of the subject matter in question — the control of fertilized ova outside a woman's body — is such as to necessitate a clarification of the operative rules.

In formulating rules to govern the status and control of a fertilized ovum, several of the reports from outside Ontario have emphasized the need to respect the wishes of the gamete donors.[225] In some cases, reference has been made to the control of the recipient couple.[226] Where the donors do not agree on the use to which the embryo in question should be put, the Queensland Report recommended that the matter should be determined by means of the procedure applicable in custody proceedings.[227] Where this is not possible — for example, where the biological parents die, leaving no instructions — it was proposed that the procedure to be used should be the one applicable in the case of adoption.[228]

The Commission does not believe that the many interests at stake can be adequately accommodated by a single proposal respecting the control of a fertilized ovum. Rather, we are of the view that the complexity of the topic necessarily requires proposals that are more sensitive to the differing circumstances in which the issue of control may arise. We have in mind three situations. In one, the fertilized ovum has been produced from the gametes of the husband and wife or the male and female cohabiting partners; in another, the fertilized ovum has been produced entirely from the gametes of donors; in yet another, the

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225 See, for example, B.M.A. Working Group Report, *supra*, note 39, para. (10), at 1594, and Queensland Report, *supra*, note 2, at 91.

226 See B.M.A. Working Group Report, *supra*, note 39, para. (11), at 1594, and The American Fertility Society, "Ethical statement on in vitro fertilization" (1984), 41 Fertility and Sterility 12, para. II, at 12.

227 Queensland Report, *supra*, note 2, at 91-92.

228 *Ibid.*, at 92.

fertilized ovum has been produced in part from the gamete of one of the married or unmarried couple, and in part from a donor gamete. We are of the opinion that the issue of control of a fertilized ovum that, by hypothesis, is not going to be transferred to the woman must be resolved differently for these different situations. We shall now discuss each in turn.

(ii) Where No Donated Gametes are Used

Where the couple participating in an I.V.F. programme are contributing their own gametes, and where there is a fertilized ovum that has not been used for the purpose of conception, the Commission sees no practical or ethical reason why the couple should not have joint legal control of that ovum. The main alternative — in effect, deeming control to pass, for example, to the physician or clinic in possession of the ovum — is both unnecessary and undesirable.[229] The couple intended to use the fertilized ovum for the purpose of conception, but no longer need or want to use the ovum for that particular purpose. To this point, the parties have not had any intention other than the use of their own gametes for themselves. Respect for the right of gamete producers to control the destiny of their genetic material seems appropriate in such a case. Should they wish to donate the fertilized ovum to another woman or couple, or have it cryopreserved, or even have it wasted immediately, their wish should be paramount. Their emotional interest in the material is strong enough to warrant their continued right to deal with the ovum.

Accordingly, the Commission recommends that a fertilized ovum outside the body, produced with the gametes of the intended recipient and her husband or partner, should be under the joint legal control of the man and woman. Consequently, for example, the husband or male partner would be entitled to revoke his express or presumed consent to the transfer of the fertilized ovum to his wife or female partner.

Given that, under our recommendation, the fertilized ovum would be under the joint legal control of the couple, a question arises concerning the locus of control where one or both of the parties die, or where they cannot agree on the use to which the fertilized ovum should be put.

In considering the case where the couple had stored an embryo for their own future use, the Warnock Committee offered several proposals for reform. For example, it recommended "that when one of a couple dies the right to use or dispose [of] any embryo stored by that couple should pass to the survivor".[230] Where "both die that right should pass to the storage authority".[231] Furthermore, it was proposed "that where there is no agreement between the couple the right to determine the use or disposal of an embryo should pass to the storage authority ...".[232]

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229 See Victoria Report on Embryos, *supra*, note 110, para. 2.16, at 31-32.

230 Warnock Report, *supra*, note 2, para. 10.12, at 56.

231 *Ibid.*

232 *Ibid.*, para. 10.13, at 56-57. The Committee also recommended that there should be "a

The Commission concurs in principle with the proposals of the Warnock Committee. Basically, these proposals recognize the general right of joint legal control in the couple, while at the same time providing for contingencies when agreement is not, or cannot be, forthcoming. Accordingly, the Commission makes the following further recommendation respecting control of a fertilized ovum, bearing in mind our earlier general proposal that the ovum is to be under the joint legal control of the woman and her spouse or male partner. First, when one of the couple dies, legal control of the fertilized ovum should pass to the survivor. Secondly, if both should die, control should pass to the physician, clinic, gamete bank, or other authority that has actual possession of the ovum. Thirdly, where the couple cannot agree concerning the use or disposition of the fertilized ovum, legal control should pass to the physician, clinic, gamete bank, or other authority.

The above recommendations attempt to deal with the control of a fertilized ovum produced with the gametes of the couple who originally intended to use the genetic material. We now turn to consider the issue of control of the fertilized ovum where one or both gametes have been donated.

(iii) Where Donated Sperm or Ova, or Both, are Used

The proposal that a woman and her husband or male partner should have joint legal control over the use and disposition of an ovum fertilized with their own gametes was based essentially on the notion that, *prima facie*, the person whose gamete is used should have a superior right to determine its destiny. On the other hand, we do not believe that such a right is immutable. While a gamete donor should be entitled to restrict or alter the use to which the gamete is put,[233] or withdraw his consent to the use of his or her gamete, at any time prior to the fertilization stage,[234] it is arguable that, in the absence of such action, legal control by a gamete donor should not survive a material change in the status of the gamete, namely, its combination with another gamete in a fertilization process.

At first blush, it may seem anomalous to permit a married or unmarried couple to control a fertilized ovum produced from their own gametes, but to deny such a right to a gamete donor, even where he or she has not restricted the use of the donation. Certainly the biological or genetic connection to the gamete in question is no less real in the one case than in the other.

However, while the biological or genetic nexus is the same in both cases, the two situations differ substantially. Even assuming that a gamete donor has not been obligated to sign an unrestricted donation agreement by the clinic or storage facility involved — and the requirement to donate on this basis may well become

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maximum of ten years for storage of embryos after which time the right to use or disposal should pass to the storage authority": *ibid.*, para. 10.10, at 56. We shall return to the question of limitation periods *infra*, this ch., sec. 4(f).

233 See our recommendation *supra*, this ch., sec. 3(c)(iii).

234 See our recommendation *supra*, this ch., sec. 3(c)(iv).

the norm — the very fact of an anonymous donation, without restriction, bespeaks a willingness to give up control of the gamete. Donations of the kind considered here would not be made to specific individuals; rather, donations would be made to the physician, clinic, or gamete bank for general purposes, ordinarily, but not necessarily, the treatment of infertile persons. Accordingly, the fact that one person does not need the fertilized ovum in question would be of no particular concern to a donor; its use by another person would equally fulfil the purpose of the donation.

We have considered the notion of continued donor control solely from the perspective of the presumed intention of most donors and the nature and purpose of the anonymous, unrestricted donation itself. We have left aside the practical problems that might arise if the advice of hitherto anonymous donors had to be sought out in every case where a fertilized ovum is not transferred to the intended recipient and some other use, or even wastage, is contemplated. Even where they can be traced, one might expect such donors to be rather startled by the thought that their advice is necessary merely because the original recipient no longer needs or wishes to use the genetic material. If the donor had wished to limit the use to which his donation would be put, presumably he would have so indicated to the donee, or, if such a limitation was unacceptable to the donee, he would simply have not made a donation.

Accordingly, for both practical and philosophical reasons, the Commission has come to the conclusion, and therefore recommends, that a gamete donor who has not imposed a restriction on the use of his or her donated gamete prior to fertilization should have no right in law to control the use or disposition of a fertilized ovum to which he or she has contributed genetic material.

Having set forth this recommendation, we must now consider the locus of control in the two cases envisaged in our discussion: (1) where both sperm and ovum have been donated; and (2) where only the sperm or the ovum has been donated.

Given our view that donors who have not restricted the use of their donations ought not to be accorded any right of control once fertilization has taken place, there seem to be three main options where both the sperm and the ovum have been donated on this basis. Control may reside in (1) the physician, clinic, gamete bank, or other storage facility having possession of the fertilized ovum, or (2) the person or couple for whom the ovum was intended, but who no longer wish or need to use it, or (3) both the institution and the couple. Where an intended recipient has no use for the fertilized ovum that was to be transferred to her, the Commission is of the view that her connection with the ovum, both biologically and emotionally, is not such as to warrant giving her any measure of control over its future use or disposition. Having regard to the fact that the fertilized ovum will not be transferred, the intended recipient is now in the position of a stranger to that ovum.

The Commission is also of the view that, whatever the wishes of the couple in the circumstances just described, as a matter of policy they should not be entitled to exercise legal control over the fertilized ovum. That leaves only the

person or institution in *de facto* control. It alone has a sufficient interest in the material. Accordingly, we recommend that, where a fertilized ovum has been produced from sperm and ovum donated without restrictions on their use, legal control over the fertilized ovum should reside in the physician, clinic, gamete bank, or other storage facility having actual possession of the ovum.[235]

We now turn to consider the case where the unused fertilized ovum has been produced by a gamete donated generally and a gamete from one of the couple for whom the ovum was intended.

We have already recommended that a gamete donor who has not imposed a restriction on his donation ought not to have any right to control the use or disposition of a fertilized ovum. But, whereas in the case of a wholly donated embryo, there may well be no intended recipient at the time of fertilization, or, if so, she and her husband or partner will have no biological, and probably no emotional, attachment to the unused fertilized ovum, in the present case one of the couple does, in fact, have a significant connection to the genetic material. We believe that the position of the spouse or partner that has such a connection cannot be equated to that of the donor who makes an unrestricted gamete donation. Nor, indeed, do we believe that the position of the former is the same as that of the other spouse or partner, who has not contributed his or her gamete to the embryo. The absence of such a contribution means that he or she would not likely have a particularly strong emotional commitment, if indeed any commitment, to the future destiny of the embryo, although, since his or her spouse or partner has made a contribution, the emotional commitment might presumably be greater than if the embryo were wholly donated.

On balance, the Commission has come to the conclusion that the interest of the non-contributing spouse or partner in an unused fertilized ovum is not sufficiently strong to permit him or her to exercise control over its future. The non-contributor is a stranger to the fertilized ovum, and the very fact that the ovum will not be used for the purpose of conceiving a child for the couple significantly alters the non-contributor's stake in the material from what it would have been had the fertilized ovum been used for its original purpose.

The same cannot be said, of course, for the spouse or partner who has contributed genetic material to the fertilized ovum. Such a person is in the same position as the man and woman who have intended that their own gametes be used for the purpose of conceiving their own child. In the latter case, we stated the view that the couple was not in the position of a general donor. So, too, with the contributing spouse or partner in the instant case. This person should not have legal control involuntarily wrested from him or her simply because the original purpose of the contribution has been frustrated or rendered unnecessary.

Accordingly, the Commission recommends that, where an unused fertilized ovum has been produced from gametes contributed by a donor who has made an unrestricted donation and one spouse or partner of a couple for whom the ovum

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235 For a view that control should not reside in a hospital, see Victoria Report on Embryos, *supra*, note 110, para. 2.16, at 31-32.

was originally intended, legal control over the fertilized ovum should reside in that spouse or partner alone.

(d) The Role of Gender Selection in the Transfer of a Fertilized Ovum

Persons who use I.V.F. have a right of access to material information at all times, since the principle of informed consent as a continuing condition of medical care underlies I.V.F. no less than any other medical procedure. One piece of relevant information, which now may be obtained prior to implantation,[236] is the gender of the embryo destined to be transferred to the woman. Such information may be sought by a particular woman or couple where it is crucial to the future child's health — for example, where inheritance of a sex-linked genetic trait is involved. Under these circumstances, it may be that the acceptability of a transfer legitimately ought to be dependent upon gender. Indeed, in such a case, it may even be unlawful and unethical to withhold the relevant information.

In other cases, however, it may be urged that the sex of the embryo should be prohibited from being disclosed to potential parents, so that they not have an opportunity to select solely upon the basis of gender. Such selection may be offensive, not least because of a perceived cultural bias in favour of males.

However, even if a case can be made out to deter or prevent gender disclosure in order to limit embryo transfer decisions relating exclusively to gender, enforceable legislation may be impossible to achieve. Moreover, we object to the enactment of legislation that would criminalize or make an offence the inadvertent or indirect disclosure of true information to those who seek it. Accordingly, the Commission recommends that legislation should not be enacted to deal with whether a woman or couple should be entitled to obtain information concerning the sex of a fertilized ovum intended to be transferred to the woman.

(e) Research and Experimentation on a Fertilized Ovum Outside the Body

(i) General

In chapter 3, the Commission examined the rather skeletal framework of the law pertaining to research and experimentation on human genetic material.[237] We recognized the overlap between therapy, designed to benefit a patient directly (even where the treatment goes beyond traditional medical care to "therapeutic innovation"[238]), and research and experimentation, designed to acquire knowledge irrespective of its direct or immediate application to an individual. However, we noted that the question of pure research and experimentation does arise separately — for example, where embryos are produced but not transferred

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236 See the discussion in the Warnock Report, *supra*, note 2, paras. 9.8-9.9, at 50-51.

237 *Supra*, ch. 3, sec. 7.

238 Dickens, "What is a medical experiment?" (1975), 113 Can. Med. Ass'n J. 635.

to a woman — and does provoke serious and growing concerns as medical science increases our control over nature.

Our review of the present state of the law made it quite clear that very little in the way of legislation, jurisprudence, or professional guidelines[239] now exists in respect of research and experimentation on human genetic material. We also canvassed the controversy in the literature concerning the control of gametes outside the body, a topic considered briefly by the Commission in the present chapter.[240] The issue of control, and the related issues of transfer and abandonment of control, are critical when determining whether, for example, a hospital may conduct research and experimentation on fertilized ova not needed for the purpose of artificial conception.

It seems to be widely recognized that embryonic research is necessary for human welfare, not simply for the development and refinement of the I.V.F. procedure itself. The processes of early embryonic survival and development, and of implantation and subsequent evolution, need to be better understood in order, for example, to reduce the incidence of infertility and to reduce the rate of spontaneous abortion, particularly of genetically normal embryos. Research also needs to be done to reduce abnormal early development of the embryo and implantation failure. The birth of future children by natural and artificial conception may be greatly assisted by knowledge achievable only by research on human embryos. Within the narrow field of I.V.F. practice, research directed to finding a better means of storage and better transfer mechanisms leading to greater success and reduced embryonic wastage is, we believe, appropriate and highly desirable in principle.

While the need for better knowledge is widely recognized, disagreement exists regarding the limits of permissible research. For philosophical, ethical, religious, or other reasons, some persons consider the embryo inviolable from the moment of conception, and no more available for research use without its own full and free consent than a newborn baby or an adult. Others claim that no limits should be imposed, and that research into the uterine environment should be permitted so that, for example, an artificial uterus and placenta may be developed, with the prospect of a full-term infant being created entirely outside the body of a mother. While this has obvious science fiction reverberations and may seem to reflect a greater joy in technology than in humanity, the stated purpose of such research is to save the lives of extremely premature infants, and to preserve their capacities for normal development and functioning by affording

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239 See, however, the short statement of The Society of Obstetricians and Gynaecologists of Canada, which endorsed the scientific examination of concepti prior to the time development has reached the implantation stage, and which affirmed the need for "a strong research component in any IVF program": see SOGC Statement, *supra*, note 21, at 4.

It has been reported that a committee of the Medical Research Council of Canada is examining research in the context of human artificial conception: see "Ethics rules for research modernized", *The Globe and Mail*, Toronto (July 28, 1984), at 17.

240 See *supra*, this ch., sec. 4(c)(i).

them a congenial environment for normal growth. A recent medical report from McMaster University in Hamilton on the poor prospects of extremely low birth-weight infants indicates how much more research needs to be done to assist their survival and capacity to function without physical or intellectual impairment.[241]

The Commission is of the view that it is neither necessary nor desirable to impose a total prohibition on research on fertilized ova outside the body. We do recognize the fear of many persons that cloning and "genetic engineering" are but one step removed from less dramatic research and experimentation. However, we do not believe that this view represents the weight of public opinion; nor do we accept the notion that science inherently cannot be controlled and that it must necessarily push beyond frontiers that are ethically acceptable to society. Medical and scientific research and innovation are hardly novel, notwithstanding what appears to be their accelerated rate of development in the second half of this century. Science has, in fact, been the subject of public control for quite some time, and manifestations of occasional aberrant behaviour should not be cited as proof of its inevitable unpredictability and immunity to regulation. Accordingly, the Commission recommends that research and experimentation on a fertilized ovum outside the body should be permitted, subject to the recommendations that follow.

In our view, a formal system of control or regulation must be put in place to govern the institutions permitted to engage in the sensitive area of research and to set the standards by which such institutions may operate. This general acceptance of research on human genetic material, along with a perceived need to guard against unrestricted research on such material — particularly the embryo, with its obvious potential for human life — also find support in the reports from outside Ontario that have considered the subject.[242]

The reports to which reference has been made have tended to discuss two issues in connection with research. One concerns the forum within which research should be conducted; the other relates to the question whether there should be a time limit within which research must take place on a fertilized ovum outside the body. The latter issue will be considered in the separate section that follows, since it relates generally to the length of time a fertilized ovum may be allowed to develop for any purpose, whether research or not. We turn, then, to consider the first-mentioned issue, namely, the appropriate forum for research and experimentation on human embryos.

Few reports from outside Ontario actually make specific recommendations concerning what institutions should or should not be used as research facilities. It would appear, however, that the very nature of embryo research would, at least at the present time, serve to limit the kind and number of institutions that could engage in this practice.

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241 See Boyle *et al.*, "Economic Evaluation of Neonatal Intensive Care of Very-Low-Birth-Weight Infants" (1983), 308 New England J. Med. 1330.

242 See, for example, SOGC Report, *supra*, note 21, at 4; B.M.A. Working Group Report, *supra*, note 39, para. (10), at 1594; M.R.C. Statement, *supra*, note 1, at 1480; and RCOG Report, *supra*, note 48, para. 14.4.6, at 17.

In the reports that have dealt with the matter expressly, one obvious preference has been for the restriction of research to hospitals. For example, one report from the United Kingdom recommended that research on pre-viable fetuses should be conducted in hospitals and with the approval of their ethical review committees. The committee would have to "satisfy itself: (a) on the validity of the research; (b) that the required information cannot be obtained in any other way; and (c) that the investigators have the necessary facilities and skill".[243]

The restriction of research on human embryos to hospitals, or to hospitals and universities, has the clear merit of ensuring a formal means of review by specialists and experts, lay representation, and a degree of public accountability. At present, Ontario universities and a number of teaching hospitals regulate research by means of review committees conforming to the guidelines set forth in the 1980 *Report of the Commission of Inquiry into the Confidentiality of Health Information* (the Krever Report).[244] That Report recommended that research be permitted,[245]

> ... provided that approval has been granted by an appropriate human experimentation committee whose members must not be confined to the principal investigator's discipline and must include one or more representatives of the public, and provided also that that human experimentation committee has been satisfied that the principal investigator has met the following criteria:
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> (a) the identifiable information sought is indispensable for the purpose of the research project;
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> (b) the importance of the research project, in the opinion of the committee, justifies the breach of the subject's privacy; and
>
> (c) the principal investigator undertakes [further protection of the subject's interests].

Furthermore, such funding agencies as the Medical Research Council of Canada require ethical approval of research by appropriately composed institutional committees.

It does bear mentioning, however, that institutions other than Ontario universities and teaching hospitals also subscribe to the principles enunciated in the Krever Report. It may be argued, therefore, that, so long as the research facility conforms to certain acceptable ethical, technical, and other guidelines, limiting research to university centres and hospitals is unjustifiably restrictive.

The notion that the critical issue in the regulation of research is the nature and scope of the limits placed on research, and that a restriction on the kinds of place within which research may be conducted is unnecessary, finds support in

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243 United Kingdom, Department of Health and Social Security, Scottish Home and Health Department, and Welsh Office, *The Use of Fetuses and Fetal Material for Research: Report of the Advisory Group* (1972), paras. 35(3) and (4), at 8.

244 Krever Report, *supra*, note 169.

245 *Ibid.*, Vol. III, at 50-51, recommendation 94.

the report of the Warnock Committee in the United Kingdom.[246] After generally endorsing research on human embryos, the Committee recommended that "research conducted on human *in vitro* embryos and the handling of such embryos should be permitted only under licence".[247] Licences for individual projects and for specified research would be granted by a "new statutory licensing authority to regulate" research and infertility services.[248] This new body would have "substantial lay representation" and the chairman would be a layperson.[249] Research would be tightly controlled, not in terms of the daily activities of the researchers, but by restricting the nature and scope of the projects approved.[250] For example, an applicant, who might be an individual or an institution, would have to establish that "the work is supported by peer review undertaken by appropriate academic referees".[251] Although the Committee did not set guidelines respecting whether an applicant should seek funding before obtaining a licence, it did state that "we consider it crucial that any applicant should have first obtained clearance from the ethical body responsible for such matters in the institution in which he or she wishes to carry out research work before submitting applications".[252]

From this brief review of the Warnock Report's examination of research on embryos, it should be noted that the Committee made no mention of the argument that research should be confined to a particular kind of person or institution. It was assumed, apparently, that facilities other than, for example, university medical centres or hospitals, could and should engage in research, so long as they met the standards to be established by legislation and by the proposed new licensing body.

The Commission endorses this view. Necessary research on human embryos should not be the exclusive preserve of universities and hospitals. Indeed, medical research in other areas is not so confined. Excellence in this field may be furthered by the promotion of research by any institution that clearly establishes conformity with appropriate ethical, scientific, and other relevant standards. As we said earlier, the Medical Research Council of Canada has developed guidelines for research — and is now examining guidelines in the context of research on human genetic material — which, while only advisory, are in fact observed by virtually all research institutions in Canada. In addition, review committees operate in hospital and university medical centres. These mechanisms offer a model for the regulatory control of research that may be undertaken by these and other institutions.

The Commission's recommendations in respect of such control are as

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246 See, generally, Warnock Report, *supra*, note 2, chs. 11, 12, and 13.

247 *Ibid.*, para. 11.18, at 64.

248 *Ibid.*, para. 13.3, at 75.

249 *Ibid.*, para. 13.4, at 76.

250 *Ibid.*, paras. 13.10-13.11, at 78.

251 *Ibid.*, para. 13.11, at 78.

252 *Ibid.*, para. 13.12, at 79.

follows. First, research and experimentation involving a fertilized ovum outside the body should be restricted to research centres approved by the Ministry of Health. Secondly, a research centre should be entitled to be approved only where it has established an ethical review committee for the internal screening of research projects. Thirdly, the Ministry of Health should develop minimum requirements respecting the composition and operation of ethical review committees in research institutions.

It should be noted that the Commission has been silent on substantive ethical and other guidelines that ought to be followed. As a general proposition, we do not believe that this is a matter within our expertise, even if it were assumed that such guidelines could be codified and yet remain sufficiently flexible to permit the evolution of new and better standards. We leave such matters to the Ministry of Health and to the internal ethical review committees.

However, we do wish to enter one caveat to the view expressed above. Notwithstanding our belief that it should be the province of the Ministry of Health and the internal ethical review committees to develop and apply appropriate standards in respect of research projects, we are of the opinion that the law should address expressly certain matters relating to research and experimentation on human embryos. We turn now to consider these matters.

(ii) Transfer of Fertilized Ova Previously Subjected to Research or Experimentation

Earlier in this section, we noted the fears of many persons that research or experimentation on human embryos may be just a prelude to unacceptable "genetic engineering". Related to this issue is the question whether it is ethical to transfer to a woman an embryo that has been the subject of research or experimentation.

As medical science advances, it will become increasingly possible to detect and cure various kinds of abnormality in embryos.[253] One report noted that "[s]uggestions of enhancing embryos through genetic manipulation have been made, as well as suggestions about the treatment of genetic disorders".[254] It is not inconceivable to anticipate a time when the treatment and cure of defects in embryos will have progressed beyond the experimental stage to become therapeutic. At present, however, genetic manipulation and gene therapy cannot be viewed in this light, so that the serious and difficult issues raised in this context are, for the moment at least, highly controversial.

Few reports canvassed by the Commission deal with this particular topic. The ones that do so, however, evince an antipathy to the transfer of embryos that have been subjected to research or experimentation. For example, the B.M.A. Working Group Report observed as follows:[255]

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253 See Victoria Report on Embryos, *supra*, note 110, para. 1.14, at 13.

254 *Ibid.*, para. 1.16, at 14.

255 *Supra*, note 39, para. (14), at 1594.

> It is not ethically acceptable for medical practitioners to be involved in in vitro fertilisation and embryo replacement procedures in which the gametes (sperm or ova), embryos, or parts thereof are subjected to manipulations, including procedures designed to change their genetic make up or to induce the formation of multiple progeny ('cloning'), if there is any intent to transfer the resulting embryos to a uterus.

It bears emphasizing that the statement of the British Medical Association was directed exclusively to "manipulations" of embryos, where some kind of change was involved, rather than to embryo research generally. The Association's view may be contrasted, then, with that apparently taken by the Warnock Committee. In its Report, the Warnock Committee recommended, without further elaboration, that "no embryo which has been used for research should be transferred to a woman".[256] Earlier, the Committee divided "research" into two categories. The first was "pure research", aimed at increasing and developing knowledge generally; the second was "applied research", that is, among other things, "research with direct diagnostic or therapeutic aims for the human embryo ...".[257] In other words, it appears that the Warnock Committee sought to preclude the transfer of an embryo even where the embryo had undergone "therapeutic" research for its own direct benefit. This prohibition seems to be wider than the one advanced by the British Medical Association.

The most recent report canvassing this topic expressed a division respecting "genetic manipulation" as a means of treating or curing defective embryos that would subsequently be transferred to a woman. The report, from Victoria, stated as follows:[258]

> Some members of the Committee regard developments in genetic manipulation of the kind to which brief reference has been made as leading to real benefits for some couples. Some members have grave reservations about any genetic manipulation, and some prefer to defer their judgment on the matter until a more detailed study of the subject may be completed. The Committee is, however, unanimously of the opinion that the subject of genetic manipulation of untransferred embryos should be carefully studied, and all of the implications of the proposal should be widely canvassed.[259]

The Commission is unanimously of the view, and accordingly recommends, that an embryo that has been the subject of experimentation that has no direct therapeutic purpose in relation to the ovum should not be transferred to a woman. While experimentation on embryos may be essential in order to discover means to alleviate the effects of infertility or genetic impairment, the potential for grave and unacceptable consequences where such embryos are transferred to a woman is too great at the present time. We cannot countenance the use of new and

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256 Warnock Report, *supra*, note 2, para. 11.22, at 66.

257 *Ibid.*, para. 11.10, at 61.

258 Victoria Report on Embryos, *supra*, note 110, para. 1.17, at 14.

259 While the Committee stated that it was divided on this specific topic, 5 of the 9 members stated that "embryo research [should] be limited to the excess embryos" (*ibid.*, para. 3.26, at 46), that is, presumably those not intended for subsequent transfer to a woman.

experimental procedures on embryos any more than we can endorse their use on children or adults.

The Commission is divided, however, on the propriety of the transfer to a woman of an embryo that has been the subject of therapeutic measures, where the purpose of such procedures is to benefit the embryo directly, for example, to cure a defect or treat an abnormality. Some Commissioners are of the view that no embryo that has been the subject of any manipulation or change, whatever the purpose or result, should be transferred to a woman. They fear that, given the elasticity of the concept of "therapy", permitting so-called therapeutic measures might open the door to techniques that are, in fact, experimental, potentially to the severe detriment of any resulting child. While these Commissioners recognize that infertile or genetically impaired couples might well benefit from "therapeutic" measures of the kind described above, they believe that the present state of medical science is not sufficiently advanced to warrant such measures. Without this treatment, an abnormal embryo would, of course, be wasted. And where the woman whose own ovum was fertilized cannot produce any more ova, the only alternative to childlessness would be the use of donor ova. However, the Commissioners who advocate a total prohibition on the transfer of embryos that have been subjected to any type of research or experimentation are of the view that this possibility must be considered to be a risk or burden necessarily to be borne by the woman in question, at least for the present time.

Conversely, other Commissioners see no reason to preclude the transfer of an embryo that has been the subject of manipulation or change, so long as the measures taken are intended to confer a direct therapeutic benefit on that embryo. These Commissioners believe that medical science has, in fact, advanced sufficiently to the point where some procedures can clearly be characterized as therapeutic, and not purely experimental. Particularly where the intended recipient cannot produce any further ova, it is believed that wastage of a defective embryo that might be successfully treated belies the very purpose and role of medicine and science.

(f) Time Limits on the Development and Storage of Fertilized Ova

In this section, we shall address the question whether a time limit should be imposed in respect of the development of a fertilized ovum outside the body and in respect of the storage of a fertilized ovum by cryopreservation.

Where fertilized ova are produced exclusively for use in an I.V.F. programme, and where all such ova are, in fact, transferred immediately to recipients, the issue of time limits respecting embryonic development and storage does not arise. However, we have seen[260] that, under certain circumstances, there might be "surplus" fertilized ova, initially produced for artificial conception purposes but later not required for transfer to a woman's body. Or a single fertilized ovum might be produced that was to be so transferred but, for some reason, is no longer wanted. How long should such genetic material be permitted

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260 See, generally, *supra*, this ch., secs. 4(a) and (b).

to develop? And, where a fertilized ovum is cryopreserved, how long should it be stored?

While, as indicated, these questions arise in the context of an I.V.F. programme, they also arise in the context of research and experimentation. Indeed, it is almost exclusively in respect of research and experimentation that the many committees that have reviewed the issue have dealt with time limits beyond which embryos should not be allowed to develop or to be stored.

Undoubtedly, public concern respecting research and experimentation on human embryos relates primarily to generalized fears that embryos will be used for what has been pejoratively called "genetic engineering", or perhaps more accurately, "eugenics", involving cloning, selective breeding, and so on. It is, in part, to allay these anxieties that so many committees and agencies have recommended a time limit beyond which an *in vitro* embryo should not be allowed to develop or to be stored.

The Warnock Committee, as well as others, have recognized that, biologically, any particular time limit would be arbitrary, given the continuous process of embryonic development from stage to stage.[261] The Committee canvassed the "wide range of opinion on this question".[262] Having regard to the importance of the subject, the Committee's discussion of the differing views is reproduced here:[263]

> One argument put forward may be termed the strictly utilitarian view. This suggests that the ethics of experiments on embryos must be determined by the balance of benefit over harm, or pleasure over pain. Therefore, as long as the embryo is incapable of feeling pain, it is argued that its treatment does not weigh in the balance. According to this argument the time limit for *in vitro* development, and for research on the embryo, could be set either when the first beginnings of the central nervous system can be identified, or when functional activity first occurs. If the former is chosen, this would imply a limit of twenty-two to twenty-three days after fertilisation, when the neural tube begins to close. As to the latter, in the present state of knowledge the onset of central nervous system functional activity could not be used to define accurately the limit to research, because the timing is not known; however, it is generally thought to be considerably later in pregnancy. With either limit, proponents suggest subtracting a few days in order that there would be no possibility of the embryo feeling pain.
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> The Royal College of Obstetricians and Gynaecologists suggested that embryos should not be allowed to develop *in vitro* beyond a limit of seventeen days, as this is the point at which early neural development begins. The British Medical Association favoured a limit of fourteen days and a number of groups, including the Medical Research Council and the Royal College of Physicians suggested that the limit should be at the end of the implantation stage. Again, some groups submitting evidence suggested that no embryo which had gone beyond the beginning of the implantation stage should be used for research.

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261 Warnock Report, *supra*, note 2, para. 11.19, at 65.

262 *Ibid.*, para. 11.20, at 65.

263 *Ibid.*, paras. 11.20-11.21, at 65.

Ultimately, the Warnock Committee chose as its initial point of reference the formation of the "primitive streak", at about fifteen days after fertilization, which "marks the beginning of individual development of the embryo"; the Committee then took an earlier date — fourteen days after fertilization — "as a desirable end-point for research". However, this fourteen day period "does not include any time during which the embryo may have been frozen".[264]

The Commission recognizes that the setting of any time limit is unavoidably arbitrary, and might sacrifice therapeutic and social benefits that likely could be obtained from research on embryos developing beyond that limit. For example, the limit proposed in the Warnock Report would preclude critical studies of implantation failure.[265] Accordingly, it has been argued that a somewhat longer period of time for research may be desirable in an attempt to reduce the rate of spontaneous abortion.

Just as the Commission endorses the view that artificial conception services, properly regulated, should be offered to infertile persons, it believes that research on human embryos should be encouraged in order to further our knowledge of embryonic development so that all persons, fertile and infertile, might benefit. However, there are certain limits, sometimes arbitrarily chosen, with which our society believes it must live. Notwithstanding the promise of unfettered scientific research, the public is equally concerned with its potential curses. While welcoming continued research and development, we believe such concern to be rationally based and worthy of respect. Accordingly, the Commission recommends that, having regard to the information now available to medical science respecting embryonic development, regulations should provide that no fertilized ovum outside the body should be allowed to develop beyond fourteen days after fertilization. Should the state of medical knowledge at some future date indicate that the fourteen day period is inappropriate, by being either too short or too long, the regulations could easily be amended.

We turn now to consider whether there should be an outside limit beyond which a fertilized ovum should not be cryopreserved or otherwise stored. While, in most cases, embryos are stored by couples who might wish further children or who might need further embryos if the initial I.V.F. treatment has proved unsuccessful, they may be stored anonymously by a gamete bank or stored specifically for research purposes.

Whatever the impetus for storage, we agree in principle with the Warnock Committee that there should be "a definite time limit set to the storage of embryos both because of the current ignorance of the possible effects of long storage and because of the legal and ethical complications that might arise over disposal of embryos whose parents have died or divorced or otherwise been separated".[266]

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264 *Ibid.*, para. 11.22, at 66. We shall deal with storage later in this section.

265 There is evidence that, in nature, 62% of embryos are lost prior to 12 weeks of pregnancy: see Edmonds *et al.*, *supra*, note 224.

266 Warnock Report, *supra*, note 2, para. 10.10, at 56.

The Warnock Committee recommended "a maximum of ten years for storage of embryos after which time the right to use or disposal should pass to the storage authority".[267] Presumably, the storage authority could then waste the embryo or donate it for the purpose of artificial conception or, perhaps, research. In other words, where the embryo is donated, some further period of use, however short, would seem to have been contemplated.

While the Commission has no great antipathy to the scheme propounded in the Warnock Report, on balance we do not wish to give the storage authority the right to donate the embryo to another couple or to a research institution. We are of the view that storage after ten years should not be permitted. The situation at the end of the ten year storage period differs from the situation where the couple die or cannot agree on the disposition of the embryo. In those cases, we proposed that the person or facility in actual possession of the embryo should have the right to determine the embryo's fate.[268] We did so because there would be no reasonable alternative to giving such control to that person or facility. However, where, at the end of the ten year storage period, the couple is simply silent, giving no directions to the storage authority, we are willing to presume that they do not wish the fertilized ovum to be donated for any purpose.

Accordingly, we recommend that there should be a maximum of ten years for the cryopreservation or similar storage of a fertilized ovum, after which time the storage authority should be under a duty to have the ovum wasted.

(g) THE CRYOPRESERVED FERTILIZED OVUM AND THE RULE AGAINST PERPETUITIES

A rather esoteric and legalistic point arises in estate planning, concerning whether a testator should be able to bind property by relation to the birth of a child from an embryo in cryostorage at the time of the testator's death. The issue relates, then, to the purpose and incidents of the rule against perpetuities, which is designed to prevent estates from being rendered inalienable for excessive periods of time.

One option is to leave the issue to be determined by the courts, bearing in mind existing legal doctrine on the rule against perpetuities.[269] Alternatively, legislation might expressly provide that a cryostored embryo is not to be considered "a life in being" from the existence of which the relevant time periods run. This might be done in exclusionary language, but might be achieved more elegantly through a provision that "a life in being" does not exist before an unborn child is *en ventre sa mere*. A further alternative is simply to enact that a cryostored fertilized ovum is "a life in being" for the purpose of the rule against perpetuities.

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267 *Ibid.*

268 See *supra*, this ch., sec. 4(c).

269 See, for example, *Perpetuities Act*, R.S.O. 1980, c. 374.

The Commission has reservations concerning whether an embryo in cryo-storage would or should be considered "a life in being" for purposes of the rule against perpetuities. However, we are of the view that no legislated policy is called for on the issue, which is rather unlikely to present major difficulties. Instead, we believe that judicial resolution of the matter is appropriate.

5. PROPOSALS RELATING TO SURROGATE MOTHERHOOD

(a) INTRODUCTION

The term "surrogate motherhood" does not refer to a distinct type of artificial conception technology. Surrogate motherhood involves the application of one of the artificial conception technologies that we have discussed in order to produce an infant who, pursuant to an antecedent arrangement, will be surrendered at birth by the gestating mother to another person to raise as his or her own child. Thus, what distinguishes surrogate motherhood from the other artificial conception technologies is not the technology itself, but the special circumstances of its employment.

Recalling the artificial conception technologies, the following kinds of surrogate motherhood arrangement are possible:

1. a woman is artificially inseminated *in vivo* by sperm of a donor and, upon birth, custody of the child is surrendered to the sperm donor;
2. a woman's extracted ovum is fertilized *in vitro*, the embryo is transplanted into the uterus of another woman who is able to bear a child and, upon birth, the child is surrendered to the ovum donor;
3. a woman is fertilized *in vivo*, the embryo is flushed from her by means of lavage and transplanted into the uterus of another woman who is able to bear a child and, upon birth, the child is surrendered to the ovum donor; and
4. a woman's ovum is fertilized *in vitro*, or *in vivo* followed by recovery through lavage, and transplanted into the uterus of a second woman and, upon birth, the child is surrendered to a third person, such as the sperm donor and his wife.

In addition to the circumstances described above, a surrogate motherhood arrangement may be sought where, in the case of ovum donation by means of *in vivo* fertilization and lavage, an inadvertent failure of the lavage procedure results in pregnancy. The intended ovum donor then may choose to gestate the fertilized ovum for the purpose of surrendering the infant to the person who had been the intended recipient of the fertilized ovum.[270]

A surrogate motherhood arrangement involves an agreement between the woman who is to bear the child and the persons who are to receive it to raise as their own. While a variety of terms may be agreed upon by the parties, the heart

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[270] See discussion *infra*, this ch., sec. 5(e)(vii)a.

of any arrangement is a promise on the part of the surrogate mother to undergo the medical procedure necessary to achieve a pregnancy and to surrender custody of the child irrevocably upon birth, and a reciprocal promise on the part of the other party or parties to accept the child. Such an arrangement may involve a payment to the surrogate mother by the intended parents in return for the fulfilment of her promises. However, some women do volunteer to bear a child for reasons of altruism.

Recourse to a surrogate motherhood arrangement may be sought where a couple suffers from an infertility problem that cannot be circumvented by other means. In the case of certain uterine problems, such as where the uterus is abnormal or absent, the artificial conception techniques that we have reviewed will be to no avail. Indeed, the problem is not one of conception at all, but of an inability to carry the fetus to term, which could be caused, for example, by implantation difficulties or chronic spontaneous abortion. For couples with such problems, a surrogate motherhood arrangement presents the only means of having a child who is genetically related to one of them, and possibly both.

But, while surrogate motherhood may be employed as a solution to infertility, it may also be sought in less exigent circumstances. A fertile woman may prefer that another woman carry a child for her in order to avoid pregnancy, possibly for reasons of career or vanity. That artificial conception technology might be so used raises questions respecting the grounds of eligibility for services, an issue that will be discussed at a later stage in this chapter.[271] At this juncture, we wish only to indicate that a nonmedical motivation may underlie recourse to this alternative.

Not surprisingly, surrogate motherhood has generated substantial controversy wherever it has been considered. A procedure that has as its essence the deliberate creation of a child exclusively for the purpose of surrendering the child permanently to the care of another is a striking departure from our collective accumulated experience. For some, this procedure directly challenges basic normative assumptions about the family. It is for this reason that the surrogate motherhood alternative warrants careful attention. But the understandably deep emotional feelings associated with surrogate motherhood, while deserving of respect, should not displace the balanced, reasoned analysis that is crucial to the development of recommendations within our Terms of Reference.

As discussed in chapter 3, the present law in Ontario, rooted securely in a world of natural reproduction, has not addressed the surrogate motherhood alternative directly. As with the artificial conception technologies, certain aspects of the existing law do apply fortuitously to these arrangements and may serve, to some extent, to resolve questions of status and to define the rights of the parties. Since we have examined the present law in detail in chapter 3,[272] we shall review only briefly, at this stage, its effect on surrogate motherhood arrangements.

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271 See discussion *infra*, this ch., sec. 5(e)(i)a.

272 See discussion *supra*, ch. 3, sec. 8.

At the outset, it should be noted that surrogate motherhood arrangements are not prohibited by statute, except to the extent that they may violate section 67 of the *Child Welfare Act*,[273] which proscribes payments in connection with the adoption of a child. Although not otherwise prohibited, it would appear that such arrangements are illegal and unenforceable at common law as being against public policy. Hence, any purported transfer of parental rights and responsibilities by a surrogate mother to another pursuant to an agreement would have no legal effect whatsoever. For all purposes, the surrogate mother would remain the mother in law and would have the attendant rights and responsibilities.

Moreover, should a party fail to honour his or her promises, the agreement would not be enforceable at the behest of the other party. If the surrogate mother were to refuse to transfer custody of the child to the persons who sought to raise the child, a court would not compel her to do so. Nor, where custody of the child has been transferred, could the intended social parents be compelled to make the promised payment.

In the event of a dispute over the custody of a child, while neither party could seek the assistance of the court on the basis of their agreement, each could apply for custody under the *Children's Law Reform Act*. As with any custody determination, the issue would be determined according to the best interests of the child.

Although the present law does not facilitate the achievement of the parties' objectives as a matter of contract law, where the husband is the biological father of the child the parties may utilize existing procedures to realize the same end. If the surrogate mother and the couple wishing to raise the child are in agreement, procedures under the *Children's Law Reform Act* may be employed in order to establish paternity in the husband and to transfer custody to the couple. Following completion of these procedures, an application for a step-parent adoption under Part III of the *Child Welfare Act*[274] may be made in order to sever the connection between the surrogate mother and the child as a matter of law, and to constitute the wife as the mother of the child for all legal purposes. It bears emphasizing that, although this circuitous route will culminate in a result identical to that sought to be achieved by contract, the court will be involved in determining custody and, later, the status of the child according to the best interests of that child, which may not necessarily conform to the intentions expressed in the agreement between the adult parties.

As we stated in chapter 3, the fact that recourse to the existing statutory framework may culminate in a judicial determination consistent with the intentions of the parties should not be construed as an appropriate response to surrogate motherhood. The method that we have described is circuitous and cumbersome. To the extent that it involves an *ex post facto* reaction to the birth of the child, rather than dealing with the issues prior to birth, or even conception,

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273 *Supra*, note 41. See, also, the *Child and Family Services Act, 1984, supra*, note 41, s. 159.

274 See, also, the *Child and Family Services Act, 1984, supra*, note 41, Part VII.

the statutory framework may balance the competing interests inadequately. Moreover, it should be obvious that the utility of the existing procedures depends entirely on the cooperation of the surrogate mother. Should she resile from her promise to transfer the child, a custody dispute would ensue, which would be extremely disruptive to the child and the adult parties. Finally, it should be observed that the procedures that we have mentioned may only be set in motion where the intended social father is also the biological father. Where semen has been donated, an order for paternity, which would constitute the basis for the application for custody, cannot be obtained by the social father.

In chapter 3, we concluded that the existing law has not adequately met the challenge presented by the advent of the artificial conception technologies. This conclusion applies with even greater force in the case of surrogate motherhood, with the result that all persons potentially affected by such an arrangement are at risk. We are of the view that such risks should not be tolerated with equanimity, but should be addressed directly by legislation.

In this connection, we observe that the General Council of the Canadian Medical Association has approved a resolution "[t]hat the CMA alert the physicians of Canada to the number and complexity of unresolved legal problems relating to surrogate motherhood and to advise them to become associated with the procedure only with great caution until its legal, social and psychological implications are clarified".[275]

In chapter 4 of this Report, we discussed the alternative approaches to law reform, contrasting a "private ordering" approach with a "state regulation" approach. We explained that the former is a facultative regime that enables individuals to arrange their affairs as they see fit, without imposing normative constraints on the exercise of choice, and that the latter limits individual choice in the interest of realizing perceived public values. We observed that, where state regulation is thought desirable, it may take the form of either prohibition or regulation of the activity in question.

We have already concluded that the inadequacy of the response of the present law to surrogate motherhood warrants intervention on the part of the Legislature. The question then becomes the form that such intervention should take. In considering this difficult question, we have examined the experience in other jurisdictions and weighed carefully the various policy arguments.

(b) Approaches in Other Jurisdictions

Our survey of other jurisdictions reveals that legislation has been enacted specifically to address surrogate motherhood only in the State of Victoria in Australia.[276] Elsewhere, as in Ontario, statutes designed to deal with other matters may inadvertently affect such arrangements. Moreover, some case law has arisen in connection with surrogate motherhood arrangements.

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275 Canadian Medical Association, *Proceedings of the 116th Annual Meeting, Including the Transactions of General Council* (1983), at 128, resolution 83-23.

276 See discussion *infra*, this sec.

In England, the Family Division of the High Court of Justice was faced with an application for access by the natural father in an abortive surrogate motherhood arrangement.[277] In his *obiter* remarks, Mr. Justice Comyn stated that he regarded the "pernicious agreement" as a purported contract for the purchase and sale of a child, and therefore void as against public policy.

In the United States, attempts by parties to use existing legislation to achieve the objectives of surrogate motherhood agreements thus far have been unsuccessful.[278] On the the other hand, a Kentucky court has refused an application by the state Attorney General to revoke the corporate charter of a private surrogate motherhood agency.[279] The Attorney General argued that the activities of the agency violated statutory proscriptions that had been enacted in connection with adoption. The Court held that the legislation did not apply to these activities.

While there has been a dearth of case law respecting surrogate motherhood, this subject has received attention from legislators, law enforcement officials, and government and other bodies.

Certain state Attorneys General have issued advisory opinions respecting whether surrogate motherhood activities would run afoul of either public policy or existing statutory provisions governing the placement of children for adoption. One of these has concluded that the practice is contrary to public policy as being tantamount to an agreement for the purchase and sale of a child.[280] With respect to the conformity of surrogate motherhood arrangements to existing legislation, other opinions suggest that their legality depends on the precise language of the relevant statute.[281]

In response to the establishment of private surrogate motherhood agencies,

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277 *A. v. C.*, unreported (June 20, 1978, H.C.J., Fam. Div.). For a brief discussion of this case, see Cusine, "Womb-leasing: Some Legal Implications" (1978), 128 New L.J. 824. The decision was affirmed on appeal: see *A. v. C.*, unreported (July 18, 1978, C.A.). While neither decision is reported, Mr. Justice Comyn's decision is summarized in [1978] Family Law 170.

278 See *In re Baby Girl*, unreported (March 18, 1983, Jefferson Co. Cir. Ct., Ky.); *Doe v. Kelley*, unreported (January 28, 1980, Wayne Co. Cir. Ct., Mich.), aff'd 106 Mich. App. 169, 307 N.W. 2d 438 (1981); and *Syrkowski v. Appleyard*, unreported (November 25, 1981, Wayne Co. Cir. Ct., Mich.), aff'd 122 Mich. App. 506, 333 N.W. 2d 90 (1983). See, also, *In the Petition of R.K.S. for Adoption*, unreported (April 13, 1984, Sup. Ct., Fam. Div., D.C.).

279 See *Commonwealth of Kentucky, ex rel. Beshear v. Surrogate Parenting Associates, Inc.*, unreported (October 26, 1983, Franklin Co. Cir. Ct., Ky.). The decision is under appeal to the Kentucky Court of Appeals.

280 See Kansas Att. Gen. Op. No. 82-150 (July 2, 1982).

281 See Ohio Att. Gen. Op. No. 83-001 (January 3, 1983), and Oklahoma Att. Gen. Op. No. 83-162 (September 29, 1982). The opinion issued by the Attorney General for Kentucky — Ky. Att. Gen. Op. No. 81-18 (January 26, 1981) — which constituted the basis for its action against Surrogate Parenting Associates, Inc., was rejected by the Court in *Commonwealth of Kentucky, ex rel. Beshear v. Surrogate Parenting Associates, Inc.*, *supra*, note 279.

governmental studies have been conducted in several states.[282] In at least ten American states, draft bills have been introduced. Not a single statute has been enacted, however, and almost all the bills have been allowed to die in committee. While a few bills have sought to prohibit surrogate motherhood,[283] the majority have proposed regulatory schemes of varying complexity. The regulatory proposals range along a continuum from simply stipulating the minimum terms that must be included in an agreement[284] to a formal adoption model that requires a judge to attest to the suitability of the natural father and his wife before a physician can lawfully perform artificial insemination of the surrogate mother.[285]

In recent years, various bodies in the United Kingdom, Australia, and the United States have examined surrogate motherhood arrangements. The majority of these bodies have indicated their opposition to these arrangements and have urged measures to discourage persons from entering into them.

In the United Kingdom, the most comprehensive discussion of the issue can be found in the Report of the Warnock Committee.[286] A majority of the Warnock Committee was opposed to the practice of surrogate motherhood. In order to discourage its use, the following recommendations were made:[287]

> 56. Legislation should be introduced to render criminal the creation or the operation in the United Kingdom of agencies whose purposes include the recruitment of women for surrogate pregnancy or making arrangements for individuals or couples who wish to utilise the services of a carrying mother; such legislation should be wide enough to include both profit and non-profit making organisations.
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> 57. Legislation should be sufficiently wide enough to render criminally liable the actions of professionals and others who knowingly assist in the establishment of a surrogate pregnancy.
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> 58. It [should] be provided by statute that all surrogacy agreements are illegal contracts and therefore unenforceable in the courts.

Before making these recommendations, the Warnock Committee considered

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282 See, for example, Virginia, *Report of the Department of Welfare Study Committee on Surrogate Parenthood to the Senate Committee on Rehabilitation and Social Services and the House Committee on Health, Welfare and Institutions* (October, 1981), and Maryland, *Report of the Committee to Study Surrogate Mother Programs in Maryland* (February, 1983), and *Surrogate Mothering Programs in Maryland: A Study Conducted by Staff of the Department of Human Resources* (August, 1983). The General Assembly of Pennsylvania has passed a resolution providing for the appointment of a special committee to investigate surrogate parenting: see House Resolution No. 109 (June 21, 1983).

283 See, for example, AB 3139 (New Jersey), and SB 63 (Michigan).

284 See, for example, A6624 (New York).

285 See, for example, H2098 (South Carolina). See, generally, Comment, "Surrogate Motherhood: Contractual Issues and Remedies under Legislative Proposals" (1984), 23 Washburn L.J. 601.

286 See Warnock Report, *supra*, note 2.

287 *Ibid.*, at 85-86. See, also, *ibid.*, paras. 8.18-8.19, at 46-47.

the arguments for and against surrogate motherhood.[288] It concluded as follows:[289]

> The moral and social objections to surrogacy have weighed heavily with us. In the first place we are all agreed that surrogacy for convenience alone, that is, where a woman is physically capable of bearing a child but does not wish to undergo pregnancy, is totally ethically unacceptable. Even in compelling medical circumstances the danger of exploitation of one human being by another appears to the majority of us far to outweigh the potential benefits, in almost every case. That people should treat others as a means to their own ends, however desirable the consequences, must always be liable to moral objection. Such treatment of one person by another becomes positively exploitative when financial interests are involved. It is therefore with the commercial exploitation of surrogacy that we have been primarily, but by no means exclusively, concerned.

Two members of the Warnock Committee dissented from the recommendations set out above. They suggested that rather than prohibit the practice, "the door [should] be left slightly ajar so that surrogacy can be more effectively assessed".[290] It was the view of the minority that the licensing authority, which the Committee had recommended generally to regulate artificial conception services, should be empowered to license an agency or agencies to arrange surrogate mother births.[291] It believed firmly that, since the issues involved in surrogate motherhood were similar to those associated with adoption, commercial agencies should be prohibited. In order to allow the couple wishing to raise the child to have the status of parents, the dissenting members suggested that a form of adoption procedure be made available. Finally, they disagreed that surrogate motherhood agreements should be declared by statute to be illegal contracts, preferring to leave the issue to the courts.

The position of the dissenting minority followed from its conclusion that it was premature "to close the door completely on surrogacy being offered as a treatment for childlessness".[292] A particular concern was that, if the demand for this alternative were to continue or to expand, one consequence of the recommendation preventing professionals from providing assistance would be that

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288 *Ibid.*, paras. 8.10-8.16, at 44-46.

289 *Ibid.*, para. 8.17, at 46.

290 *Ibid.*, para. 9, at 89.

291 In this regard, the minority explained as follows (para. 5, at 88):

> These arrangements would include the matching of commissioning parents with surrogate mothers, and the provision of adequate counselling to ensure that the legal and personal complications of surrogacy were fully understood. The only agencies which could be licensed would be those in which child-caring skills were well represented and in which there was no commercial motive. Thus adoption and fostering agencies or some new agency, similarly staffed and run, could be appropriate candidates for licensing. We are not suggesting that the licensing authority establish an agency, only if one is proposed it be empowered to consider its application. Access to a licensed agency could only be by referral from a consultant gynaecologist.

292 *Ibid.*, para. 5, at 88.

couples might undertake self-help measures and thereby not receive the necessary medical and counselling services.[293]

The Law Society of England, in its submission to the Warnock Committee,[294] stated that "womb leasing for which payment is made" is "thoroughly undesirable".[295] The Law Society speculated as to whether the time was propitious to render criminal those practices associated with commercial surrogate motherhood arrangements. Interestingly, the submission of the Law Society of Scotland[296] seemed to indicate that surrogate motherhood would be an appropriate alternative if there was a medical reason for recourse to the procedure and an adoption procedure was to establish the relationship between the child and the couple who wished to raise it. The submission also approved payment of the reasonable expenses of the surrogate mother, including "appropriate" compensation for loss of employment, and possibly other payments as well.[297]

Independent of the Warnock Committee inquiry, certain medical bodies in Great Britain have considered the propriety of employing surrogate motherhood arrangements in the context of *in vitro* fertilization. Both the Working Group on Human In Vitro Fertilisation, established by the British Medical Association Council,[298] and the Ethics Committee of the Royal College of Obstetricians and Gynaecologists[299] have indicated their rejection of this reproductive alternative. The position of the Working Group on In Vitro Fertilisation was not supported by articulated reasoning.[300] By contrast, the conclusion of the Ethics Committee of the Royal College, that it was "unethical to implant embryos conceived by IVF into surrogate mothers",[301] was based, in part, on concerns about the psychological impact on the child and the surrogate mother.[302]

Finally, the Council of the British Medical Association has approved a resolution stating that, "in consideration of the difficulties, anxieties, and uncertainties to all individuals concerned ... it is unethical for a doctor to become involved in techniques and procedures leading to surrogate motherhood".[303] This resolution represents the official policy of the British Medical Association.

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293 *Ibid.*, para. 4, at 88.

294 England, The Law Society, *Memorandum by the Society's Standing Committee on Family Law: Human Fertilisation and Embryology* (1983).

295 *Ibid.*, para. 2.6, at 3.

296 Law Society of Scotland Report, *supra*, note 37.

297 *Ibid.*, at 12.

298 B.M.A. Working Group Report, *supra*, note 39.

299 RCOG Report, *supra*, note 48.

300 B.M.A. Working Group Report, *supra*, note 39, para. 13, at 1594.

301 RCOG Report, *supra*, note 48, para. 7.6, at 8.

302 *Ibid.*, paras. 7.2-7.3, at 7-8.

303 British Medical Association, "Annual Report of Council 1983-4" (1984), 288 Brit. Med. J. 25 (hereinafter referred to as "B.M.A. Annual Report").

Recently, the Council for Science and Society[304] in the United Kingdom released a report prepared by an *ad hoc* Working Party on the ethical aspects of the new artificial conception techniques.[305] After acknowledging that there was "a strong presumption against 'surrogate motherhood' ",[306] arising from concerns about the psychological effect on the surrogate mother and, to a lesser extent, the child, and the possibility of commercialization, the Working Party concluded that " 'surrogate motherhood' should not be prohibited by law".[307] It observed that "the procedure *might* be justifiable in very exceptional circumstances".[308] The Working Party suggested that, if the procedure were ever used, adequate counselling of the parties should be assured, and the surrogate mother should be selected carefully on the basis that she will conduct herself with care during the pregnancy. Interestingly, the Working Party took the view that, if the woman were to refuse to surrender the child, she should not be forced to do so.

In the United States, surrogate motherhood has excited some concern within the medical community, due perhaps to the proliferation of private agencies offering this service. In 1983, both the American Medical Association (A.M.A.) and The American College of Obstetricians and Gynecologists articulated their positions. In its Statement of Policy, "Ethical Issues in Surrogate Motherhood",[309] The American College of Obstetricians and Gynecologists expressed "significant reservations about this approach to parenthood". Notwithstanding the identification of several specific ethical concerns associated with surrogate motherhood arrangements, the College took the view that the decision to participate should be left to the conscience of individual physicians. However, certain guidelines were suggested in the Statement of Policy. Among these was an enjoinder that "[t]he physician should not participate in a surrogate program where the financial arrangements are likely to exploit any of the parties".

The A.M.A. has taken an entirely different view of this matter. In December, 1983, the House of Delegates of the A.M.A. adopted a report of the Judicial Council,[310] which concluded that " 'surrogate mother' arrangements do not provide a satisfactory reproductive alternative". The Report alluded generally to "many ethical, legal, psychological, societal and financial concerns". In

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304 The Council for Science and Society is a registered charity, formed in 1973. Its object is to promote "the study of, and research into, the social effects of science and technology, and of disseminating the results thereof to the public".

305 Council for Science and Society, *Human Procreation — Ethical Aspects of the New Techniques* (1984).

306 *Ibid.*, at 50.

307 *Ibid.*, at 51.

308 *Ibid.* (emphasis in original). It stated that "[i]t might be considered justifiable only when a couple have a physical inability to have a child in any other way, and never for purposes of convenience" (*ibid.*, at 51).

309 The American College of Obstetricians and Gynecologists, "Ethical Issues in Surrogate Motherhood", in ACOG Statement of Policy (May, 1983) (hereinafter referred to as "ACOG Policy Statement").

310 American Medical Association, *Judicial Council Report (I-83)* (1983).

particular, it referred to the possibility of a "defective child", psychological risks to the surrogate mother, and difficulties attendant upon abortion and refusal to surrender the child. Apart from brief mention of these concerns, however, the Judicial Council did not support its disapproval with a detailed discussion.

In Australia, opposition also has been expressed to the use of surrogate motherhood arrangements in several reports and, in the State of Victoria, prohibitory legislation has been enacted. In a recent Report,[311] a Committee appointed by the Queensland government recounted the usual objections to surrogate motherhood and then commented that "the most prudent course would seem to be to leave such agreements unenforceable, at least until experience demonstrates whether regulation of such agreements is required in the interest of society and of the parties involved".[312] The Committee considered "that it would not be desirable, at least at present, to make surrogacy arrangements criminal offences, and that lack of enforceability of surrogacy contracts will probably suffice to prevent the widespread encouragement of surrogate motherhood arrangements".[313] It envisaged that, if questions respecting parental rights and obligations, including custody and status, arose, they would be decided in custody or other proceedings under the general law.[314] The Committee did conclude, however, "that it should be made illegal to advertise to recruit women to undergo surrogate pregnancy, or to provide facilities for persons who wish to make use of the services of such women".[315] Finally, the Queensland Committee recommended that the Royal Australian College of Obstetricians and Gynaecologists should address, from a medical perspective, the ethical problems raised by surrogate motherhood.

Recently, the Victoria Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization published its *Report on the Disposition of Embryos Produced by In Vitro Fertilization.*[316] The Committee recommended "that surrogacy arrangements shall in no circumstances be made at present as part of an IVF programme in Victoria".[317] The Committee opposed both commercial surrogate motherhood arrangements and gratuitous arrangements, but reserved its harsher criticism for the former, which it characterized as "inhuman".[318]

The opposition of the Victoria Committee to commercial surrogate motherhood agreements followed from its view that such agreements involved the

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311 Queensland Report, *supra*, note 2.

312 *Ibid.*, at 116.

313 *Ibid.*, at 117.

314 However, the Committee did recommend that "any doubt which may exist that the woman who gives birth to a child is considered to be its mother, should be removed by legislation which so provides an irrebutable presumption": *ibid.*, at 118.

315 *Ibid.*

316 Victoria Report on Embryos, *supra*, note 110.

317 *Ibid.*, para. 4.17, at 54.

318 *Ibid.*, para. 4.11, at 52.

buying and selling of infants.[319] With respect to strictly voluntary arrangements, where there is no element of commerce,[320] the Committee expressed two practical concerns: first, conflicts might arise over custody in the event of a refusal by the surrogate mother to surrender the child; and secondly, a defective child might be rejected by the couple who had initially wanted a child.[321] On a more fundamental level, some members of the Committee were troubled about "the deliberate manufacture of a child for others".[322]

In November, 1984, the Legislative Assembly of Victoria enacted the *Infertility (Medical Procedures) Act* 1984.[323] Although concerned primarily with the regulation of artificial conception technologies and, in particular, *in vitro* fertilization, the Act does address surrogate motherhood. It seeks to discourage the practice by enacting certain prohibitions in relation to it and by providing that a surrogate motherhood agreement is void.

The Act defines a surrogate mother very broadly:

> 30.-(1) In this section, a reference to a woman who acts, or agrees with another person or other persons to act, as a surrogate mother is a reference to a woman who has entered into, or enters into, a contract, agreement or arrangement with that other person or those other persons, whether formal or informal, and whether or not for payment or reward under which the woman agrees —
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> (a) to become pregnant, or to seek or attempt to become pregnant, with the intention that a child born as the result of the pregnancy become and be treated, whether by adoption, agreement or otherwise, as the child of that other person or of those other persons; or
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> (b) being pregnant, that a child born as the result of the pregnancy become and be treated, whether by adoption, agreement or otherwise, as the child of that other person or those other persons.

It should be noted that this definition does not restrict the meaning of "surrogate mother" to a woman who is pregnant, or who seeks to become pregnant, by means of artificial conception. Thus, it appears to embrace a woman whose pregnancy is a consequence of sexual intercourse.

The *Infertility (Medical Procedures) Act* 1984 prohibits three types of conduct in relation to surrogate motherhood arrangements. First, it prohibits the publication of a statement, advertisement, notice or other document that is intended or likely to induce a person to agree to act as a surrogate mother, that seeks a woman willing to agree to act as a surrogate mother, or that states or

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319 *Ibid.*

320 The Committee, it should be noted, stated that "[a]n arrangement that such a woman's medical, hospital and travelling expenses be paid would not result in it being labelled as commercial": *ibid.*, para. 4.12, at 53.

321 *Ibid.*, paras. 4.14-4.15, at 53-54.

322 *Ibid.*, para. 4.16, at 54.

323 *Supra*, note 48.

implies that a woman is willing to agree to act as a surrogate mother.[324] This prohibition applies irrespective of payment.

Secondly, the Act provides that "[a] person shall not ... make, give or receive, or agree to make, give or receive, a payment or reward for or in consideration of the making of a contract, agreement or arrangement under which a woman agrees to act as a surrogate mother".[325] This would appear to proscribe the offering or payment of money by a couple seeking a child and the remunerative activities of intermediaries seeking to arrange surrogate motherhood agreements.

Thirdly, the Act provides that "[a] person shall not ... receive or agree to receive a payment or reward in consideration for acting, or agreeing to act, as a surrogate mother".[326]

Violation of any of these prohibitions may lead to a penalty of imprisonment for two years. In addition to discouraging surrogate motherhood by these prohibitions, the Act provides that "[a] contract or agreement (whether made before or after the commencement of this section) under which a woman agrees with another person or other persons to act as a surrogate mother is void".[327]

Finally, mention should also be made of the Report of the South Australia Working Party on In Vitro Fertilization and Artificial Insemination by Donor.[328] In that Report, the Working Party recommended "that there should be no change to the law to enable surrogacy to be practised ... and that a policy should be formally adopted by the Government in relation to the *Adoption of Children Act* to prevent surrogacy being practised ...".[329] The Working Party was of the view that "[t]he community in general regards surrogacy as unacceptable". Despite its breadth, this assertion was supported by very few specific concerns. Attention was drawn to the "serious emotional consequences" to a couple and "bitter litigation" that might ensue if the surrogate mother were to refuse to surrender the child. The Working Party also observed that the contract would likely be regarded as contrary to public policy and unenforceable.[330]

(c) POLICY IN PRINCIPLE

From the foregoing discussion, it is apparent that a considerable body of informed opinion in the United Kingdom, Australia, and the United States has, at the very least, serious reservations about the practice of surrogate motherhood. In

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324 *Ibid.*, s. 30(2)(a).

325 *Ibid.*, s. 30(2)(b).

326 *Ibid.*, s. 30(2)(c).

327 *Ibid.*, s. 30(3).

328 South Australia, *Report of the Working Party on In Vitro Fertilization and Artificial Insemination by Donor* (1984).

329 *Ibid.*, at 29.

330 *Ibid.*

some of the reports, however, we observe that opposition to the practice is expressed without supporting reasoning, as if the impropriety of this reproductive alternative were self-evident. In others, the particular concerns are articulated expressly, and it is to these arguments that we turn now in order to decide between prohibition and regulation.

Several of the most commonly expressed arguments centre around the fact that surrogate motherhood arrangements often are accompanied by payment of a fee to the surrogate mother.[331] It has been argued that it is an affront to human dignity and integrity for a woman, in effect, to rent her uterine capacity to another. It has been contended, moreover, that such a practice invites exploitation of disadvantaged women by the more economically powerful. If widespread, the practice could lead to the establishment of a veritable "class" of child-bearing women. A corollary of this argument is that surrogate motherhood degrades the child for whose conception and transfer money is exchanged, by treating him or her like a commodity. In this argument, the promises of the surrogate mother respecting the child are assimilated to an agreement to buy and sell an existing child, which, in some jurisdictions, is either proscribed generally or, as in Ontario, proscribed in relation to adoption.

On a more abstract, philosophical level, it has been contended that, by its very nature, surrogate motherhood embraces an offensive utilitarianism, independent of payment, insofar as it involves the use of one person as a means to the ends of another. That one person may be so used by another, it has been argued, is in and of itself unethical.[332]

Certain arguments relate to the alleged effects of a surrogate motherhood arrangement on the surrogate mother and the child. It has been suggested that the practice should be prohibited because of the physical and psychological risks assumed by the surrogate mother. The physical risks are those associated with pregnancy. The psychological risks arise from surrender of the child following birth. While the former are well known and can be appreciated, the latter are unfamiliar in the absence of accumulated experience and empirical study.

There has also been speculation that there may be a risk to the unborn child in being carried by a mother who intends to surrender the child immediately after birth. Further, it has been contended that the child is at some risk due to the severance of bonds with the surrogate mother. Finally, there have been suggestions that psychological damage may be caused to the child upon learning of the circumstances of his introduction into the family.

Other arguments relate to the possible death of one or both of the social parents prior to the birth of the child and to the possibility that a handicapped child may be born. Yet another matter that has been raised is the difficulty of enforcing such an arrangement in the face of a recalcitrant surrogate mother.

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331 See, for example, Queensland Report, *supra*, note 2, at 116-17.

332 See Warnock Report, *supra*, note 2, para. 8.17, at 46.

In response to the arguments raised against surrogate motherhood, it bears emphasizing that many of the criticisms are based primarily on the fact that such arrangements are operated often on a profit basis. The objections relating to the debasement and exploitation of women and the treatment of children as commodities, while directed generally against the practice of surrogate motherhood, in fact focus exclusively on the profit-making aspects of these arrangements. Were such aspects controlled, these arguments would be undermined considerably.

We find unpersuasive the argument that surrogate motherhood should be proscribed because one person should not serve as a means to an end for another. As an abstract principle, the proposition appears attractive as a ringing rejection of a utilitarian approach to humanity. However, as an absolute precept for governing conduct, its impracticability is demonstrated daily. On a very trivial level, we see the principle ignored wherever services are purchased and sold. A more relevant illustration of its inapplicability occurs in the case of an organ donation for a therapeutic purpose by a live donor. While the recipient is "using" another person to realize an "end", we do not find this conduct offensive to fundamental values, even though, in the case of a kidney transplant, the donor may be taking a risk, since the remaining kidney may later fail. Accordingly, we would suggest that the principle that one person should not serve as a means to an end for another is not an absolute one to which deference must be paid, but that each situation must be evaluated independently to assess its ethical propriety.

With regard to the physical risks associated with pregnancy, we observe that, while they certainly do exist, they can be minimized by providing proper medical care. Moreover, the risks can be communicated and need not be assumed by anyone with even a residuum of doubt.

We are more concerned about the arguments respecting the potential psychological dangers to the surrogate mother and the child arising from the transfer of custody after birth. While in no way deprecating these arguments, we wish to indicate that, at this juncture, the effects of surrendering custody on mother and infant are not evident. Particularly speculative, we understand, is the present state of knowledge about the degree of bonding of the infant in the womb. In view of this uncertainty, we are not persuaded that prohibition is warranted.

With respect to the concerns that have been expressed about the possible death of the social parents, the birth of a handicapped child, and enforcement of the agreement, we believe that each can be addressed effectively by legislation.

On the question of the general approach to be taken to surrogate motherhood, the Commission is divided. A majority of the Commission endorses the practice, but recommends that legislation should be enacted to establish a regulatory scheme governing surrogate motherhood arrangements. One Commissioner favours recommending prohibition of surrogate motherhood as being

contrary to public policy; he is of the view that regulation would imply state approval of such arrangements.[333]

The conclusion of the majority in respect of surrogate motherhood reflects the position articulated by the Commission concerning the propriety of the artificial conception technologies. It will be recalled that, when considering the propriety of these technologies, we addressed the argument that the new reproductive technologies ought to be prohibited because they are "unnatural". For many, this objection is fundamental to surrogate motherhood as well, in the sense that no amount of regulation could cure what for them is its inherent ethical unacceptability. However, the labelling of surrogate motherhood as "unnatural" unfortunately has the effect, whether intended or not, of casting the burden of justifying the practice upon its proponents, without advancing compelling arguments in favour of prohibition.

The majority of the Commission is of the view that, in principle, prohibitory action is warranted only where there is an extremely powerful justification; the onus should be on those who would advocate such action, not on those whose conduct is to be the subject of legislative or other interference.

In the context of surrogate motherhood, as in the earlier context of artificial conception generally, the majority of the Commission is of the view that recourse to medical means of alleviating the effects of infertility or genetic impairment cannot conscionably be forbidden. It does not see the endorsement of this practice as foreshadowing the dissolution of the family, nor does it accept that only harm can come to the child or children involved. Indeed, by assisting an otherwise childless couple, surrogate motherhood may be the sole means of affirming the centrality of family life. While, then, the majority acknowledges and respects the views of those who espouse prohibition, and believes that such opposition may properly animate individual moral values and decisions, it rejects the notion that prohibitory action in relation to surrogate motherhood is warranted in the public interest.

A further factor, which weighed heavily, was our belief that, given the relative accessibility of artificial insemination, prohibition would result in recourse to clandestine private arrangements that would realize the worst fears of those who oppose this practice. Dangers of exploitation of the weak by the powerful, pregnancies contracted by the irresponsible, and the introduction of infants into inappropriate, even dangerous, circumstances, would seem to be accentuated if the practice were driven underground. At greatest risk would be the child whose place in society would be uncertain. Indeed, the child might be in a worse position than under existing law, where recourse to the courts may be made to determine parentage and custody, the latter according to the best interests of the child.

Accordingly, we have rejected prohibition in favour of a form of regulation, in the belief that the latter best would protect the interests of all concerned,

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[333] Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, dissents from the recommendation: see Vice Chairman's Dissent, at page 287 of this Report.

particularly the child who is to be conceived and transferred.[334] It is of importance to note that the Commission's multidisciplinary Advisory Board, which included experts in the fields of child psychiatry, reproductive medicine, social work and law, also took the view that concerns about the well-being of the affected persons would best be met by regulation.

We realize that our position in favour of legislation regulating the practice of surrogate motherhood will be controversial. Those who find the practice abhorrent no doubt will find our reasoning unconvincing. In the final analysis, the question becomes one of fundamental values, which cannot be resolved conclusively to the satisfaction of everyone; the differences merely can be acknowledged.

Having concluded that regulation of surrogate motherhood arrangements is the preferred course, we shall now consider the choice of a regulatory model.

(d) Choice of a Regulatory Scheme

In deciding on a basic scheme to regulate surrogate motherhood arrangements, we find that there are two basic approaches that might be adopted. One is suggested by the existing law, under which the court may be involved *ex post facto*. A second appears in the regulation of adoption under the *Child Welfare Act*, which involves prior judicial screening.[335]

From our earlier discussion,[336] it should be apparent that we regard the present law as inadequate to meet the problems raised by surrogate motherhood. That there may be a circuitous avenue available for regularizing the relationship between the child and the intended social parents does not provide the requisite protection for the persons affected, nor the certainty of status and identity for the child who has been conceived. As we have indicated, the efficacy of this procedure depends on the cooperation of the surrogate mother, which is not necessarily assured. Furthermore, the procedure depends on proof of the paternity of the social father. Finally, and most importantly, judicial involvement after the fact comes at a stage when it simply may be too late to protect all concerned.

It is our view that, given the nature of surrogate motherhood arrangements, regulation should take the form of intervention before any aspect of the agreement is implemented and, in particular, before artificial conception technology is employed to achieve a pregnancy. We believe that mandatory minimum standards to which these arrangements must conform should be established unambiguously by statute. Each prospective surrogate motherhood arrangement should be scrutinized to ascertain whether it complies with the enunciated standards. In our opinion, the institutions best suited to undertake this crucial

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334 We observe that our position reflects the views of public and voluntary social welfare agencies in the United States, surveyed by the Child Welfare League of America in May, 1983. While many agencies were apprehensive of surrogate motherhood agreements, 66% favoured regulation, 10% favoured no legislation, and 24% favoured prohibition.

335 See *supra*, ch. 4, sec. 3(b).

336 See *supra*, this ch., sec. 5(a).

supervisory responsibility are the courts concerned exclusively with family law issues, that is, the Provincial Court (Family Division) and the Unified Family Court.

Accordingly, we recommend that, before an artificial conception procedure may be employed in furtherance of a surrogate motherhood arrangement, the approval of the Provincial Court (Family Division) or the Unified Family Court, as the case may be, should be obtained in accordance with the proposals that we shall make in the balance of this chapter. In order for a court to evaluate the acceptability of a surrogate motherhood arrangement in accordance with legislative standards, we recommend that the terms of the agreement should be in writing. The court should be required to approve the terms and to ensure that they adequately protect the child and the parties and are not inequitable or unconscionable.

Our preference for prior judicial screening raises a question concerning the form that judicial intervention should take. The most obvious model of prior judicial intervention is found in the adoption provisions under the *Child Welfare Act*.[337] This model is useful, insofar as it involves the court in determining the status of the child on the basis of the best interests of that particular child. However, while we regard adoption as an informative precedent for a scheme of prior intervention, we believe that neither of the two forms of adoption set out in the *Child Welfare Act* is suitable for replication in the context of surrogate motherhood.

It will be recalled that adoption by step-parents and close relatives[338] is subject to a lesser degree of scrutiny than adoption by other persons, to whom we referred earlier as "strangers". In the case of the latter, the prospective adoptive parents are subjected to a homestudy, in which they are closely evaluated by a social worker prior to placement of the child in their home. Before the court issues an order finalizing the adoption, the child must be in the home for a probationary period of at least six months, during which the mutual adjustment of child and adoptive parents is monitored. In the case of step-parent or close relative adoption, placement of the child does not require prior approval. Nor is there a requirement that a homestudy be conducted of the step-parent or close relative wishing to adopt. On the hearing of the application, a report on the adjustment of the child in the home is not mandatory, although the court has a power to direct that such a report be prepared and submitted.

We believe that the rigorous intervention in the case of adoption by strangers is an inappropriate regulatory model for surrogate motherhood arrangements. In most cases, we anticipate that such arrangements will involve artificial insemination of the surrogate mother by the semen of the male partner of the couple wishing to raise the child. Since he is the natural father of the child, we do not consider it appropriate that he be treated as a stranger, and that he and his partner

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337 See, now, the new *Child and Family Services Act, 1984, supra*, note 41, Part VII.

338 With respect to "family adoption" under the *Child and Family Services Act, 1984, ibid.*, see ss. 130(1)(c) and 140(2).

be subjected to the invasive scrutiny of a homestudy. While there may be occasions where artificial conception technology is employed to achieve a pregnancy where the male is not the natural father, we consider that such cases will be relatively few in number and, therefore, should not affect the view espoused above.

We also believe that the procedure for step-parent or close relative adoption is not appropriate in this context. Notwithstanding that the relationship between the social parents and the child may in form resemble that in a step-parent adoption — the male will usually be the biological father of the child, in which case his wife will be a step-parent — the reasons for less rigorous intervention that apply to step-parent adoption do not apply to surrogate motherhood. In the case of step-parent adoption, the judicial order regularizes an existing relationship between one spouse in a marriage and a natural child of the other spouse, born in an earlier relationship or possibly out of the marriage. An application for an adoption order presents the court with what is in effect a *fait accompli:* if the application were to be refused, the child would remain the legal responsibility of the natural parent and continue to reside with the applicant for adoption. In recognition that little purpose may be served in refusing the application, courts almost invariably approve step-parent adoption applications without exercising their power to require a report on the adjustment of the child in the home.

In the case of adoption by one of the special class of relatives, it would appear that the less rigorous scrutiny may be founded on an assumption that there is a close relationship between the child and the applicant, and that, in many cases, the child is already living with the applicant.

The procedure for step-parent or close relative adoption is, therefore, a procedure intended to respond to an existing set of circumstances, rather than a procedure with a prospective focus, designed to determine whether a particular situation should be allowed to occur. Such a determination, we think, should be assigned to the courts in supervising surrogate motherhood agreements.

At this juncture, we wish to outline the major features of the recommended scheme. Under this scheme, a prospective surrogate mother and the couple who wish to raise the infant must reach a written agreement that, at a minimum, addresses certain matters specified by the legislation. Before the necessary artificial conception procedure may be performed lawfully, the parties to the agreement must submit the agreement to the court and obtain its approval. On the approval hearing, the court will be required to assess the suitability of the parties to participate in the surrogate motherhood arrangement. If the court is satisfied as to their suitability and the conformity of the agreement with specified legislative criteria, it will approve the arrangement. Immediately following the birth of the child, consistent with the agreement, the surrogate mother will be required to surrender custody of the child to the approved parents. The status of the child in its new family will be confirmed by legislation and reflected in its birth registration.

Having outlined the basic regulatory scheme, we shall proceed to discuss its constituent elements. Each aspect of the procedure is a response to a particular

concern that has arisen, or that may arise, in connection with surrogate motherhood arrangements. The ensuing discussion will first consider the participants — the prospective parents, the surrogate mother, and the court. We shall discuss the terms that should be required by statute to be incorporated in each agreement, with particular emphasis being given to the promise of the surrogate mother to surrender the child. Specific proposals respecting the child will be made. It bears emphasizing that all the proposals that we shall make, individually and in concert, are directed to protecting the child by ensuring that it is introduced into a healthy, nurturing environment without uncertainty or controversy.

We shall give separate consideration to the possible intervention of intermediate agencies in the arrangement of surrogate motherhood agreements. Finally, we shall discuss briefly certain miscellaneous issues and our proposed response to efforts to evade the regulatory scheme.

(e) THE PROPOSED REGULATORY SCHEME

(i) The Prospective Parents

As indicated, our recommendation in favour of regulation is based on our view that this approach would best serve the interests of all persons affected by surrogate motherhood arrangements. With respect to the prospective parents, there may be certain tensions associated with recourse to surrogate motherhood, tensions with which some individuals or couples will be unable to cope effectively. In addition, the suitability of the prospective parents will be crucial to the well-being of the child. Both these concerns can be met, we believe, if the prospective parents are evaluated prior to their involvement in surrogate motherhood arrangements.

Accordingly, we recommend that, on the hearing of the application for approval of a surrogate motherhood arrangement, the court should be required to assess the suitability of prospective parents for participation in such an arrangement.

The questions of who should be approved as parents under a surrogate motherhood arrangement and what standards should be applied in assessing applicants raise philosophical and practical issues similar to those that we considered earlier in our discussion of eligibility for participation in an artificial conception programme.[339] We turn now to consider these questions.

a. Medical Indications for Approval

Earlier we noted certain medical reasons why a couple may seek the assistance of a surrogate mother. A woman may lack a uterus or suffer from a serious heart condition that would render a pregnancy a risk to her life or health. However, there may be other reasons for recourse to this alternative. In the literature, it has been suggested that surrogate mothers might be sought for

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[339] See *supra*, this ch., sec. 3(b).

reasons of convenience. The usual example refers to women who prefer not to disrupt other endeavours, such as a career, or who wish to avoid the physical effects of pregnancy.

While we are not aware of any documented instance of surrogate motherhood being used for a nonmedical reason, the fact that artificial conception technology may be so employed obliges us to consider whether this is appropriate.

We observe that all members of the Warnock Committee, including those who dissented with respect to the prohibition of surrogate motherhood, were unanimous in their denunciation of surrogate motherhood for reasons of convenience. The Report stated that "surrogacy for convenience alone, that is, where a woman is physically capable of bearing a child but does not wish to undergo a pregnancy, is totally ethically unacceptable".[340] Other bodies that have expressed reservations about the practice of surrogate motherhood have indicated that their concerns are accentuated by the possibility of its use for reasons of convenience.[341]

We share these views concerning the use of surrogate motherhood for nonmedical reasons. Our sole purpose in allowing individuals to pursue surrogate motherhood arrangements under strict control is to respond to infertility, not to afford individuals the opportunity to satisfy their lifestyle preferences. Accordingly, it is our recommendation that, before the court approves a surrogate motherhood arrangement, the prospective parents should be required to satisfy the court that there is a medical need not amenable to alleviation by other available means, including the employment of the artificial conception technologies. In other words, surrogate motherhood should be a solution of last resort.

b. Assessing the Parents: Marital Status and Other Factors

Under our proposed regulatory scheme, the court would be asked to approve prospective parents for participation in a surrogate motherhood arrangement. From conferral of this responsibility a question naturally arises as to how the court is to assess their suitability. It will be recalled that, in the context of the artificial conception technologies, we left the determination of suitability to medical practitioners who, we recommended, were to be guided by regulations made under the *Health Disciplines Act*.[342] These regulations would limit the availability of artificial conception technology to stable single women and to stable men and women in a stable marital or nonmarital relationship.[343]

In formulating a test for assessing the suitability of prospective parents for participation in a surrogate motherhood arrangement, we do not consider that the rigorous scrutiny undertaken in the course of stranger adoption is appropriate.

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340 Warnock Report, *supra*, note 2, para. 8.17, at 46.

341 See, for example, ACOG Policy Statement, *supra*, note 309.

342 *Supra*, note 25.

343 See *supra*, this ch., sec. 3(b)(i).

We wish to emphasize that we do not question the propriety of the legislative "best interests" standard that guides the court in deciding whether to make an adoption order.[344] What we do consider inappropriate in the context of surrogate motherhood is the extremely strict criteria that are employed by children's aid societies in assessing the suitability of prospective adoptive parents prior to the placement of newborn children. This rigour reflects the dearth of infants available for adoption, which allows, and indeed perhaps even requires, agencies to be extremely selective. In our view, these criteria simply reflect the practical circumstances in which the "best interests" test is applied, rather than a substantive definition of that standard.

In considering the assessment of the prospective parents, we first addressed the issue whether eligibility to apply to the court for approval should be restricted on an *a priori* basis. On this issue, we are divided. A majority of the Commission believes that the availability of surrogate motherhood should not be restricted on an *a priori* basis, but should depend on an assessment of the suitability of applicants according to legislated standards. A minority takes the view that only married couples in stable unions should be allowed to apply to the court for approval to participate in a surrogate motherhood arrangement.[345]

Notwithstanding this difference of views, all members of the Commission agree that legislation should enunciate a substantive test that should be applied by the court in assessing the suitability of prospective parents. Further, we agree that, as the basic test, the court should be required to be satisfied that the intended child will be provided with an adequate upbringing and that, in making this determination, the court should be required to consider certain guidelines. With respect to such guidelines, the Commission is divided. The members of the Commission who oppose a restriction on the availability of surrogate motherhood on an *a priori* basis recommend that the court should be required to consider all relevant factors, including the marital status of the applicants, the stability of their unions, and their individual stability. The members of the Commission who favour restricting the availability of surrogate motherhood to married couples in stable unions would not, of course, include the marital status of the applicants and the stability of their unions as mere factors to be considered. However, leaving aside these two matters, they would propose that the court be required to consider all relevant factors, including the stability of the applicants.

Accordingly, a majority of the Commission recommends that the availability of surrogate motherhood should not be restricted on an *a priori* basis, but should depend on an assessment of the suitability of the prospective parents according to

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344 See *Child Welfare Act, supra*, note 41, s. 76(b), and the new *Child and Family Services Act, 1984, supra*, note 41, s. 140(1) and (2). For the considerations that may bear upon a determination of the best interests in the context of adoption of a child under the latter Act, see *ibid*, s. 130(2).

345 Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, dissents from the recommendation in favour of regulating surrogate motherhood arrangements: see Vice Chairman's Dissent, at page 287 of this Report. However, if such a procedure were adopted in Ontario, Dr. Leal would require that the prospective parents be married couples in stable unions.

legislated standards. The court should be required to be satisfied that the intended child will be provided with an adequate upbringing, and, in making this determination, the court should be required to consider all relevant factors, including the marital status of the applicants, the stability of their unions, and their individual stability.

While, for the most part, the proposed standard is self-explanatory, we wish to make one comment. By recommending that the court be satisfied that the child will be given an "adequate" upbringing, we intend to eschew the rigorous standards that are employed by children's aid societies in evaluating couples for adoption, standards that, as we have said, reflect the dearth of infants available for adoption.

c. Use of Gamete Donors

For various reasons, it may be necessary for the social parents to rely on gamete donation in the context of a surrogate motherhood arrangement. For example, where the husband may transmit a harmful genetic condition, donor semen must be used if a surrogate mother is to become pregnant. Alternatively, where the wife does not have a uterus, and the surrogate mother has tubal or ovarian problems, an ovum would have to be donated.

Where prospective parents seek the assistance of gamete donors, we believe that the donors should acquire no standing in the approval proceedings. On grounds of both principle and logic, they should be subject to the recommendations that we have proposed to govern gamete donation for the purpose of artificial conception.[346] Accordingly, we recommend that, where a donated gamete is to be used in a surrogate motherhood arrangement from a donor who is neither the prospective surrogate mother nor a prospective social parent of the intended child, the treatment of the donor should be governed by the previously recommended provisions concerning gamete donors.

(ii) The Surrogate Mother

Judicial approval of prospective surrogate mothers prior to performance of the artificial conception procedure is, in our view, absolutely crucial to the protection of the unborn child, the prospective parents, and indeed, the surrogate mother herself.

As far as the unborn child is concerned, whether the surrogate mother is to gestate an ovum supplied by another or her own fertilized ovum, her physical and mental state, both before and during pregnancy, will affect the health of the fetus. Where she is the genetic mother, her greater contribution to the child's development will increase the importance of assuring her health and, in particular, the absence of any deleterious genetically transmissible condition.

From the perspective of the social parents, the physical and mental state of the surrogate mother is important not only because it bears upon the health of the

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346 See *supra*, this ch., sec. 3(c).

child whom they will raise, but because it affects whether she will be conscientious in adhering to her agreement. A prospective surrogate mother should appreciate fully the nature of the obligations she has undertaken so that her cooperation will be assured when it is time to transfer custody of the infant.

Judicial approval of the surrogate mother may also be of importance to the woman herself. Certain physical and psychological risks would appear to be associated with participating as a surrogate mother. The physical risks are those usually attendant upon pregnancy, which may involve various complications and may even have a long-term effect on a woman's health. While there have been no studies of psychological risks associated with the transfer of the newborn infant, this possibility must be acknowledged. Because of these risks, it would be advisable to exclude from participation in surrogate motherhood arrangements women who are demonstrably unsuited to the role, either because they are patently maladjusted or unstable, or because they clearly do not appreciate the nature of surrogate motherhood.

For these reasons, we recommend that, on the hearing of the application for approval of a surrogate motherhood arrangement, the court should be required to assess the suitability of the prospective surrogate mother.

We turn now to consider first, whether there should be any limits on eligibility to become a surrogate mother and, secondly, the criteria for assessment of prospective surrogate mothers.

a. Eligibility to Act as a Surrogate Mother

It has been suggested that the opportunity to participate as a surrogate mother should be restricted to certain categories of women. It has been argued, for example, that such participation should be limited to women who already have given birth to children, because only they can truly appreciate the risks associated with pregnancy and the implications of surrendering a child upon birth. Alternatively, it has been said that women with children in their care should not be allowed to be surrogate mothers because these children may be traumatized upon surrender of the infant, fearing that they too will be given away. In addition, some commentators have suggested that married women are to be preferred, in the expectation that their husbands will be bulwarks of emotional support; others have taken an opposite view, in the belief that husbands will be potential sources of conflict.

We consider that there is no theoretical or empirical basis upon which to adopt a categorical approach to the eligibility of women to serve as surrogate mothers. This conclusion is, however, subject to a single exception. Under no circumstances whatsoever do we believe that a minor should be permitted to participate in a surrogate motherhood arrangement as a surrogate mother.

Earlier, we recommended that legal minors should be prohibited from acting as ovum donors because of the surgical risks involved and concerns about the

genuineness of their consent.[347] In addition, in the case of *in vivo* fertilization and lavage, we were concerned that the ovum donor might become pregnant through the failure of the lavage technique. Similar concerns animate our rejection of minors becoming surrogate mothers. While this view may appear harsh in circumstances where, for example, a mature seventeen year old wishes to assist a close relative, we believe strongly that minors should not be exposed to the risks attendant upon surrogate motherhood.

It should be noted that, in order to prevent minors from applying for approval as surrogate mothers, it will be necessary to enact specific legislation. Pursuant to the regulations made under the *Public Hospitals Act*,[348] persons aged sixteen or over are legally competent to give autonomous consent to medical care;[349] accordingly, a minor could present herself for an artificial conception procedure.

Accordingly, we recommend that there should be no restriction on the eligibility of women to serve as surrogate mothers, so long as they have reached the age of majority at the date of the application for court approval of their participation in a surrogate motherhood arrangement.[350]

b. Assessment of Prospective Surrogate Mothers

Not surprisingly, there is virtually no scholarly writing about the qualities that are desirable in a surrogate mother. Reflecting the lack of experience with this phenomenon, empirical study of applicants and their motivations remains in a nascent stage of development.[351] Notwithstanding the absence of scientific guidance, we have confidence that this assessment can be left to the court, with its attention being directed to certain factors that, in our view, deserve special consideration.

We believe that the court should assess the physical and mental health of the prospective surrogate mother. It is envisaged that evidence respecting her condition, consisting, for example, of reports by doctors, psychologists, or other professionals, will be submitted by counsel for the prospective parents or by her own counsel.[352] Should the information appear incomplete, the court simply

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347 See *supra*, this ch., sec. 3(c)(ii).

348 *Supra*, note 165.

349 R.R.O. 1980, Reg. 865, ss. 50 and 51.

350 Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, dissents from the recommendation in favour of regulating surrogate motherhood arrangements: see Vice Chairman's Dissent, at page 287 of this Report. However, if such a procedure were adopted, Dr. Leal would require that surrogate mothers be married women or widows who have reached the age of majority and have had a child.

351 See Parker, "Motivation of Surrogate Mothers: Initial Findings" (1983), 140 Am. J. Psychiatry 170.

352 See *infra*, this ch., sec. 5(e)(iii)b.

could withhold approval of the agreement until further satisfactory evidence is adduced.

Apart from considering the physical and mental state of the woman, the court should consider other matters, which may appear less obviously relevant. We believe that, where prospective surrogate mothers have partners in marital or nonmarital unions, the disposition of these partners to their participation in surrogate motherhood arrangements should be a factor to consider.[353] Where a partner is opposed to her participation, this may augur badly for the woman's state of mind during the pregnancy. This, in turn, may be harmful to the fetus and deleterious to the stability of the surrogate mother's family.

A further factor that should be considered is the effect of the arrangement on the children of the surrogate mother. If there are indications that they might be psychologically harmed by her participation and, in particular, by the planned transfer of custody, a court should not approve her involvement. It would be unconscionable to sacrifice knowingly the emotional stability of an otherwise secure child in the interests of creating another child.

We therefore recommend that, in assessing the suitability of a prospective surrogate mother, the court should consider, among other factors, her physical and mental health, her marital and domestic circumstances, the opinion of her spouse or partner, if any, and the likely effects of her participation in a surrogate motherhood arrangement upon existing children under her care.

(iii) The Court

For reasons discussed earlier,[354] we believe that the court should have the crucial responsibility for assessing the suitability of participants in a surrogate motherhood arrangement. While the role that we have assigned to the court may appear roughly similar to that of the court in the context of adoption, in fact the responsibility would differ substantially. In adoption, whether by a stranger or by a step-parent or close relative, the court gives legal finality to the relationship between the child and his or her new family *after* the child has been placed in the home. Moreover, even in the case of a stranger adoption, the court does not engage in detailed prior scrutiny of the prospective parent; that task is undertaken by social workers acting under the auspices of a children's aid society, a private adoption agency, or a licensed individual. Under our proposed scheme, by contrast, the court is to make the critical assessment before any action is taken lawfully to alter the *status quo*.

Notwithstanding this difference, we envisage that the general configuration of the hearing will be similar to adoption, in the sense that the proceedings will be non-adversarial in character. We anticipate that the parties represented will be the prospective social parents, the prospective surrogate mother and, as we shall

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353 See Parker, *supra*, note 351, and Parker, "Surrogate Motherhood: The Interaction of Litigation, Legislation and Psychiatry" (1982), 5 Int'l J. L. & Psychiatry 341.

354 See *supra*, this ch., sec. 5(d).

explain shortly,[355] possibly a children's aid society. At the hearing, the interests of the surrogate mother will be coincidental with those of the prospective parents. Thus, in the absence of countervailing submissions and evidence, the court generally will be asked to approve an application that is unchallenged.

In this section, we shall discuss certain issues relating to the substantive task that we recommend should be assigned to the courts and to the conduct of the hearing in which that responsibility will be discharged.

a. Standard of Proof for the Approval of Agreements

In earlier sections, we discussed the substantive tests that should be used in deciding whether to approve the participation of the parties to a surrogate motherhood arrangement.[356] A question arises whether, in light of the protective policy underlying the establishment of our regulatory scheme, the standard of proof otherwise applicable to civil proceedings is appropriate.

In civil proceedings, the balance of probabilities standard prevails. In other words, in order to succeed a party must persuade the court that his version of the facts or his argument is more likely than not supported by the evidence. This standard is to be contrasted with the stricter criminal burden of proof, which requires the establishment of facts beyond a reasonable doubt.

In the course of our deliberations, we considered the argument that a standard higher than the usual civil standard is warranted in these proceedings in view of their non-adversarial character. According to this argument, a heavier burden of persuasion should be cast on the applicants in order to compensate for the fact that their position is not going to be tested by a party opposed in interest.[357]

We are not persuaded, however, that a different standard of proof should apply in this context. We observe that family law matters in Ontario are subject to the traditional balance of probabilities standard. Moreover, this standard governs proceedings that are non-adversarial, including those where the welfare of a child is at stake. For example, in adoption proceedings, which are usually uncontested, the applicant is not required to satisfy a higher burden of proof. Hence, the special regard for the interests of children, which so pervades family law in Ontario, has not led to the modification of the ordinary standard of proof.

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355 See *infra*, this ch., sec. 5(e)(iii)d.

356 See *supra*, this ch., secs. 5(e)(i) and (ii).

357 A standard somewhat less strict than the criminal standard, but nevertheless demanding, has been approved by the United States Supreme Court in domestic proceedings. This standard is directed to protecting children from risk, but also respects the reasonable expectations of the parents not to be denied custody of their children. It requires that proof be established on a standard of clear and convincing evidence: see *Santosky v. Kramer,* 455 U.S. 745 (1982). In this case, the standard had to be satisfied by the evidence of the party seeking to have a child removed from parental custody.

Against this background, we believe that it is neither necessary nor advisable for the Commission to make a recommendation respecting the standard of proof that should apply on the hearing of applications to approve surrogate motherhood arrangements. This issue should be left to the courts charged with the responsibility of determining the application. Presumably, this would mean reliance on the ordinary civil burden of proof unless, and until, it is decided that it is inappropriate.

b. The Prospective Surrogate Mother as a Co-Applicant

We have already discussed the importance of approving the participation of the prospective surrogate mother and the test for assessing her suitability.[358] Ancillary procedural issues relate to whether the surrogate mother should be a co-applicant in the proceeding, along with the prospective parents, and whether she should be required to attend the proceedings.

With respect to the first issue, the status of a surrogate mother as a co-applicant is necessary if the court order is to be binding on her. With respect to the second issue, the attendance of the prospective surrogate mother at the hearing would appear desirable as a matter of principle. It would allow the court better to consider her suitability and to ascertain her understanding of her contractual commitment. In particular, the court could attempt to determine whether she has received independent legal advice and counselling by professionals unconnected to the prospective social parents.

Requiring the attendance of the prospective surrogate mother at the hearing of the application, however, might involve her meeting the prospective social parents. Where both parties prefer that they should be unknown to each other, such a requirement would defeat their intentions. We see no reason to recommend a measure that might frustrate the legitimate wishes of the parties.

From our survey of the relevant literature, it is apparent that persons in the United States involved in these agreements choose various arrangements, depending on their individual and mutual preferences. While some agreements may involve disclosure of identity and personal meetings between the parties, others are negotiated and implemented in circumstances of mutual anonymity.

Based on the available literature, there is at present no basis for proposing normative guidelines concerning the nature of the relationship of the parties to a surrogate motherhood arrangement. We prefer to remain silent on this matter, allowing the parties and their lawyers to make their own determinations of what best suits their needs. Thus, while we are of the view that prospective surrogate mothers should be co-applicants in the proceedings, we do not wish to compel their attendance at the hearing as a rule. Should the court wish to receive testimony from the surrogate mother or to observe her in person, it could request her attendance and provide that the prospective social parents be absent.

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358 See *supra*, this ch, sec. 5(e)(ii).

We do wish, however, to emphasize the necessity of the prospective surrogate mother receiving separate legal representation at the hearing. Separate representation will accord a measure of protection to the surrogate mother and lessen the danger of exploitation, which justifiably has concerned those critical of unregulated surrogate motherhood arrangements.

Accordingly, we recommend that the surrogate mother should be a co-applicant in the proceedings, but that she should not be required to be in attendance at the hearing of the application in every case. We recommend also that the surrogate mother should receive separate legal representation.

c. Blood, Tissue and Other Testing of Parentage

Upon the birth of a child following judicial approval of a surrogate motherhood agreement, a question may be raised concerning whether the child is in fact the product of that arrangement. The biological paternity of the child may be contested by a prospective social father if the child is found to be affected by a genetic defect, or if his wife wants assurance that it is his child whom she is to be legally responsible for rearing. Similarly, a surrogate mother, perhaps seeking to resist surrender of the child, may deny the paternity of the prospective social father.

This issue would appear to be of special concern where a prospective surrogate mother is cohabiting with a husband or male partner. In such a case, the prospective parents will want assurance that the child has developed from the sperm of the social father or, where donated semen is used, from the sperm of the carefully selected, screened, and matched donor, and not from that of the surrogate mother's husband or partner. Accordingly, the surrogate mother will usually be asked to give undertakings that sexual relations will be avoided at the time of insemination, in order to ensure that the sperm then used will account for any pregnancy that ensues.

The issue could also arise, although much less frequently of course, in the context of a maternity dispute, where, for example, a donated ovum is used. Indeed, the ovum might be donated by the prospective social mother.

Disputes respecting the parentage of a child, which will be accompanied inevitably by disagreements over custody, obviously are detrimental to all concerned, especially the child, whose parentage and future will be cast in doubt.

Scientific means are available to avoid unnecessary disputes about parentage. Blood tests, tissue tests and similar methods of genetic diagnosis may establish the child's biological parents with reliable accuracy.[359] Acquisition of

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[359] For a discussion of the efficacy of Human Leucocyte Antigen (H.L.A.) blood tissue testing, see Shaw and Kass, "Illegitimacy, Child Support and Paternity Testing" (1975), 13 Houston L. Rev. 41, and Lee, "Current Status of Paternity Testing" (1975), 9 Family L.Q. 615.

blood or tissues for such a diagnosis from the surrogate mother and the prospective social parents should cause no special problem, since the physicians involved would be expected to establish their respective blood groups and similar characteristics. Where anonymous donor gametes are used, the gametes may be required to carry documented information of the donor's blood group and similar biological status. Conscientious screening of donors should make the data readily available.

A disadvantage of testing is that it may require a newborn child to suffer blood-drawing or a biopsy. The risk and discomfort of these procedures are normally considered acceptable.[360] Moreover, it should be emphasized that the *Children's Law Reform Act*[361] permits blood testing of infants.

We believe that the available technology should be used to avoid, or at least reduce, unnecessary uncertainty respecting the parentage of a child, and to limit the opportunity of a surrogate mother to refuse to surrender the child on the ground that it is not the child of the approved arrangement. As the testing of children and adults to determine parentage after birth is permitted now under the *Children's Law Reform Act,* there is no need for specific legislation to address this matter. In order to require that the blood groups and other relevant biological characteristics of the adults involved — the surrogate mother, her husband or male partner, if any, and the persons who produced the gametes involved — are reliably and accessibly recorded prior to birth, legislation would have to be enacted.[362]

We believe that the responsibility for ensuring that this information is compiled should rest with the court as part of its supervisory function. Accordingly, we recommend that, in order to minimize uncertainty concerning a child's parentage upon birth, prior to the approval of a surrogate motherhood arrangement the court should require to be placed before it information relating to blood type and other relevant biological characteristics of the surrogate mother, her husband or partner, if any, and the persons who produced the gametes involved.

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360 See *S. v. McC; W. v. W.*, [1972] A.C. 24 (H.L.).

361 *Supra*, note 122, s. 10.

362 Section 10(1) of the *Children's Law Reform Act, supra*, note 122, provides that, "[u]pon the application of a party in a civil proceeding in which the court is called upon to determine the parentage of a child, the court may give the party leave to obtain blood tests of such persons as are named in the order granting leave and to submit the results in evidence". This provision would allow blood testing to determine parentage only after the birth of a child. Our concern is to ensure that information pertaining to parentage is available prior to the birth of a child pursuant to a surrogate motherhood arrangement in order to avoid a parentage dispute or, where a dispute nonetheless occurs, to expedite its resolution.

d. Participation of the Children's Aid Society

While we have recommended that the important responsibility for vetting prospective parties be assigned to the court, we believe that children's aid societies may play a useful role in the process. We have indicated already that the hearing of the application will be non-adversarial in nature, since the interests of the prospective parents and the surrogate mother will coincide. Neither party will have an interest in adducing evidence tending to demonstrate the unsuitability of the other. We believe, therefore, that there is good reason to provide for the involvement of a reliable source of information independent of the parties, whose participation can avoid the approval of the patently unsuitable.

In our view, children's aid societies are well suited to undertake this responsibility. We should emphasize, however, that we do not favour involvement similar to that in the context of stranger adoption, where a homestudy of the prospective parents is required in every case. Rather, we believe that children's aid societies should have standing to intervene in the proceedings only where their records disclose information demonstrating the unsuitability of either the surrogate mother or the prospective parents for participation in the proposed arrangement. Where the information available does not disclose any reason to be concerned about the parties, participation in the proceedings would not be necessary.

We realize that the introduction of this additional precaution may cause some discomfort to the parties, whose confidentiality will be compromised through the unavoidable disclosure of their identities to a children's aid society.[363] One response to concerns about the disclosure of parties' planned participation in a surrogate motherhood arrangement is that the staff of children's aid societies do observe proper confidentiality. In our view, however, the decisive consideration is that the applicants are seeking judicial approval of an arrangement that will culminate in the birth of a child, whose best interests are the overriding factor. To that factor, all others are subordinate, including concerns about possible embarrassment or vulnerability attendant upon revelation of admittedly sensitive information.

Accordingly, we recommend that notice of an application to the court for approval of a surrogate motherhood arrangement should be served upon the appropriate children's aid society, and that the society should have standing to attend at the hearing of the application. However, a children's aid society should intervene only where its records disclose information demonstrating the unsuitability of either the surrogate mother or the prospective social parents for participation in the surrogate motherhood arrangement.

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363 Where, for example, a party is a member of the Roman Catholic community of Toronto, Hamilton or Windsor, the local Catholic Children's Aid Society will become involved. In view of the position of the Roman Catholic Church in relation to the artificial conception technologies and surrogate motherhood, this discomfort may be significant.

e. Confidentiality of the Proceedings and the Court Record

In the previous section, we alluded briefly to our expectation that the participants in a surrogate motherhood arrangement would wish to preserve confidentiality. The reasons for respecting the privacy of the parties and the unborn child should be so patent as not to warrant explanation. Suffice it to say simply that the sensitivity and intimacy that we associate with human reproduction is accentuated significantly in the circumstances of artificial conception.

We observe that, in the context of adoption, the relevant legislation provides for certain measures that are intended to protect the privacy of all persons affected by the order for adoption. The *Child Welfare Act* requires that an application for adoption be heard and determined *in camera.*[364] Further, it provides that the documents used in the application for an adoption order must be sealed and filed in the offices of the court and cannot be opened for inspection, except upon an order of the court or the written direction of the Director of Child Welfare.[365] The regulations also require that the court records be maintained in a manner designed to ensure anonymity.[366]

While somewhat less rigorous standards of confidentiality apply to other sensitive proceedings under the *Child Welfare Act,*[367] we believe that the adoption

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364 *Child Welfare Act, supra*, note 41, s. 71(2). See, also, the *Child and Family Services Act, 1984, supra,* note 41, s. 145(1).

365 *Child Welfare Act, supra,* note 41, s. 80. The rule respecting the secrecy of these documents is subject to an exception where information is disclosed through the operation of the voluntary disclosure registry: see *Child Welfare Act, supra,* note 41, s. 81. The information, however, may be provided only to an adopted child eighteen or older or to a person who was a parent of the child at the time of the child's birth. Of course, the secrecy of the court records in relation to the world at large would remain unaffected. See the *Child and Family Services Act, 1984, supra*, note 41, ss. 145(2) and 157. Section 145(2) provides that, subject to exceptions in favour of the court and its authorized employees, the parties to an application for an adoption order and their solicitors and agents, and a Director and a local director, "[n]o person shall have access to the court file concerning an application for an adoption order". Section 157(1) provides for the confidentiality of information relating to an adoption kept by the Ministry of Community and Social Services, by a children's aid society or licensee, or in the voluntary disclosure register. Certain exceptions permit inspection or disclosure of information: *ibid.*, s. 157(2).

366 Rule 61 of the Rules of the Provincial Court (Family Division), R.R.O. 1980, Reg. 810, provides that, in adoption proceedings, the child may be identified in any document by his given names in full followed by the first letter of his surname and his birth registration number, and the applicant may be identified in any document, other than the adoption order, by the first letter of his surname.

367 Proceedings for the care and protection of children, which are held under Part II of the *Child Welfare Act,* are to be held *in camera,* unless the judicial officer holding the hearing, having regard to the wishes and interests of the parties and whether the presence of others would be injurious to the emotional health of any child present at the hearing, directs otherwise. While the judicial officer has power to allow representatives of the press, radio or television media to attend the hearing, it is forbidden to publish or make public any information that has the effect of identifying the affected parties: see *Child*

analogy is the appropriate one in dealing with this issue. However, not all aspects of the legislation providing for confidentiality in adoption are transferable to this context. For example, since the Director of Child Welfare is not involved in the proposed scheme, he or she should have no power to direct the opening of a court file. Access to court files should be determined by the court alone. Also irrelevant are the regulations providing that the surname of the child is not to be recorded on documents, as the child does not exist at the time of the hearing. These differences are minor in character.

Accordingly, we recommend that the anonymity of the prospective social parents and surrogate mother and the confidentiality of court records pertaining to the surrogate motherhood proceedings should be preserved. In particular, we recommend that the application should be heard and determined *in camera,* the court records should be sealed, and access to the records should be granted only upon judicial approval for good reason.

(iv) Terms of the Agreement

In this section, we turn to discuss whether our legislative scheme should require that specific matters be addressed in every surrogate motherhood agreement. In the course of reviewing the literature, it soon became evident that certain difficult issues were seen as more important, and capable of having a substantial impact on the persons affected. This led to the question whether these issues should be determined by legislation or whether the court, in approving the agreement, should be required to ensure that they have been confronted and resolved satisfactorily by the parties. As will be apparent from the following discussion, we are of the view that certain issues are so important that they should be addressed by legislation, rather than being left to be resolved by the parties.

In the ensuing discussion, we shall consider four of the most contentious issues — the surrender of the child, the question of payment to the surrogate mother, the possibility of a handicapped child, and the possibility of an abortion by the surrogate mother. We then shall review briefly a list of certain issues that, we believe, the parties to a surrogate motherhood agreement should be required to consider and resolve.

a. Surrender of the Child

Perhaps the most difficult issue that we have addressed in designing an appropriate regulatory scheme is whether, upon birth of the child, the surrogate mother should be under a legal compulsion to surrender the child in accordance with her promise to do so under the surrogate motherhood agreement. In its most stark incarnation, this question reduces to whether, in the face of a refusal by the woman to transfer custody of the newborn infant, a court should be obliged to issue an order to surrender the infant, which could be enforced against her will by seizure of the child.

Welfare Act, supra, note 41, s. 57. See, also, the *Child and Family Services Act, 1984, supra*, note 41, s. 41.

Without elaborate discussion, it should be obvious that this is one of the most emotionally charged issues involved in surrogate motherhood. That a recalcitrant surrogate mother might be compelled through judicial process to surrender her newborn infant would seem to strike at the very heart of our shared values. For some, this possibility confirms the "unnaturalness" of this reproductive alternative.

We are acutely aware of the necessity of resolving this difficult and controversial issue if the parties to these arrangements, and through them the affected children, are to avoid uncertainty and conflict upon the birth of the child. In striving to arrive at the appropriate solution, we sought guidance in two distinct areas of the law.

First, we turned to contract law and, in particular, the law respecting specific performance. While we have yet to use this term in discussing the issue, the question can be cast in terms of whether the promise of the surrogate mother ought to be specifically enforceable. Although it may appear inappropriate to consider a problem respecting children by reference to contract law, it is useful to do so for analytical purposes.

Speaking generally, specific enforcement of a contract is a remedy available only where monetary compensation is inadequate.[368] For example, a strong argument can be made for specific performance if the contract concerns something that is unique, making it extremely difficult to assess the loss for which monetary compensation otherwise would be given. It also has been established that contracts for personal services are not specifically enforceable, in part because the courts cannot supervise the quality of the service to be rendered.

Applying these principles to a surrogate motherhood agreement, one might well argue that specific performance would be an appropriate remedy in the face of a refusal to surrender the child. Certainly the subject matter of the agreement is unique, and monetary compensation would not replace the loss to the social parents. And, while the entire surrogate motherhood agreement might be regarded as a contract for personal services, the enforcement of which would require judicial supervision — particularly in relation to a promise by the surrogate mother to maintain her health during pregnancy — the promise to transfer the child involves a discrete act that would not necessitate supervision.

While contractual principles may be applied for purposes of analysis, it bears emphasizing that, under the present law, these principles clearly are regarded as inappropriate for resolving disputes concerning the future of children. In an analogous context, the *Family Law Reform Act*[369] provides that "[i]n the determination of any matter respecting the support, education, moral training or custody of or access to a child, the court may disregard any provision

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368 See, generally, Sharpe, *Injunctions and Specific Performance* (1983), and Waddams, *The Law of Contracts* (2d ed., 1984), at 507-27.

369 *Supra*, note 127, s. 55(1).

of a domestic contract pertaining thereto where, in the opinion of the court, to do so is in the best interests of the child". This provision expressly requires the court to consider a principle — the best interests of the child — that is separate from, and superior to, the intentions evinced in the agreement. In deferring to this principle, the court is undertaking an inquiry very different from that undertaken in dealing with a commercial transaction.

For example, in a custody dispute, where custody is awarded to the parent who has been given custody under a separation agreement, the court is not truly enforcing the agreement. The agreement, along with various other factors, may be relevant to the court's view of the best interests of the child, but the contractual resolution of custody in no way circumscribes judicial discretion respecting this matter.

The other relevant area of the law that we have considered concerns adoption. Under the *Child Welfare Act,*[370] an adoption order can be made only with the written consent of both parents or the persons having lawful custody and control of the child,[371] except where the court has dispensed with this requirement.[372] Consent, however, cannot be given until after the child is seven days old.[373] Furthermore, any person who has given his or her consent can withdraw it as of right within twenty-one days after it has been given.[374] These measures recognize the importance and potentially traumatic nature of the decision to consent to adoption, and appear intended to ensure that the consent is in fact genuine and continuing. This is most evident in the limitation respecting consent to the adoption of newborn infants, which seeks to protect women in the particularly emotionally vulnerable period shortly after childbirth.

These two areas of the law suggest the only alternative resolutions to the question of surrender. Either the regulatory scheme should provide that the surrogate mother must honour her promise and surrender the child after birth, irrespective of any attitudinal change on her part in the intervening period, or the surrogate mother should be given a right, in effect, to rescind the agreement unilaterally within a period after birth. In the first case, the risk of disappointment and trauma rests on the surrogate mother, while, in the second, it is placed on the social parents.

The crucial question, however, is not where the risk of disappointment should lie, but which resolution will serve the best interests of the child. Unfortunately, the available scientific literature would appear to indicate no clear

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370 *Supra*, note 41.

371 *Ibid.*, s. 69(2). See the *Child and Family Services Act, 1984, supra*, note 41, s. 131(2).

372 *Child Welfare Act, supra,* note 41, s. 69(7). See the *Child and Family Services Act, 1984, supra*, note 41, s. 132.

373 *Child Welfare Act, supra,* note 41, s. 69(2). See the *Child and Family Services Act, 1984, supra*, note 41, s. 131(3).

374 *Child Welfare Act, supra,* note 41, s. 69(2). See the *Child and Family Services Act, 1984, supra*, note 41, s. 131(8).

answer to this question. However, the Advisory Board that assisted the Commission, which included a child psychiatrist and a social worker, favoured requiring immediate surrender of the child to the approved social parents. It was thought that immediate surrender would serve to prevent bonding with the surrogate mother and to facilitate bonding with the person — the social mother — who, in the vast majority of cases, would be the ultimate recipient of the child and who, therefore, would be the primary influence in its life during the neonatal period and infancy.

We have been persuaded that, on balance, the legislation should provide for immediate surrender of the child. Hence, where a surrogate mother refuses to transfer custody, she could be compelled to do so by court order.

It may seem harsh and unfeeling to countenance a situation where, in the face of continuing recalcitrance, officers may be ordered to deliver the infant to the social parents. Yet physical seizure of a child may be effected under the present law in the context of a dispute over custody.[375] Further, there are judicial statements that infants may be taken from their mothers on birth by children's aid society workers where there has been a judicial finding that they are in need of protection.[376]

Accordingly, we recommend that a child born pursuant to an approved surrogate motherhood arrangement should be surrendered immediately upon birth to the social parents. Where a surrogate mother refuses to transfer the child, the court should order that the child be delivered to the social parents. In addition, where the court is satisfied that the surrogate mother intends to refuse to surrender the child upon birth, the court, prior to the birth of the child, should be empowered to make an order for transfer of custody upon birth.

Before leaving this issue, we wish to address a potential problem. In rare cases, in the intervening period between the judicial approval of the agreement and the birth of the child, circumstances may so change as to render undesirable the surrender of custody to the approved parents. While certain reasons why the

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375 Section 37(2) of the *Children's Law Reform Act*, *supra*, note 122, which deals with the enforcement of orders for custody and access, provides that, where a court is satisfied that there are reasonable and probable grounds for believing, *inter alia,* that any person is unlawfully withholding a child from a person entitled to custody of or access to the child, it may by order "direct the sheriff or a police force, or both ... to locate, apprehend and deliver the child to the person named in the order". Section 37(4) provides that, if such a direction is given, the "sheriff or police force ... shall do all things reasonably able to be done to locate, apprehend and deliver the child in accordance with the order". Section 37(5) provides further, that, for the purpose of locating and apprehending a child in accordance with an order under s. 37(2), "a sheriff or a member of a police force may enter and search any place where he has reasonable and probable grounds for believing that the child may be with such assistance and such force as are reasonable in the circumstances".

376 See *Re Children's Aid Society for the District of Kenora and J.L.* (1981), 134 D.L.R. (3d) 249 (Ont. Prov. Ct. (F.D.)) *(obiter dicta),* cited with approval in *Re Superintendent of Family and Child Service and McDonald* (1982), 37 B.C.L.R. 32, 135 D.L.R. (3d) 330 (S.C.).

social parents may become unsuitable to accept the child may be anticipated in the surrogate motherhood agreement, an event may occur that is beyond the reasonable expectations of the parties. Alternatively, information that was not available at the original hearing may come to light, indicating that the social parents are unsuitable. An extreme example might be the conviction of a social parent for commission of a serious offence, such as sexual assault of a child.

While the local children's aid society may intervene upon receiving credible evidence that the child would be in need of protection if delivered to the approved parents, we do not believe that the basis for preventing transfer should be restricted to the circumstances set out in the *Child Welfare Act*. In our view, it would be preferable to allow the surrogate mother, who presumably will have an interest in the welfare of the child, to apply to the court for a review of the approval of the arrangement, where circumstances indicate that the social parents are unsuitable to receive the child. In addition, where, subsequent to the approval of the surrogate motherhood arrangement, the children's aid society receives information indicating that the social parents are unsuitable, the children's aid society should be entitled to apply to the court for a review of the arrangement. On the hearing of the application, the court should be able to rescind the agreement even where the child would not be "a child in need of protection" within the meaning of the *Child Welfare Act*.[377] The custody of the child might be sought by the surrogate mother or by the local children's aid society.

Such a scheme would ensure that the welfare of the child is not sacrificed in the interests of certainty in the rare case where it becomes apparent that the social parents should not receive the child. Whatever dislocation necessarily is entailed in this position is preferable to placing the child at risk.

Accordingly, we recommend that, where there has been a change in circumstances, or where new information has become available, indicating that the approved social parents are unsuitable to receive the child, the surrogate mother or the children's aid society should be permitted to apply, at any time prior to the birth of the child, for a review of the approval of the surrogate motherhood arrangement. The judge should be empowered to rescind the agreement.

b. Payment to the Surrogate Mother

Among the most contentious issues that have arisen in connection with surrogate motherhood is that of payment to the surrogate mother by the persons to whom she will transfer custody of the child. As we have indicated,[378] the matter of payments has been the focus of much of the criticism of surrogate motherhood arrangements. Indeed, most arguments concerning the ethical impropriety of these arrangements are premised on the commercialization of the practice through the payment of a fee to the surrogate mother. Concerns have been

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377 *Supra*, note 41, s. 19(1)(b). The definition of "child in need of protection" has been revised in the new *Child and Family Services Act, 1984, supra*, note 41, s. 37(2).

378 See *supra*, this ch., sec. 5(b).

expressed about the possibility of exploitation of disadvantaged women by the more affluent, and the dehumanization and debasement of both the surrogate mother and the child attendant upon payment for gestation and relinquishment of custody.[379]

In the course of our deliberations, we have considered four categories of payment. The first relates to the payment of a fee in the way of profit to the surrogate mother for her participation in the arrangement. Whether this fee is characterized as payment for a child, or merely as payment for services,[380] it is this controversial payment that raises the spectre of "baby-buying" and exploitation.

A second category of payment relates to the expenses incurred by the surrogate mother in the course of the arrangement. Our recommendation that the surrogate mother retain independent counsel necessarily will involve legal costs. In addition, a variety of medical and other expenses will be incurred. These will relate, for example, to medical screening and to the production of psychiatric, psychological, and social worker reports for submission to the court in relation to the assessment of the surrogate mother's suitability. Further costs will be incurred during pregnancy, relating to continuing medical supervision and maintenance of a sound diet. Finally, costs will be incurred in delivery and postnatal care, including counselling services for the mother. While the Ontario Health Insurance Plan may be expected to meet many of these costs, not all payments for services agreed between the mother and the social parents may be reimbursed by the Plan, and not all services may be conveniently available through medical practitioners who practice under the Plan or whose bills are limited to Plan fee schedules.

A third category of payment that has been suggested is payment for lost income and lost earning opportunities during the course of the pregnancy and the postpartum recuperative period. A fourth type of payment relates to compensation for pain and suffering, including, perhaps, postpartum grief for loss of the child.

All members of the Commission agree that no payment should be made in relation to a surrogate motherhood arrangement without the approval of the court. However, we are divided on which items of payment should be permitted by the legislation and the degree of discretion to be given the court.

One view is that the issue of payment should be left entirely to the court, without any legislative guidance as to which payments are to be permissible. A second view is that the court should be given a general power to approve payments, and should be expressly instructed that this power may extend, but is not limited, to payments for medical and similar costs, related out-of-pocket expenses, and lost income or earning opportunities. A third view is that the

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379 See discussion, *supra*, this ch., sec. 5(c).

380 See, for example, Note, "Surrogate Mothers: The Legal Issues" (1981), 7 Am. J. L. & Med. 323, at 331, and Keane, "Legal Problems of Surrogate Motherhood", [1980] S. Ill. U.L.J. 147, at 157-58.

power of the court to approve payment should be confined to specified items only; however, there is a division respecting the items for which payment may be made. One Commissioner favours allowing the court to approve payments for medical and similar costs, related out-of-pocket expenses, and lost income or earning opportunities; the other[381] would restrict the list of items to medical and similar costs and related out-of-pocket expenses.

Notwithstanding this divergence of views, it bears emphasizing that we are in agreement respecting the fundamental principle that all payments relating to a surrogate motherhood agreement must receive the prior approval of the court. We believe that mandatory judicial control over payments is an effective answer to the concerns that have been voiced in connection with payment of the surrogate mother. In particular, we are of the view that this prophylactic measure will reveal any financial exploitation of a surrogate mother by the prospective social parents. Accordingly, we recommend that legislation should provide that no payment may be made in relation to a surrogate motherhood arrangement without the prior approval of the court.

c. Birth of a Handicapped Child

In the discussion about surrogate motherhood, as reflected in the literature and certain written submissions made to this Commission, concern has been expressed about the possibility that a handicapped child will be born for whom neither the surrogate mother nor the social parents wish to assume responsibility. This concern, however, appears to have little basis as a matter of law. In Ontario, parents of an infant are legally responsible for its welfare, irrespective of their particular preferences. Should the parents decline to fulfil their responsibilities to the peril of the child, the children's aid society will intercede, and the parents will be required to discharge their duty to provide financial support.

Under our proposals, legislation will provide that, upon the birth of a child pursuant to an approved surrogate motherhood arrangement, the social parents will be the parents of the child for all legal purposes.[382] Accordingly, the social parents will be responsible for the child, whatever its condition. While the legislation will assure certainty of parentage for a handicapped child, however, it will no more guarantee that parental responsibility will be assumed willingly than does the present law for handicapped children whose conception is natural. If the social parents do not wish to accept custody of the child, they cannot be compelled to do so as a matter of law or as a practical matter, and the children's aid society will undoubtedly intervene.

No special provision, then, need be incorporated in surrogate motherhood

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381 Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, dissents from the recommendation in favour of regulating surrogate motherhood arrangements: see Vice Chairman's Dissent, at page 287 of this Report. However, if such a procedure were adopted, Dr. Leal would require that no payments be made to a surrogate mother without the prior approval of the court, and would limit the items for which payment may be made to medical and similar costs and related out-of-pocket expenses.

382 See *infra*, this ch., sec. 5(e)(v), where the status of the child is discussed.

agreements to address the ultimate legal responsibility in the event of the birth of a handicapped child. It follows from our resolution of the issue of parentage.

A related issue, however, would appear to warrant attention in a surrogate motherhood agreement. As a practical matter, it would appear advisable that the parties be required to resolve how a handicapped newborn is to be medically managed. Since circumstances may arise suddenly, demanding immediate resolution, provision should be made for the allocation of the power of decision. A decision concerning who is to bear responsibility is of particular significance in the case of the birth of a seriously impaired child whose surgical or other medical care may require parental consent, as neither the surrogate mother nor the intended social parents may have a commitment to the child's survival.

Under the present law, parents are bound to provide their children with the necessaries of life[383] and with medically advised treatment,[384] so that a refusal to consent to ordinary medical care is controlled.[385] Refusal of ordinary care will justify involvement of the local children's aid society, which may consider bringing protection proceedings in order to achieve such supervision of the child as will result in consent being given to his or her care. Moreover, the child's medical attendants may have the authority to take life prolonging rescue measures on behalf of the child without the consent of the parent.[386]

Where aggressive or extraordinary care is in issue, however, parents are under no legal duty to consent to treatment, but have a discretion to do so; such care may be declined in favour of conservative or palliative care, which may not have the effect of preventing death. While that decision — in effect to allow the child to die — is lawful *per se*, it may be offensive where it seems to be based upon the parents' preferences for themselves, rather than upon a perception of the interests of the child. Circumstances may exist in which refusal of extraordinary care may be legally proper,[387] but the refusal appears more acceptable when coming from a person or agency unaffected by any possible conflict of interest.

The birth of a handicapped child in the context of a surrogate motherhood arrangement would be governed by the abovementioned principles. Hence, with respect to ordinary care necessary to preserve the life of the child, there would appear to be no problem: in the face of a parental refusal or inability to consent, the children's aid society might be notified or the attending physicians might take the requisite measures. Nonetheless, it would be helpful if the parties were to stipulate in their agreement who is to have the power to give consent if the social parents are unavailable.

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383 *Criminal Code, supra*, note 187, s. 197(1)(a).

384 *Child Welfare Act, supra*, note 41, s. 19(1)(b)(ix). See the *Child and Family Services Act, 1984, supra*, note 41, s. 37(2)(e).

385 See Dickens, "The Right to Natural Death" (1981), 26 McGill L.J. 847.

386 *Ibid.*, at 856-62.

387 See *Re Superintendent of Family and Child Service and Dawson et al.* (1983), 145 D.L.R. (3d) 610 (B.C.S.C.). For commentary, see Dickens, "Medicine and the Law — Withholding Paediatric Medical Care" (1984), 62 Can. Bar Rev. 196.

More difficult is the question of extraordinary care. If parental consent to such treatment is not forthcoming, the infant will die. While the present law does permit such a result, we believe that, in this context, it should not be allowed to occur by default, for instance, through the inability to notify the social parents. In our view, the parties should be required to address this possibility and arrive at a resolution in their agreement. For example, the agreement might stipulate that, if extraordinary care offers the only hope to save the life of the newborn infant, the power of decision should be delegated to the surrogate mother or to the attending physician. Alternatively, it might be provided that extraordinary care, if available, should be declined, with the power to refuse such care delegated to the surrogate mother.

We realize that the issues associated with the medical care of handicapped infants are profound and extend far beyond the bounds of this Reference. We believe, however, that the conditions of parental choice that prevail under the present law should apply also in this context. Accordingly, we recommend the court should be required to ensure that a surrogate motherhood agreement contains adequate provision dealing with the allocation of the power of decision relating to the medical care of a newborn handicapped child and with the nature of that decision.

d. Abortion and the Surrogate Mother

In the debate about the propriety of surrogate motherhood, some concern has been expressed about the possible impact of allowing these arrangements on the incidence and availability of abortion. This question has been raised by both those who oppose abortion and those who wish to preserve the availability of abortion. The former have argued that surrogate motherhood arrangements may lead to abortions if the results of prenatal testing disappoint the prospective social parents by, for example, revealing a birth defect. The latter have indicated a concern that the involvement of the surrogate mother in the agreement not limit the rights that she has under the law to seek an abortion, irrespective of the wishes of the social parents.

Although virtually all the discussion has concerned induced abortion, this emphasis disregards the possibility that a surrogate mother may suffer a spontaneous abortion during the pregnancy.[388] By definition, spontaneous abortion does not raise the contentious moral and legal issues that are associated with induced abortion. Accordingly, we see no reason to make a substantive recommendation in relation to it. We anticipate that the possibility of its occurrence would be addressed in the surrogate motherhood agreement, which might provide for the reimbursement of any expenses advanced in anticipation of a birth.

The question of induced abortion is more relevant in the United States, where the United States Supreme Court has held that a woman has an absolute right to abortion in the first trimester of pregnancy.[389] In view of the present

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388 For a brief discussion of the incidence of spontaneous abortion, see *supra*, ch. 2, note 4.

389 See *Roe v. Wade*, 410 U.S. 113 (1973).

Canadian law respecting the availability of abortion, we need only canvass this undeniably difficult issue in a very cursory manner.

Under the present law, induced abortion is lawful in Canada only where continuation of the pregnancy would or would be likely to endanger the pregnant woman's life or health.[390] It is envisaged that the terms of the agreement would address the possibility that conditions may arise that justify an abortion in accordance with the *Criminal Code.*

However, leaving the matter to be addressed in the agreement only resolves in part the legal issues arising in connection with induced abortion in this context. Where a surrogate mother plans to seek a therapeutic abortion, the prospective social parents may prefer that she honour her promise to bear and deliver a child. A question therefore arises concerning whether, notwithstanding that the child to be born may have no genetic relation to either of the social parents,[391] they should be able to challenge the surrogate mother's decision before the therapeutic abortion committee or before a court, on the ground that no danger exists to her life or health. Needless to say, there is no jurisprudence bearing precisely on this question. However, while it has been held that a husband has no right to preclude a lawful abortion planned by his wife,[392] his standing to challenge the legality of the abortion has been recognized.[393] How these principles would be applied by the courts in this context remains to be seen.

Difficulties might arise also if an abortion were to be sought outside Canada. For example, in their agreement, the parties might contemplate recourse to abortion in another country, and it would be the responsibility of the court to determine whether such a term should be approved. In the absence of prior agreement concerning this matter, the social parents might seek a remedy against the surrogate mother if an abortion were sought outside Canada on grounds other than those stipulated in the *Criminal Code.*

We are of the view that it is inappropriate to make a proposal respecting the possibility of abortion. There is a body of developing jurisprudence concerning the right of a woman to pursue an abortion lawfully and the exercise of that right in relation to the assertion of other claimed rights, and we prefer to leave the issue to be resolved within that larger context.

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390 *Criminal Code*, *supra*, note 187, s. 251(4)(c).

391 If, for example, the surrogate mother were artificially inseminated by donor semen, this would be the case.

392 See *Whalley v. Whalley* (1981), 122 D.L.R. (3d) 717 (B.C.S.C.), and *Paton v. Trustees of BPAS and Another*, [1979] Q.B. 276, [1978] 2 All E.R. 987.

393 See *Medhurst v. Medhurst* (1984), 46 O.R. (2d) 263, 9 D.L.R. (4th) 252 (H.C.J.), *per* Reid J., jud. rev. denied, *Re Medhurst and Medhurst* (1984), 45 O.R. (2d) 575, 7 D.L.R. (4th) 335 (H.C.J.).

e. Residual Terms of Surrogate Motherhood Agreements

The regulatory scheme that we have proposed requires the court not only to approve the participation of the prospective parties, but also to approve the specific terms of their agreement. It will be the responsibility of the court to ensure that the agreement adequately protects the child and the parties and does not include any inequitable or unconscionable terms that would offend against the public interest.[394]

In previous sections, we discussed whether, and how, the approved surrogate motherhood agreement should address certain very controversial matters. In this section, we shall enumerate a number of important issues that we believe should be addressed by the parties in settling the terms of such an agreement.[395] The parties will be required to direct their minds to these questions and to resolve them. While they may include in the agreement terms to deal with one or more of these issues, they may conclude that it is unnecessary to do so. Whatever their decision, it will be subject to the approval of the court, which must be satisfied that the agreement is fair and equitable to all concerned.

Accordingly, we recommend that, while the parties to a surrogate motherhood agreement should be free to introduce terms of their choosing, they should be required to consider, and agree upon a resolution of, the following issues:

1. health and life insurance protection for the prospective surrogate mother;
2. arrangements for the child should the intended social father or mother, or both, die before the birth of the child;
3. arrangements for the child should the intended social parents cease to live together as a couple;
4. circumstances regarding the particular manner in which immediate surrender of the child to the social parents is to be effected;
5. the right, if any, of the surrogate mother to obtain information respecting, or to have contact with, the child after surrender;
6. prenatal restrictions upon the surrogate mother's activities before and after conception, including dietary obligations;
7. conditions under which prenatal screening of the child may be justified or required, for example, by ultrasound, fetoscopy, or amniocentesis.

In requiring parties to address these issues, we would not require that they reach particular conclusions, provided that the court is satisfied that the ultimate resolution of each issue is in the interests of the child and is otherwise fair and equitable. Indeed, provided that the parties have considered a particular issue,

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394 See *supra*, this ch., sec. 5(d).

395 For an example of a surrogate motherhood agreement, see Brophy, "A Surrogate Mother Contract to Bear a Child" (1981-82), 20 J. Family L. 263.

they might not be required to include in the agreement a term relating to that issue. In the circumstances, the courts might find a failure to include such a term quite acceptable. Alternatively, the court might direct that a term resolving the specific issue be included in the agreement.

(v) Status and Inheritance Rights of the Child

Thus far, we have sought to protect the best interests of the child by making recommendations relating to the various actors whose participation is required under the proposed scheme. In this section, we shall make specific recommendations bearing directly on the child.

We have explained that, upon birth of the child, custody will be given to the approved social parents. In order that the child will rest securely in its new environment, its status and parentage should be established in law with certainty, as was the case with respect to children born as a result of artificial conception technologies.[396] We recommend that, upon the birth of a child pursuant to an approved surrogate motherhood arrangement, the social parents should be recognized as the parents of the child for all legal purposes and the surrogate mother should have no legal relationship to the child.

In a previous section, we proposed that a power should be conferred on the court, upon the application of the surrogate mother or the children's aid society prior to the birth of the child, to review the agreement and, if necessary, to rescind it.[397] Where the agreement has been rescinded, the social parents would not become the legal parents. However, a problem may arise where a child is born prematurely, after the application for review has been made, but before the court has determined the matter. In anticipation of such circumstances, we recommend that, where the court subsequently rescinds the agreement, it should be given the power to make an order providing that the social parents are not to be recognized in law as the parents.

Leaving aside this relatively arcane problem, we believe that two further recommendations should be made in order to ensure certainty of parentage. Similar proposals have been made earlier in this chapter in connection with the artificial conception technologies.[398]

First, we recommend that the birth of a child in consequence of an approved surrogate motherhood arrangement should be registered under the *Vital Statistics Act*[399] showing the social parents as the mother and father. The surrogate mother should not be named in the register of births; nor should the fact that the child has been born to a surrogate mother appear in the register.

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396 See *supra*, this ch., sec. 3(d)(i).

397 See *supra*, this ch., sec. 5(e)(iv)a.

398 See *supra*, this ch., secs. 3(d)(iii) and (iv).

399 *Supra*, note 123.

Secondly, we wish to address the question of the inheritance rights of the child. While our recommendation that the social parents of a child born pursuant to an approved agreement should be recognized for all legal purposes as the parents of the child should dispose of the matter of inheritance, in order to clarify this beyond peradventure we recommend that such children should acquire inheritance rights through the approved parents. We should add that, consistent with our recommendation respecting status and parentage, the child should have no inheritance rights against the estate of the surrogate mother simply by virtue of the biological relationship. However, this would not prevent the surrogate mother from making a specific bequest to the child in her will.

(vi) Agencies Arranging Surrogate Motherhood Agreements

In the United States, notwithstanding the unclear legal status of surrogate motherhood arrangements and the opposition of certain state Attorneys General, there has been a steady proliferation of private agencies offering to bring together prospective social parents and surrogate mothers. Based on this experience, we expect that, if our recommended scheme were implemented, similar liaison services would seek to be established in Ontario. While such services may come to be offered by hospitals or private infertility clinics as part of their treatment of infertility, we anticipate that individuals may attempt to set up agencies to be operated on a commercial basis.

Whether intermediaries should be permitted to function at all within the context of our regulatory scheme is an important question. More significant, however, is the issue whether private profit-oriented agencies should be tolerated. We have already indicated our concern that surrogate motherhood arrangements not be tainted by an offensive commercialism. In this regard, we have recommended that no payment should be made in relation to a surrogate motherhood arrangement without the prior approval of the court.[400] The unregulated operation of private agencies may serve to undermine the integrity of these proposals by introducing a dangerous commercialism through the back door.

An abiding concern about the dangers associated with the intervention of intermediaries is apparent in the regulation of adoption in Ontario under the *Child Welfare Act*. Apart from the local children's aid society, adoptions may be arranged lawfully only by private adoption agencies or by licensed individuals. Private adoption agencies are licensed organizations that are authorized generally to place children for adoption; at present, there are four in the Province. Licensed persons are individuals who receive a licence to place a particular child with a particular couple. These individuals do not have a general authority, similar to that of the private adoption agencies, to place children for adoption.

It must be emphasized that, notwithstanding the appearance of a degree of autonomy, private adoption agencies and licensed persons are subject to rigorous control by the Ministry of Community and Social Services. In the first instance,

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[400] See *supra*, this ch., sec. 5(e)(iv)b.

control is imposed through the requirement of licensing by the Director of Child Welfare. More directly, there is mandatory supervision of individual child placements. As we explained in chapter 4, the *Child Welfare Act* provides that no placement may be effected without the prior approval of the Director of Child Welfare after the completion of a homestudy of the prospective adoptive parents.[401] A further restriction, which is directed to preventing exploitation by the intermediaries, limits the amount that may be charged to an adoptive parent for expenses incurred or services provided in connection with the adoption to a maximum of $1,500. This amount may be increased only by the Director of Child Welfare.[402]

In recent years, as part of its comprehensive study of Ontario legislation affecting children, the Ministry of Community and Social Services has given considerable attention to private adoption.[403] This process has culminated in the new *Child and Family Services Act, 1984,* under which private adoption will continue to supplement public adoption in Ontario.

Against the background of the statutory framework regulating adoption, and in light of the present views of the Ministry of Community and Social Services, we suggest that there may be a place for private agencies to arrange surrogate motherhood agreements. We believe, however, that such agencies should be allowed to operate only under the supervision of the Ministry of Community and Social Services.

At this stage, we prefer to express our general views on this matter, rather than to articulate detailed proposals. Since the Ministry of Community and Social Services has broad experience in the related area of adoption, we believe that it should be given the responsibility of developing policy regulating surrogate motherhood agencies, modelled closely on its control of adoption agencies. We anticipate that regulation would deal with the credentials of operators of agencies, the calibre and number of their staff, advertisement and recruitment practices, services offered, and fees charged. An important further safeguard would exist, of course, in the requirement of court approval of the agreements prior to their implementation.

Accordingly, we recommend that the Ministry of Community and Social Services should be required to regulate any agencies that arrange surrogate motherhood agreements.

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401 See *supra*, ch. 4, sec. 3(b). With respect to the requirement of the approval of the Director and a homestudy where a licensee is involved under the new *Child and Family Services Act, 1984, supra*, note 41, see ss. 135 and 136.

402 R.R.O. 1980, Reg. 96, s. 44.

403 See Ontario, Ministry of Community and Social Services, *The Children's Act: A Consultation Paper* (1982), and Ontario, Ministry of Community and Social Services, *The Children and Family Services Act: Draft legislation and background paper* (1983).

(vii) Miscellaneous Issues

a. Failure of Flushing to Remove an In Vivo Fertilized Ovum

Earlier in this Report, we discussed the artificial conception technology involving *in vivo* fertilization followed by removal by lavage of the fertilized ovum for transplantation to the uterus of another woman who intends to retain the child upon birth. We explained that instances may occur where lavage fails to remove the *in vivo* fertilized ovum, resulting in the pregnancy of the intended ovum donor.

In such a case, the intended ovum donor may decide to keep the child.[404] Alternatively, she may be willing to transfer custody of the child to the couple to whom she had intended to donate the ovum. Under the present law, the child and the couple would remain in a state of uncertainty respecting status and parentage.

We suggest that it would be salutary if, upon diagnosis of the pregnancy, the woman were to be allowed to agree with the couple that, upon birth, the child will be surrendered to them, and that she will continue her pregnancy as a surrogate mother. However, in order for such an agreement to be recognized in law, and to establish the legal relationship between the child and the intended parents, the agreement would have to receive judicial approval. Although the court would face a *fait accompli* regarding the commencement of pregnancy, it might usefully review the terms of an abbreviated form of agreement for the purpose of ensuring protection of the interests of the future child and the parties. In appropriate circumstances, notice of the application might be served on the local children's aid society.

It may be argued that this *ex post facto* procedure for judicial approval is not necessary, as the risk of unwanted pregnancy is implicit in this technique of ovum donation and should be anticipated by the parties. Conceivably, legislation might require that, in the case of every ovum donation by means of lavage, participants make an application to the court for approval of a surrogate motherhood arrangement in the event that the ovum donor becomes pregnant. We suggest, however, that subjecting this form of ovum donation to such a costly and cumbersome procedure in anticipation of an event that may not occur would involve an unwarranted expenditure of resources. On balance, we believe that it is preferable to address the problem of pregnancy when it arises, even if this means an expedited process of scrutiny.

On discovery of pregnancy, therefore, proceedings for judicial approval of a

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404 If the intended ovum donor decides to keep the child, the intended social parents may have no effective recourse. If the male is not the sperm donor, the couple will be in no better legal position in a custody claim than would complete strangers to the child. If the male is the sperm donor, and can prove paternity, he may attempt to claim custody. In addition, should custody be granted to the ovum donor, he would be notified of any proceedings affecting the child if, for some reason, the children's aid society later were to intercede to protect the child. See, for example, *Child Welfare Act, supra,* note 41, s. 28(6), and *Child and Family Services Act, supra,* note 41, s. 39.

surrogate motherhood arrangement would be initiated. Since, due to time constraints, the parties might be unable to agree on all the terms of the agreement, it would be useful to empower the court to settle the terms in respect of which there is disagreement in a manner compatible with the best interests of the child.

Accordingly, we recommend that, where a woman undergoes *in vivo* fertilization of an ovum intended for donation and becomes pregnant, she and the intended social parents should be able to apply to the court for approval of a surrogate motherhood arrangement in accordance with our previous recommendations. In approving the arrangement, the court should be empowered to determine unresolved terms of the agreement where all parties have approved the terms in principle, but have been unable to settle the details thereof by the time that the application for approval is presented.

b. Introduction of Replacement Surrogate Mothers

After a surrogate motherhood arrangement has received judicial approval, the surrogate mother may become medically or otherwise unsuitable or unwilling to undertake her role prior to the performance of the particular artificial conception technique. In view of their obvious emotional interest and the investment of human and material resources, the prospective social parents may attempt to find a replacement, conclude an agreement, and seek judicial approval.

Where conception is to be effected by means of artificial insemination, finding a replacement surrogate mother will not be urgent. Where, however, an ovum has been fertilized *in vitro* or *in vivo*, and it was intended to transfer it to a proposed surrogate mother who has become unavailable, finding a suitable replacement will be a matter of considerable urgency, because a delay in transferring the fertilized ovum may mean its wastage. In these circumstances, our recommended scheme, requiring comprehensive judicial scrutiny of the parties to any agreement, may so postpone transfer of the fertilized ovum that its destruction will be assured. Although embryo freezing may ease time pressures to find a replacement, the thawing process may result in loss of the fertilized ovum.

We suggest that, in view of the expense incurred in preparation for the transfer of the fertilized ovum to the approved surrogate, the special status some accord the fertilized ovum, and, where the ovum donor is an intended social mother unable to bear a child, the special interest she may have in the ovum when her capacity for future ovulation is impaired, its avoidable wastage should not be contemplated casually.

While it may be argued that withdrawal of the approved surrogate mother is an inherent risk that is accepted by the social parents, when balanced against the factors that we have delineated above we see little of value in requiring them to initiate the entire procedure once again.

We believe that, where an approved surrogate mother who is the intended recipient of a fertilized ovum becomes unavailable, there should be a summary procedure to hear an application to add a replacement. In the earlier hearing of the application, the intended social parents will have been approved as suitable for participation, and it is this appraisal that is most critical to the protection of the interests of the unborn child. On the second, expedited hearing, there will be no need to reassess the social parents, and owing to the exigencies of the situation, the suitability of the replacement surrogate mother may properly be assessed in a summary manner.

One consequence of an abbreviated procedure may be that approved surrogate mothers, aware of the possibility that they may be replaced in this manner, may feel free to withdraw from agreements should they have doubts about their commitment. We do not regard this as undesirable: prior to conception, surrogate mothers should not feel constrained to honour their promises if, in fact, they wish not to participate.

Accordingly, we recommend that, where an approved surrogate mother who is the intended recipient of a fertilized ovum becomes unavailable, there should be a summary procedure for the approval of a replacement surrogate mother, where this is necessary to secure transfer of the fertilized ovum in order to avoid its wastage.

c. Recognition of Surrogate Motherhood Agreements Made Outside Ontario

While we have proposed a scheme to regulate surrogate motherhood arrangements in Ontario, we recognize that the proximity of the United States and the existence there of private agencies willing to arrange surrogate motherhood transactions may attract prospective social parents from Ontario. Whether, and the extent to which, there will be recourse to these agencies will depend on the response of American jurisdictions to this phenomenon and on the availability of services in Ontario. Should the demand for services in this jurisdiction be met effectively, and if the degree of regulation is considered fair, and not excessively rigorous, it is less likely that Ontario couples will seek assistance elsewhere. Since the effect of regulation cannot be predicted, we believe that the issue of the recognition to be given to surrogate motherhood agreements that are made out of the jurisdiction must be addressed in this Report.

Where children are born and their births are registered outside the jurisdiction, and where the courts of other jurisdictions have approved adoption of children by Ontario residents,[405] no issue arises in connection with the effect in Ontario of the surrogate motherhood agreement. Under the existing law, the adoption will be accorded recognition in Ontario[406] and, assuming that the

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405 Whether a couple resident in Ontario will be allowed to adopt a child in the United States will depend on the residency requirements of the particular state.

406 Section 87(1) of the *Child Welfare Act, supra,* note 41, provides that an adoption made according to the law of another province or territory of Canada or of any other state or

parents are citizens of Canada or permanent residents, they should not encounter difficulty in the immigration of the infant to Canada.[407]

Where, however, a surrogate motherhood agreement is entered into outside Ontario and the birth is to take place or actually does take place in Ontario, the question whether recognition should be extended to that agreement must be considered. If recognition is not given, the agreement will have no legal effect in Ontario. Consequently, the parties to an extraprovincial agreement will be in no better position than they are under the present law, or if they were to make an agreement in Ontario in disregard of the proposed scheme.[408]

If, by chance, a child is born to a surrogate mother in Ontario, perhaps in premature labour, where none of the parties to the surrogate motherhood agreement has a significant connection with the Province, the matter is of little consequence in the Province, and may be treated according to the proper law of the agreement. Of greater concern, however, are planned evasions of Ontario requirements, in which surrogate motherhood agreements, lawful where made, but in violation of Ontario law, are implemented deliberately in the Province. This may be advantageous if the requirements in another jurisdiction are more lenient than those under our proposed scheme, particularly where the scrutiny of prospective parents and control over payments are less stringent.

There may be a certain appeal in a legislative response to this problem that provides for recognition of extrajurisdictional agreements only insofar as they are compatible with, or not fundamentally offensive to, Ontario law.[409] Such an approach would allow courts to determine whether offensive provisions were severable, or whether the whole agreement should be denied recognition. This solution, however, may fail to address key questions pertaining to the welfare of children born pursuant to agreements containing offensive aspects.

For the present, we are persuaded that the better approach is to leave any problems that may arise to be resolved by the courts. Guidance may be sought in

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country or part thereof shall have the same effect in Ontario as an adoption under the *Child Welfare Act.* See, also, the *Child and Family Services Act, 1984, supra,* note 41, s. 153.

407 If a child is born in the United States to a surrogate mother who is not a Canadian citizen, and it can be proved that the social father, a Canadian citizen, is indeed the biological father, the child will have a right to enter Canada because he or she will also be a Canadian citizen: see s. 6(1) of the *Canadian Charter of Rights and Freedoms,* being Part I of the *Constitution Act, 1982,* which is itself Schedule B of the *Canada Act 1982,* c. 11 (U.K.); *Immigration Act, 1976,* S.C. 1976-77, c. 52, s. 4; and *Citizenship Act,* S.C. 1974-75-76, c. 108, s. 3(1)(b). In such a case, adoption would be irrelevant to the right of the child to enter Canada. Where the social father is not the biological father, or where he or his spouse is a permanent resident, an application for landing can be made after the adoption.

408 For the consequences of making a surrogate motherhood arrangement in violation of the proposed regime, see *infra,* this ch., sec. 5(e)(viii).

409 For an example of a legislative response in another context, see *Family Law Reform Act, supra,* note 127, s. 57.

the existing body of private international law and family law dealing with the recognition of foreign agreements involving residents of Ontario, where such agreements contain elements inconsistent with public policy in the Province. However, if the courts cannot resolve problems of surrogate motherhood agreements made outside Ontario so that the interests of children are protected, or if the courts pursue inconsistent approaches leading to uncertainty, remedial legislation may be necessary.

Accordingly, we recommend that, for the initial period during which surrogate motherhood agreements are regulated by statute, no specific provision should be enacted to address the question of such agreements that are made outside Ontario and intended for implementation in the Province.

d. Medical Records

In our discussion of the issues common to all the artificial conception technologies, we expressed the view that legislation was not necessary to compel the maintenance of medical records by physicians, as this was required pursuant to regulations made under the *Health Disciplines Act*.[410] Similarly, in this context, we believe that no legislation need be enacted to address the maintenance of such records, and, accordingly, we make no recommendation in regard thereto.

(viii) Failure to Comply with the Proposed Scheme

We have recommended a comprehensive regulatory regime designed to give legal recognition and effect to surrogate motherhood agreements that receive the approval of the court. However, for various reasons, there may be persons who choose to enter surrogate motherhood arrangements outside the proposed regulatory scheme. Perhaps a couple may fear that they will not receive judicial approval. We need not dwell unduly on the range of motivating factors; suffice it to say that the possibility that persons may seek to evade the regulatory scheme does concern us. In this section, we shall consider appropriate responsive measures.

a. Penalties

One effect of surrogate motherhood arrangements for which approval is not sought under the proposed regime or that are pursued in disregard of judicial disapproval is that they will remain unenforceable and the persons affected will be uncertain as to their rights and responsibilities until a judicial determination of them.[411]

A scheme of statutory control that is designed to be actively regulatory, however, demands a sanction beyond mere ineffectiveness of agreements made in

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410 R.R.O. 1980, Reg. 448.

411 With respect to the status of children of unapproved surrogate motherhood arrangements, see the following section of this chapter.

defiance of it. Merely rendering contracts unenforceable may not be sufficient to discourage unauthorized agreements from being concluded and being performed voluntarily by the parties. A stronger deterrent is warranted. If unauthorized surrogate motherhood arrangements are to be actively prohibited, a provincial offence should be created for which there would be liability to a penalty.

Subject to an exception, to be discussed below, the essence of the offence should be participation in a surrogate motherhood arrangement that a person knows or believes is intended to evade the proposed scheme of regulatory control.[412] We believe that liability for violation of this prohibition should be visited on all persons involved in the impugned arrangement — the parties, their advisors, and any intermediaries who may have brought them together.

In proposing that the parties to an illegal arrangement be rendered liable to a penalty, we differ from certain other bodies that have considered this issue. The Warnock Committee recommended that legislation render criminal "the creation or the operation ... of agencies whose purposes include the recruitment of women for surrogate pregnancy or making arrangements for individuals or couples who wish to utilise the services of a carrying mother".[413] It recommended that this legislation embrace "the actions of professionals and others who knowingly assist in the establishment of a surrogate pregnancy".[414] The Warnock Committee, however, did not wish to impose criminal liability on the parties to the prohibited arrangement, explaining that it was "anxious to avoid children being born to mothers subject to the taint of criminality".[415]

The Queensland Report took the view that, while "surrogacy arrangements" should not be made criminal offences, "it should be made illegal to advertise to recruit women to undergo surrogate pregnancy, or to provide facilities for persons who wish to make use of the services of such women".[416]

The recently enacted Victoria *Infertility (Medical Procedures) Act* 1984[417] has taken a different approach, imposing criminal liability on both intermediaries and parties. Section 30(2) provides as follows:

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412 It would not be necessary in the surrogate motherhood context to provide a penalty for the performance of the artificial conception procedure by other than medically trained persons. We have already recommended the enactment of legislation providing that artificial conception procedures constitute the practice of medicine, which would make it an offence for such procedures to be undertaken by anyone other than a licensed physician or someone under the latter's supervision or direction: see *supra*, this ch., sec. 3(a).

413 Warnock Report, *supra,* note 2, para. 8.18, at 47.

414 *Ibid.*

415 *Ibid.*, para. 8.19, at 47.

416 Queensland Report, *supra*, note 2, at 117-18.

417 *Supra*, note 48.

30.-(2) A person shall not—

(a) publish, or cause to be published, a statement or an advertisement, notice or other document that—

(i) is intended or likely to induce a person to agree to act as a surrogate mother;

(ii) seeks or purports to seek a woman who is willing to agree to act as a surrogate mother; or

(iii) states or implies that a woman is willing to agree to act as a surrogate mother;

(b) make, give or receive, or agree to make, give or receive, a payment or reward for or in consideration of the making of a contract, agreement or arrangement under which a woman agrees to act as a surrogate mother; or

(c) receive or agree to receive a payment or reward in consideration for acting, or agreeing to act, as a surrogate mother.

We seek to prevent the subversion of our proposed scheme not only by self-interested intermediaries, but also by the prospective parties to the agreement. In this respect, we derive support from the Victoria legislation and the Ontario *Child Welfare Act*. The latter statute imposes penalties for breach of certain prohibitions on persons who seek to become the adoptive parents of a child, but, in doing so, act in violation of the legislation.[418] The purpose of providing for such liability is to deter them from ignoring a regulatory scheme that has as its primary purpose the protection of the best interests of the children to be served thereby. At its heart is a subordination of the wishes of the prospective parents to the interests of the child.

We have indicated our view that, in principle, there should be a penalty for participation in a surrogate motherhood arrangement where it is known or believed that the arrangement is intended to evade our proposed regulatory scheme. Where, however, a professional is confronted with a *fait accompli* — for example, where an obstetrician is asked to deliver a pregnant surrogate mother's baby, or where a psychologist is asked to counsel a pregnant surrogate mother — he or she should not be deterred from assisting by the existence of a penalty. Indeed, intervention may serve to alleviate the harmful effects of the agreement on the parties or the child.[419] Accordingly, the recommended penalty would not attach to all forms of participation in a surrogate motherhood arrangement, but only to actions directed to the evasion of our proposed scheme.

We believe that the severity of the penalty is of less importance than the fact of its existence. Generally speaking, violations of provincial offences tend to

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418 *Child Welfare Act, supra,* note 41, s. 94(2)(b) and (5). See the *Child and Family Services Act, 1984, supra,* note 41, s. 160(2).

419 We observe that, while the resolution approved by the Council of the British Medical Association in March, 1984, stated "that it is unethical for a doctor to become involved in techniques and procedures leading to surrogate motherhood", it declared also that "[t]his statement does not, however, affect the duty of care of the doctor to any woman who has conceived under these circumstances": see B.M.A. Annual Report, *supra,* note 303.

render the offender liable to relatively modest fines and to relatively brief periods of imprisonment. However, we do observe that, where legislation concerns the protection of children, the Legislative Assembly of Ontario has been willing to impose somewhat more onerous penalties. Under the *Child Welfare Act,* a person who places or receives a child for adoption in contravention of the Act may be liable to a fine of not more than $2,000 or to imprisonment for a term of not more than two years, or both.[420] A person who violates the prohibition against making, offering, or receiving payments in connection with adoption is liable to a fine of up to $5,000 or imprisonment for three years, or both.[421]

We suggest that it would be inappropriate to provide for incarceration of prospective parents who seek to avoid the proposed regulatory scheme. Such persons may be considered misdirected in their efforts, but not so inherently vicious as to warrant imprisonment. Moreover, where they have already obtained custody of an infant pursuant to an unapproved arrangement, incarceration would hardly be in the best interests of the child. Similarly, we regard the incarceration of health care and other professionals as a disproportionate response.

In accordance with these views, we recommend that a penalty of a fine should be provided for participation in a surrogate motherhood arrangement where it is known or believed that the arrangement is intended to evade the proposed regulatory scheme. However, where a professional whose assistance is sought is confronted with a *fait accompli* — for example, where an obstetrician is asked to deliver a pregnant surrogate mother's baby — he or she should not be subject to the proposed penalty for giving such assistance.

b. Status of Children of Unapproved Surrogate Motherhood Arrangements

Our previous recommendation, favouring the establishment of a penalty for violation of the proposed legislation, addresses only one of the questions raised by the possibility of evasion. The other major issue, which is no less important, particularly in light of this Project's Terms of Reference, concerns the effect of evasion on the status of a child born pursuant to an unapproved surrogate motherhood arrangement.

As we have explained earlier,[422] under certain circumstances, existing law may be utilized to regularize the relationship of the infant and the couple who wish to be recognized in law as its parents. In this way, the objectives of a surrogate motherhood agreement may be realized by the parties, although not as a function of the agreement itself. The particular procedures available will depend on the genetic parentage of the child.

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420 *Child Welfare Act, supra,* note 41, s. 94(2)(b). See the *Child and Family Services Act, 1984, supra,* note 41, s. 160(1) and (2).

421 *Child Welfare Act, supra,* note 41, s. 94(5). See the *Child and Family Services Act, 1984, supra,* note 41, s. 160(4).

422 See *supra,* this ch., sec. 5(a).

Upon birth of the child, the surrogate mother will be its mother in law. If she is married and living with her husband at the time of conception, he will be registered as the father.[423] Where the intended social father is the sperm donor, he may establish his paternity and seek to obtain sole custody in proceedings brought under Part II of the *Children's Law Reform Act.*[424] His wife may then seek to adopt the child by using the procedures for step-parent adoption. The surrogate mother must consent to the adoption, unless the court makes an order dispensing with her consent.[425] It will be recalled that, in the case of a step-parent adoption, there is no requirement of a homestudy. While, on the hearing of the application for an order for adoption, the court has power to require a report on the adjustment of the child in the home, it need not do so.

If the social father is not the biological father of the child born pursuant to an unapproved surrogate mother arrangement, regularization of the child's status would be by way of a stranger adoption. At present, where a couple wishes to adopt a child who has not been placed for adoption with them under the *Child Welfare Act,* but who nonetheless resides with them, they may make use of the Act *ex post facto* and seek an order for adoption. The practice in such a case is that they find a person to apply for a private licence to place the child with them. The licensee is responsible for arranging a homestudy and for submitting the necessary reports about the persons wishing to adopt the child. The surrogate mother and her spouse, if any, will have to consent to the adoption, unless the court dispenses with their consent.

A question arises as to whether parties who have deliberately, or even inadvertently, ignored the recommended scheme should be allowed to realize their intentions indirectly by means of existing legislation. At first blush, it may appear objectionable that actions taken in violation of our proposed scheme should meet with success, however cumbersomely achieved. Yet, such a perspective, while perhaps understandable as a visceral response, should not prevail. We suggest that the child's best interests would be served by giving certainty to its relationship with the social parents, notwithstanding the fact that this may produce the precise result sought in the impugned arrangement. To deny the social parents the opportunity of regularizing their relationship with the child, as a means of discouraging unapproved arrangements, would have the effect of punishing children for the conduct of their parents.

We believe, therefore, that social parents who acquire custody of children pursuant to unapproved surrogate motherhood arrangements should be allowed to utilize existing procedures to establish their parentage in law after the fact, and we so recommend. However, we would impose upon the social parents a requirement that may not apply under existing law. In our view, whenever social parents seek to utilize existing procedures to regularize the status of a child born

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423 *Vital Statistics Act, supra,* note 123, s. 6(4) and (5).

424 *Supra*, note 122.

425 Where the social father has obtained an order declaring that he is the father of the child, it will, of course, be unnecessary to obtain the consent to the adoption of the husband of the surrogate mother, who is a stranger to the child.

outside our proposed scheme, the local children's aid society should be required to submit a homestudy to the court. Had the social parents proceeded according to the recommended scheme, the court asked to approve the surrogate motherhood arrangement would have received evidence respecting their suitability.[426] A court requested to issue an order for adoption after the child has been transferred should not make a decision respecting the status of the child with less information than it would have had if the law had been observed.

It should be appreciated that, while an unfavourable homestudy may persuade a court to refuse to issue an order for adoption, it will not necessarily result in removal of the child from the home. Seizure of the child will take place only where it is justified under the existing law, that is, where the child is "in need of protection" within the meaning of the *Child Welfare Act.*

Accordingly, we recommend that, where social parents seek an adoption order in relation to a child who is born pursuant to an unapproved surrogate motherhood arrangement and transferred to them, notice of the application should be served upon the appropriate children's aid society. Upon receipt of the notice, the children's aid society should be required to conduct a homestudy and submit to the court a report in relation thereto.

6. FURTHER REVIEW

In this Report, we have sought to respond to the many difficult legal issues that have been created by the advent and continuing refinement of the artificial conception technologies. Our task has not been an easy one. The relevant technologies are developing at an ever increasing rate, raising novel legal issues involving fundamental moral and ethical concerns that have long perplexed man. Hence, we are not hesitant to acknowledge that it is most unlikely that law reform proposals in this area will be blessed with perfect prescience. Given the context, the recommendations must necessarily contain some speculative and experimental aspects.

In view of the unavoidably tentative character of several of our proposals, we suggest that, some time after our recommended scheme has been implemented, a review of its efficacy should be undertaken. This will allow refinement of the elements of the regime, or indeed fundamental amendment, should the latter prove to be necessary. It will also facilitate an appraisal of the response of the College of Physicians and Surgeons of Ontario and individual members of the medical profession.

At this stage, we do not wish to suggest which particular body should undertake this review. The task might be given to the Ontario Council of Health, the Ministry of Community and Social Services, the Ministry of Health, an interministerial committee, or an *ad hoc* committee, which might be composed of representatives of various ministries and other interested bodies. We consider it unnecessary to establish a standing committee of the Legislative Assembly of

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426 See *supra*, this ch., sec. 5(e)(i).

Ontario to monitor the effects of our proposals, since a number of ministerial and other bodies are likely to maintain an interest in developments. Moreover, while a central ministerial repository of data might be useful, and might receive information from various ministries dealing with issues of health, family and child welfare and, for instance, vital statistics, we do not believe that the creation of a new governmental monitoring or data gathering agency is warranted. As we have suggested, much of the relevant information will be compiled by interested ministries and agencies, and can be submitted to the body charged with the responsibility of conducting the review.

We therefore recommend that, five years after our proposed regime has been implemented in whole or in part, a review of all aspects of the regime should be undertaken by an appropriate governmental body.

SUMMARY OF RECOMMENDATIONS

The Commission makes the following recommendations:

THE PROPRIETY OF ARTIFICIAL CONCEPTION TECHNOLOGIES

1. Artificial conception technologies, that is, artificial insemination, *in vitro* fertilization, and *in vivo* fertilization followed by lavage, should continue to be available and accepted as legitimate techniques to be used (except where a fertile and genetically healthy single woman receives treatment: see Recommendation 5) where medically necessary to circumvent the effects of infertility and genetic impairment.

2. (1) The use of the new artificial conception technologies should be subject to the recommendations proposed below.

   (2) Unless otherwise stated, the recommendations proposed below should not apply to artificial insemination where the sperm used is that of the recipient woman's husband or partner (A.I.H.).

GENERAL RECOMMENDATIONS FOR REFORM

3. Legislation should expressly provide that artificial conception procedures, that is, artificial insemination (including A.I.H.), *in vitro* fertilization, and *in vivo* fertilization followed by lavage, constitute the "practice of medicine" under the *Health Disciplines Act.*

4. Physicians should not be required to obtain a special licence or to practise in a specially licensed health facility in order to perform artificial conception procedures.

* 5. 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.

6. The proposed criteria for participation in an artificial conception programme (see Recommendation 5) should be set out in regulations made under the *Health Disciplines Act.*

7. Given the present variety of means by which grievances may be redressed, no additional or different means of challenge or appeal should be made available to a person who is denied access to artificial conception services.

8. Subject to Recommendation 9, legislation should remain silent on criteria for the selection of gamete donors. Questions of reproductive history, marital status, and genetic and other medical status should be left to professional standards to be set by the medical profession.

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* Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, dissents from this recommendation: see Vice Chairman's Dissent, at page 287 of this Report.

9. Having regard to recent federal initiatives respecting the setting of standards for donor selection, at least in the context of licensed sperm banks, and in the belief that such standards should be uniform across Canada, there should be consultation between the provincial governments and the federal government so that such uniformity may be furthered.

10. The issue of sperm donation by minors should be left to the general law, which now permits such donation.

11. (1) Minors should be prohibited from undergoing any procedure undertaken deliberately to donate ova.

    (2) However, so long as they have given their free and adequately informed consent (see Recommendation 12), minors should not be prohibited from donating ova acquired indirectly as a result of therapeutic surgery, such as a hysterectomy.

12. Legislation should expressly require a donor's free and adequately informed consent as a precondition to the donation or use of his or her gametes.

13. At the time of donation, a donor should be entitled to restrict the use of the donated gamete to a specified purpose. Such a restriction should continue in effect even after the gamete has been used in a fertilization procedure, unless, prior to fertilization, the donor has altered the specified purpose or has indicated that the restriction is no longer to apply.

14. (1) After donation, but prior to the use of their gametes in a fertilization procedure, donors should be entitled either to require their donation to be wasted or returned to them, so that the gametes may not be used for artificial conception, research, or any other purpose.

    (2) A donor's consent to the donation of his or her gametes, given at the time of donation, should remain of legal effect until withdrawn or otherwise altered (see paragraph (1) and Recommendation 13), so that a fresh consent should not be required at each time the gametes are used.

15. (1) Donors of sperm should be allowed to be paid their reasonable expenses. Such payment should be based roughly upon the time and inconvenience involved in the initial screening with a view to recruitment into donor programmes, and the periodic follow-up checking while remaining active donors. However, payment for "discomfort" should not be available. The sum paid should not be so great as to be an incentive to deceive, nor so great as unduly to burden a clinic having to pay for the time of applicants it rejects. In Ontario, existing payments tend to fall within the $25-$50 range, which is acceptable.

    (2) The same principles as those proposed in paragraph (1) should be applied to ovum donors, although payments may prove to be greater where ovum recovery involves invasive procedures, such as laparoscopy, or where a woman's naturally released ovum is recovered nonsurgically, by means of *in vivo* fertilization and lavage.

16. The frequency of employment of individual gamete donors should be left to the professional judgment and ethics of medical practitioners and to the preference of participants in artificial conception programmes.

17. (1) Gamete banks, that is, banks that buy and sell sperm, ova, and embryos, should be permitted to operate on a commercial basis. However, they should be allowed to operate only under licence and under stringent regulations setting standards of operation, with respect, for example, to payment by users to defray reasonable costs and, perhaps, to provide a reasonable profit. They should be operated subject to public accountability or under the auspices of a public organization, preferably on the model of the Canadian Red Cross Society blood donor clinics.

(2) Having regard to the recent federal initiatives respecting the licensing of sperm banks, there should be consultation between the provincial governments and the federal government so that the goal of uniformity of standards across Canada may be furthered. (See, also, Recommendation 9.)

(3) Licensed gamete banks should be prohibited from supplying gametes or embryos to any person or agency other than a licensed physician, a hospital or other approved health care facility, or another licensed gamete bank.

18. (1) The use of gametes and embryos imported from outside Ontario should be permitted but should conform to the standards governing gamete banks in the Province. (See Recommendation 17.)

(2) Having regard to recent federal initiatives in this general area, there should be consultation between the provincial governments and the federal government to ensure that uniform standards in regard to importation of gametes and embryos are established for the whole of Canada. (See, also, Recommendations 9 and 17(2).)

19. (1) For all purposes, a woman bearing a child through artificial conception in order to rear it should be conclusively deemed to be the child's legal mother, and the woman's husband or male partner who consents to the initiation of the artificial conception procedure or procedures (having regard to paragraph (3)) should be conclusively deemed to be the child's legal father.

(2) A donor of sperm or an ovum should have no legal relationship to the child arising from the fact of donation; in other words, a donor should have no parental rights or duties regarding the artificially conceived child.

(3) The consent of the husband or partner (referred to in paragraph (1)) should be presumed as a matter of law. However, this presumption should be rebuttable at his instance or at the instance of another person with a legitimate interest.

(4) The proposed legislation respecting the status and legal parentage of artificially conceived children should be retroactive in effect.

20. With respect to registration of the birth of an artificially conceived child,

    (a) in the case of artificial conception with donor gametes, the woman who bears and intends to rear the child should be registered as the child's mother, and the mother's spouse or partner who, under Recommendation 19(1), is deemed to be the natural father, should be registered as the child's father.

    (b) the gamete donor should not be named in the register of births, nor should the fact of artificial conception appear in such register.

    (c) where a woman gives birth to a child conceived posthumously by means of her deceased husband's or partner's preserved sperm, the woman should be entitled to register the birth showing the deceased as the father of the child.

21. (1) A child conceived artificially with donor gametes

    (a) should acquire inheritance rights to the estates of those persons who are legally recognized as his or her parents (see Recommendation 19), and to the estates of others as if the child was the natural child of such parents, unless the contrary is expressed by the testator, and

    (b) should have no inheritance rights through the gamete donor, unless the donor expressly provides for the child in his or her will.

    (2) A child conceived posthumously with the sperm of the mother's husband or partner

    (a) should be entitled to inheritance rights in respect of any undistributed estate once the child is born or is *en ventre sa mere,* as if the child were conceived while the husband or partner was alive, and

    (b) should be entitled to inheritance rights where the child is born or is *en ventre sa mere* when the time for the ascertainment of possible beneficiaries arrives.

22. (1) Subject to the recommendations that follow, no specific legislation or rules dealing with medical records relating to the provision of artificial conception services should be enacted or established.

    (2) In order to ensure that the legislation and other guidelines respecting medical records are as comprehensive as possible, particularly in light of the proposal to be made in paragraph (3) concerning a system of linkage between donors and recipients, the relevant statutes, regulations, and professional rules should be amended to make it clear that gamete donors are patients for the purposes of record keeping.

    (3) Pursuant to the power given to the Council of the College of Physicians and Surgeons of Ontario under section 50 of the *Health Disciplines Act,* and subject to the approval of the Lieutenant Governor in Council and the prior review of the Minister of Health, the

Council should make regulations that would establish a system of record keeping permitting doctors to link gamete donors with recipients, subject, however, to paragraph (4).

(4) Anonymity concerning the identity of all parties involved in artificial conception — the donor, the recipient, her spouse or partner (if any), and the child — should be preserved in the medical records.

(5) (a) Where a genetic or transmissible defect or disease in a donor or a donor's child becomes known to a doctor, the doctor should be under a duty, imposed by regulations governing the medical profession, to make all reasonable efforts to report all relevant information to any person whose health and welfare the doctor reasonably believes may be affected by it.

(b) Sanctions for the failure to abide by such a regulation should lie in potential civil liability in negligence and in the "professional misconduct" regulations under the *Health Disciplines Act,* rather than in a specific new penalty.

(6) There should be no positive duty on artificial conception practitioners to take steps to ascertain whether conception and birth have taken place or to ascertain the medical status of any child. However, should it be thought necessary or desirable to deal more formally with this matter, any legal obligation to follow up the outcome of artificial conception treatment should be incorporated in the regulations governing the medical profession under the *Health Disciplines Act.*

(7) (a) The decision to disclose to the child the nature of its biological origins or parentage should not be regulated or dealt with by legislation or other formal rules.

(b) The decision concerning access to medical records by the parties involved — the woman, her husband or partner (if any), the child, and the donor — should be left to individual members of the medical profession. However, under no circumstances should any doctor or other person disclose information that could in any way identify the parties.

23. It should be made a provincial offence knowingly to conceal or misrepresent information in offering or agreeing to donate gametes for artificial conception purposes.

24. Legislation should provide that principles of strict liability, and particularly the implied warranties of merchantable quality and fitness for purpose, should not be applied to the direct or indirect donation or supply of gametes or embryos; rather, recovery in such a transaction should be dependent upon general principles of the law of negligence.

25. The claims by a parent known as wrongful conception and wrongful birth claims, and the claims by a child known as wrongful life and dissatisfied life claims, should not be resolved in a study on human artificial reproduction. Rather, these claims should be the subject of a separate

study, in the context of tort law generally, so that an integrated jurisprudence in the area may be adequately developed.

PROPOSALS RELATING TO THE FERTILIZED OVUM OUTSIDE THE BODY

26. There should be no prohibition of the practice of transferring multiple fertilized ova to a woman, regardless of whether the ova are her own or are donated, and, where the ova are donated, regardless of whether a single donor or different donors are used.

27. (1) (a) A fertilized ovum outside the body, produced with the gametes of the intended recipient and her husband or partner, should be under the joint legal control of the man and woman.

(b) Where one of the couple dies, legal control of the fertilized ovum should pass to the survivor. If both should die, control should pass to the physician, clinic, gamete bank, or other authority that has actual possession of the ovum.

(c) Where the couple cannot agree concerning the use or disposition of the fertilized ovum, legal control should pass to the physician, clinic, gamete bank, or other authority that has actual possession of the ovum.

(2) Subject to Recommendation 13, concerning the case where a gamete donor has imposed a restriction on the use of his or her gamete,

(a) a gamete donor should have no right in law to control the use or disposition of a fertilized ovum to which he or she has contributed genetic material;

(b) where a fertilized ovum has been produced from donated sperm and a donated ovum, and is not to be transferred to the woman for whom it was originally intended, legal control over the fertilized ovum should reside in the physician, clinic, gamete bank, or other authority that has actual possession of the ovum; and

(c) where a fertilized ovum has been produced by a donor gamete and a gamete from one spouse or partner of a couple for whom the ovum was originally intended, and is not to be transferred to the woman for whom it was originally intended, legal control over the fertilized ovum should reside in that spouse or partner alone.

28. Legislation should not be enacted to deal with whether a woman or couple should be entitled to obtain information concerning the sex of a fertilized ovum intended to be transferred to the woman.

29. (1) Research and experimentation on a fertilized ovum outside the body should be permitted, subject to the recommendations that follow.

(2) Research and experimentation involving a fertilized ovum outside the

body should be restricted to research centres approved by the Ministry of Health.

(3) A research centre should be entitled to be approved only where it has established an ethical review committee for the internal screening of research projects. The Ministry of Health should develop minimum requirements respecting the composition and operation of ethical review committees in research institutions.

30. A fertilized ovum that has been the subject of experimentation that has no direct therapeutic purpose in relation to the ovum should not be transferred to a woman.

31. Having regard to the information now available to medical science respecting embryonic development, regulations should provide that no fertilized ovum outside the body should be allowed to develop beyond fourteen days after fertilization. Should the state of medical knowledge at some future date indicate that the fourteen day period is not appropriate, by being either too short or too long, the regulations should be amended.

32. There should be a maximum of ten years for the cryopreservation or similar storage of a fertilized ovum, after which time the storage authority should be under a duty to have the ovum wasted.

33. The question whether, having regard to the rule against perpetuities, a testator should be able to bind property by relation to the birth of a child from a fertilized ovum in cryopreservation at the time of the testator's death (and, therefore, whether such an ovum is a "life in being" under the rule) should be left to judicial, not legislative, resolution.

SURROGATE MOTHERHOOD

* 34. Legislation should be enacted to establish a regulatory scheme governing surrogate motherhood arrangements.

35. Before an artificial conception procedure may be employed in furtherance of a surrogate motherhood arrangement, the approval of the Provincial Court (Family Division) or the Unified Family Court should be obtained in accordance with the proposals made below.

36. All surrogate motherhood agreements should be in writing. The court should be required to approve the terms of the agreement and to ensure that they adequately protect the child and the parties and are not inequitable or unconscionable.

37. On the hearing of the application for approval of a surrogate motherhood arrangement, the court should be required to assess the suitability of the prospective parents for participation in such an arrangement.

38. Before the court approves a surrogate motherhood arrangement, the prospective parents should be required to satisfy the court that there is a

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* Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, dissents from this recommendation: see Vice Chairman's Dissent, at page 287 of this Report.

medical need that is not amenable to alleviation by other available means, including the artificial conception technologies.

* 39. The availability of surrogate motherhood to prospective parents should not be restricted on an *a priori* basis, but should depend on an assessment of the prospective parents by the court according to legislated standards. The court should be required to be satisfied that the intended child will be provided with an adequate upbringing; in making this determination, the court should be required to consider all relevant factors, including the marital status of the prospective parents, the stability of their union, and their individual stability.

40. Where a donated gamete is to be used in a surrogate motherhood arrangement from a donor who is neither the prospective surrogate mother nor a prospective social parent of the intended child, the treatment of the donor should be governed by the previously recommended provisions concerning gamete donors.

* 41. There should be no restriction on the eligibility of women to serve as surrogate mothers, so long as they have reached the age of majority at the date of the application for court approval of their participation in a surrogate motherhood arrangement.

42. On the hearing of the application for approval of a surrogate motherhood arrangement, the court should be required to assess the suitability of the prospective surrogate mother.

43. In assessing the suitability of a prospective surrogate mother, the court should consider, among other factors, her physical and mental health, her marital and domestic circumstances, the opinion of her spouse or partner, if any, and the likely effects of her participation in a surrogate motherhood arrangement upon existing children under her care.

44. The question of the standard of proof for approval of surrogate motherhood arrangements should be left to the courts responsible for determining the matter.

45. The surrogate mother should be a co-applicant in proceedings to approve a surrogate motherhood arrangement, but should not be required to be in attendance at the hearing of the application in every case. The surrogate mother should receive separate legal representation.

46. In order to minimize uncertainty concerning a child's parentage upon birth, the court should require that information relating to the blood type and other relevant biological characteristics of the surrogate mother, her husband or partner, if any, and the persons who produced the gametes involved should be placed before it prior to approval of the surrogate motherhood arrangement.

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* Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, disagrees with this recommendation: see *supra*, ch. 6, note 345.

* Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, disagrees with this recommendation: see *supra*, ch. 6, note 350.

47. Notice of an application to the court for approval of a surrogate motherhood arrangement should be served upon the appropriate children's aid society, and the society should have standing to attend at the hearing of the application. However, a children's aid society should intervene only where its records disclose information demonstrating the unsuitability of either the surrogate mother or the prospective social parents for participation in the surrogate motherhood arrangement.

48. The anonymity of the prospective social parents and the surrogate mother and the confidentiality of court records pertaining to surrogate motherhood proceedings should be preserved. The application should be heard and determined *in camera,* the court records should be sealed, and access to the records should be granted only upon judicial approval for good reason.

49. A child born pursuant to an approved surrogate motherhood arrangement should be surrendered immediately upon birth to the social parents. Where a surrogate mother refuses to transfer the child, the court should order that the child be delivered to the social parents. In addition, where the court is satisfied that the surrogate mother intends to refuse to surrender the child upon birth, it should be empowered, prior to the birth of the child, to make an order for transfer of custody upon birth.

50. Where, following approval of a surrogate motherhood arrangement, there has been a change in circumstances, or new information has become available, indicating that the approved social parents are unsuitable to receive the child, the surrogate mother or the children's aid society should be permitted to apply, at any time prior to the date of the birth of the child, for a review of the approval of the surrogate motherhood arrangement, and the judge should be empowered to rescind the agreement.

* 51. Legislation should provide that no payment may be made in relation to a surrogate motherhood arrangement without the prior approval of the court.

52. In light of Recommendation 56, to the effect that, upon the birth of a child pursuant to an approved surrogate motherhood arrangement, the social parents will be the parents of the child for all legal purposes, legislation should not require that surrogate motherhood agreements contain special provisions dealing with legal responsibility for a handicapped child that is born pursuant to a surrogate motherhood agreement.

53. The court should be required to ensure that a surrogate motherhood agreement contains adequate provision dealing with the allocation of the power of decision relating to the medical care of a newborn handicapped child, and with the nature of that decision.

54. The matter of spontaneous abortion during a surrogate pregnancy should be left to agreement between the parties, as should the possibility that conditions may arise that justify a therapeutic abortion in accordance with the *Criminal Code.*

55. (1) The parties to a surrogate motherhood agreement should be free to

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* Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, disagrees in part with this recommendation: see *supra*, ch. 6, note 381.

include in the agreement terms of their choosing; however, they should be required to consider, and to agree upon a resolution of, the following issues:

(a) health and life insurance protection for the prospective surrogate mother;

(b) arrangements for the child should the intended social father or mother, or both, die before the birth of the child;

(c) arrangements for the child should the intended social parents cease to live together as a couple;

(d) circumstances regarding the particular manner in which immediate surrender of the child to the social parents is to be effected;

(e) the right, if any, of the surrogate mother to obtain information respecting, or to have contact with, the child after surrender;

(f) prenatal restrictions upon the surrogate mother's activities before and after conception, including dietary obligations; and

(g) conditions under which prenatal screening of the child may be justified or required, for example, by ultrasound, fetoscopy or amniocentesis.

(2) Provided that the parties have considered each issue, they need not be required by the court to include in the agreement a term relating to that issue.

56. Upon the birth of a child pursuant to an approved surrogate motherhood arrangement, the social parents should be recognized as the parents of the child for all legal purposes, and the surrogate mother should have no legal relationship to the child.

57. Where a child is born prematurely, after an application by the surrogate mother or the children's aid society to review the surrogate motherhood arrangement (see Recommendation 50), but before the court has determined the matter, the court should have the power to make an order that the social parents are not to be recognized in law as the parents of the child.

58. The birth of a child pursuant to an approved surrogate motherhood arrangement should be registered under the *Vital Statistics Act,* showing the social parents as the mother and father. The surrogate mother should not be named in the register of births; nor should the fact that the child has been born to a surrogate mother appear in the register.

59. Children born pursuant to an approved surrogate motherhood arrangement should acquire inheritance rights through the approved parents. The child should have no inheritance rights against the estate of the surrogate mother simply by virtue of the biological relationship.

60. The Ministry of Community and Social Services should be required to regulate any agencies that arrange surrogate motherhood agreements.

61. Where a woman undergoes *in vivo* fertilization of an ovum intended for donation and becomes pregnant, she and the intended social parents should be able to apply to the court for approval of a surrogate motherhood arrangement in accordance with our previous recommendations. In approving the arrangement, the court should be empowered to determine unresolved terms of the agreement where all parties have approved the terms in principle, but have been unable to settle the details thereof by the time that the application for approval is presented.

62. Where an approved surrogate mother who is the intended recipient of a fertilized ovum becomes unavailable, there should be a summary procedure for the approval of a replacement surrogate mother where this is necessary to secure transfer of the fertilized ovum in order to avoid its wastage.

63. For the initial period during which surrogate motherhood agreements are regulated by statute, no specific provision should be enacted to address the question of such agreements made outside Ontario and intended for implementation in the Province.

64. No legislation need be enacted concerning the maintenance of medical records specifically in the context of surrogate motherhood. Rather, the previous recommendations dealing with medical records relating to the provision of artificial conception services should apply (see Recommendation 22).

65. A penalty of a fine should be provided for participation in a surrogate motherhood arrangement where it is known or believed that the arrangement is intended to evade the proposed regulatory scheme. However, where a professional whose assistance is sought is confronted with a *fait accompli* — for example, where an obstetrician is asked to deliver a pregnant surrogate mother's baby — he or she should not be subject to the proposed penalty for giving such assistance.

66. (1) Social parents who acquire custody of children born pursuant to unapproved surrogate motherhood arrangements should be allowed to utilize existing procedures, as modified by paragraph (2), to establish their parentage in law after the fact.

    (2) Where social parents seek an adoption order in relation to a child who is born pursuant to an unapproved surrogate motherhood arrangement and transferred to them, notice of the application should be served upon the appropriate children's aid society. Upon receipt of the notice, the children's aid society should be required to conduct a homestudy and submit to the court a report in relation thereto.

FURTHER REVIEW

67. Five years after the recommended regulatory regime has been implemented in whole or in part, a review of all aspects of the regime should be undertaken by an appropriate governmental body.

VICE CHAIRMAN'S DISSENT

We live in a world of impressive and burgeoning technological change. As an institution responsible for advising on the means for acceptable social ordering through law, we are deeply conscious of the necessity of formulating policy with these terms of reference in mind. We would ignore them at our peril. That is not to say, however, that all developments of high technology carry with them their own categorical imperative. In the realm of the physical sciences, the decision to manufacture and use the atomic bomb was not inevitable simply because the technology was available. The decision transformed the course of world events to the detriment of all mankind — friend and foe alike! It will not be easy, as we have experienced, to reverse this process, but it is vital that it be done since human survival depends upon it.

Likewise, in the realm of the health and related sciences, we are on the threshold of unlocking the mysteries of life itself. Many of the developments in medical science are applauded and welcomed because they, self-evidently, promote the betterment of the human condition. Others can be accepted with the controls necessary to ensure this result. Still others may have to be rejected, at least for our time, to accommodate our perception of an acceptable, just and workable society. I believe firmly that we can be the masters of our own destiny, both individually and collectively. At each fork in the path of our restless striving to build a better world and more civilized society, there are critical choices to be made. With an evolving sense of justice, may we have the abundant wisdom and courage to address these issues and make these value judgments in the best interests of our wider human society.

The directed study by this Commission of Human Artificial Reproduction and Related Matters has been an extremely burdensome and anxious task involving, as it must, many fundamental moral, ethical, social and legal issues. Not surprisingly, in this context, the nature of firmly held convictions on many major issues has led to a division of views. It is a matter of great personal regret to me that I must record my dissenting view with respect to two critical issues decided by my colleagues.

The first involves the status of those who would be eligible to apply for state subsidized medical assistance through the utilization of the artificial reproduction technologies. The second issue is whether surrogate motherhood should be permitted and, if so, what legal regime should be fashioned to accommodate it.

On the first issue, my colleagues have recommended that stable single women, and stable men and women in a stable marital or non-marital union, should be eligible to participate in an artificial conception programme. I would restrict eligibility for participation in this type of programme to couples in a stable marital union. In doing so, I am not unmindful of, nor indifferent to, the perceived hardship such a prescription might visit upon those who either do not wish to marry or are not free to marry. My reasons are pragmatic, in a sense,

but they do involve a consideration of the best interests of parents and children alike. Our existing legal regime governing the family relations is predicated upon the fact that the procreation and rearing of children should take place within a marital union. It is admitted that there are exceptions made for the legitimacy of children born outside marriage and the imposition of mutual support obligations for partners, in certain circumstances, in non-marital unions, but these exceptions are morally defensible and necessary. In my view, they also serve to reaffirm the existence of the basic principle of our social ordering to which I have alluded.

Recently, a judge in British Columbia was asked to entertain an application for the enforcement of a support obligation in favour of one party in a lesbian union who had been artificially inseminated and had given birth to a child. The other party had consented and encouraged resort to these procedures in order that they might live as a "family", but she later withdrew from the union. The court, in dismissing the application, held that the legal prescriptions relevant to the family relations did not countenance this type of union and, accordingly, the remedy sought was not available. I do not pause here to contemplate whether one day this may all be changed and that marriage, as we know it, may cease to be the societal imperative that it is today. If and when that day arrives, I anticipate that the whole fabric of the law will have to be refashioned to accommodate this change in its basic premise. To accept and encourage resort to the artificial reproduction technologies by persons outside a stable marital union under the existing legal regime, in my view, is to sow the seeds of injustice, hardship, and social disorder and I would oppose it.

The issue whether or not to permit surrogacy within Ontario is more complex and equally troublesome. I remind myself that this issue was the immediate cause for the Reference having been made to this Commission by the Attorney General although, admittedly, the terms of reference were framed more broadly. The majority of my colleagues on the Commission, after the most anxious consideration, have decided to recommend that surrogacy be permitted and have also recommended the enactment of an elaborate legal regime within which surrogacy would be recognized and administered.

Again, I regret having to record my dissent from the basic decision to permit surrogacy, but have no reservation whatever in saying that if it is to be permitted, then all the legislative controls recommended by my colleagues are essential in order to attempt to contain the practice within acceptable societal norms and to minimize its potential for injurious social results.

I am encouraged in my opposition to the basic principle of permitting surrogacy by the knowledge that this view is shared in the reports of multi-disciplinary groups studying this specific issue in the United Kingdom and Australia.[1] It is also apparent that a substantial body of public opinion in the

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[1] Indeed, in Victoria, the recently enacted *Infertility (Medical Procedures) Act* 1984, No. 10163, provides *inter alia,* that a person shall not "make, give or receive, or agree to make, give or receive, a payment or reward for or in consideration of the making of a contract, agreement or arrangement under which a woman agrees to act as a surrogate

United States also favours this view. This is reflected in the fact that a number of state legislatures are contemplating prohibitory legislation. It should be added that my views crystallized even before the appearance of the reports referred to and, in that sense, were arrived at quite independently. Understandably, however, in rationalizing and formulating my reasons for decision, I have drawn heavily upon what others have thought and written.

Perhaps it is unnecessary to say that I am very much aware that for an uncertain, but I suspect a small number, of married couples, surrogacy may exist as a remedial practice of last resort. In taking a position that would deny this relief to them, I trust I will not be viewed as lacking in compassionate feeling. Essentially, the issue involves a critical balancing of societal interests and, in my view, the scales are tipped substantially and irreversibly in favour of a legal and social rejection of the practice.

The fundamental objection to the practice of surrogacy is its potential for exploitation. In an American study involving 125 women who had applied to act as surrogate mothers, it was found that in nearly every case a substantial fee was an essential precondition for participation in a surrogate arrangement.[2] In the only Ontario case which has been litigated, it was alleged that a fee of $10,000 was agreed to be paid to the surrogate. It is not suggested that a fee of this magnitude is exorbitant having in mind medical expenses, fees for psychological screening and counselling of the surrogate during and after pregnancy, living allowance for the surrogate during pregnancy, possible loss of salary or wages during pregnancy, etc. Added to these costs is that of a substantial fee usually payable to the surrogacy agency through which the arrangement was negotiated.

The reality of the practice is that surrogate mothers conceive and give birth to children with the intention of handing them over to someone else. This is usually done for a fee. The concept is totally foreign to a legal system such as ours in which we have sought to diminish exploitation of women and children by proscribing payment in the adoption process. The analogue may not be complete but it is close enough to be perilously relevant. It is also interesting to observe the growing support, in the search for control of prostitution, for the creation of criminal offences involving the male client. Surely this is a defensible means of achieving more effective control of a practice which is also basically exploitive.

My colleagues have striven valiantly to deal with the issue of payments and would limit the nature and quantum of the payment to that approved by the court. I am not sanguine about the enforceability of these strictures in a context where both parties to a surrogacy agreement are prepared to have funds change hands outside the agreement. Unhappily, collusive agreements are neither novel nor

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mother" (s. 30(2)(b)) or "receive or agree to receive a payment or reward or consideration for acting, or agreeing to act, as a surrogate mother" (s. 30(2)(c)). It further provides that "[a] contract or agreement (whether made before or after the commencement of this section) under which a woman agrees with another person or other persons to act as a surrogate mother is void" (s. 30(3)).

[2] See Parker, "Motivation of Surrogate Mothers: Initial Findings" (1983), 140 Am. J. Psychiatry 170.

infrequent where the desires of the parties coincide in the pursuit of an unlawful purpose.

In dwelling upon the issue of the payment of a fee, I do not suggest that all actual or potential surrogates are prompted by strictly mercenary motives. Indeed, during the course of our study, I have been privileged to hear a panel presentation by an American surrogate and her husband involving an arrangement where no fee, presumably apart from medical expenses, was involved. One was greatly impressed by the sincere altruism which motivated this couple in their concern for others less fortunate than they. However, in the unfolding of this moving human drama, there was a terminal jarring note. In answer to a direct question of why she did it, the surrogate responded that she had done it to help her male superior at the office. Again, I am persuaded that in this particular case, there was no improper motive even in these circumstances. One need not be a total cynic, however, to see the fatal flaw in this arrangement. Quite obviously, surrogate agreements have the potential for exploitation, even in circumstances where direct payments are not being made.

On another point, in the instant case, the husband of the surrogate had had a vasectomy but the presentation also disclosed that following her artificial insemination by the genetic father, the husband of the surrogate thought it advisable to check the effectiveness of those operative procedures. Presumably this precaution was directed to the possibility of her retention of the child in the event that her husband was found to be the father of the child. This, of course, raises another source of conflict and difficulty with respect to surrogacy. Although the experience with surrogacy to date is relatively limited, there are already a number of significant cases where things have actually gone awry and one does not have to rely entirely on scenarios which are the product of a fertile imagination. At least one American case has already been litigated on the issue of proper identification of the father of the surrogate child. Surrogate agreements would normally involve an undertaking of abstinence from spousal sexual relations during the relevant periods of surrogate conception. In this case, the child born to the surrogate mother was abnormal and the purported genetic father disclaimed paternity. The court so found.

Surely there are few issues in human social and legal experience so fraught with difficulty and anxiety as that of compulsory surrender of a young child by its mother. Solomonesque judgments are superficially attractive in the abstract, but in real life they are simply not permissible.

There are other areas of concern involving the conduct of the surrogate mother which are quite beyond the power of the court and the contract to control adequately. Common prudence would dictate that the surrogate agreement would deal specifically with the obligation of the surrogate to take proper prenatal care. This human instinct is compelling during gestation of one's own child, although it may often be disregarded through ignorance. The contractual obligation arising from the surrogacy agreement may not be nearly so compelling and the possibility of its breach surely cannot be said to be in the best interests of the child in any

way. The absence of any assurance that it will be observed in natural reproduction is no justification for accepting the risk in cases of artificial reproduction through surrogacy.

Because many of the concerns arising from artificial reproduction through surrogacy cannot be quantified, at least with our present limited experience, it does not mean that we are justified in ignoring them. In this category, we would place the avowed concerns involving the psychological effects on existing children of the surrogate mother when confronted with the fact that their mother is having a child which is to be given away at birth. Is such a situation conducive to their best interests?

Likewise, we are aware of the shifting sands of opinion, expert and otherwise, concerning the desirability and effects of disclosure to the child of information of the circumstances of its birth. We have been wrestling with this problem in the area of adoption for quite some time now and, unhappily, we do not seem to be any closer to an acceptable solution. Surrogate birth simply exacerbates that difficult human problem. When viewed in the abstract, the solution may seem relatively easy. Its application in individual cases is always difficult, troublesome and unsatisfactory. In this connection, one may well question the futility of the exercise of the young lady in California who is pledged to devote her lifetime and all her resources to establishing the identity of her genetic father. She was prompted to do so because she learned that her mother had been artificially inseminated by a semen donor. The practice at the time of her birth was to rely heavily on medical student donors as a source of human gamete material, but her desire to know is not otherwise based on medical reasons. Although it is reported that she has narrowed the field substantially, one suspects that her goal is proving to be frustratingly elusive and the task of identifying and locating gamete genetic siblings has not yet begun.

It would be tedious for the reader of this Report for me to attempt to recanvass all the issues of surrogacy which have been dealt with in the substantial chapter devoted to it. I have attempted to visit in this dissent the most obvious obstacles to the acceptance of surrogacy as an alternative means of childbearing. I have considered very carefully the responses of my colleagues and the statutory scheme which they recommend for eliminating them. I regret that I am not persuaded to their point of view. Like the Report of the Warnock Committee in the United Kingdom, I would reject the practice of surrogacy, recommend that surrogacy agencies be prohibited, recommend that the present law with respect to the non-enforceability of surrogate agreements on the ground of public policy be retained, and recommend that a provincial offence be created with respect to any professional assisting in the establishing of a surrogate pregnancy. I am conscious, of course, of the fact that couples may seek to fulfill their desires in this respect by going outside the jurisdiction, but there would appear to be little that one can do about this within the limits of the constitutional competence of the provincial legislature.

CONCLUSION AND ACKNOWLEDGMENTS

1. CONCLUSION

In the course of this Report, we have considered many difficult and controversial issues concerning human artificial reproduction. As we have observed, there is no community consensus with respect to the resolution of some of these issues, but rather divergent, and indeed often conflicting, positions. Whether these differences simply reflect the extremely intimate, sensitive nature of the subject or, more profoundly, particular philosophical or moral views, matters little. What is important is that there clearly are differing perceptions in the community, which no doubt will contribute to a vigorous debate after this Report has been published.

In anticipation of continuing controversy about many of the issues, it is important to emphasize that our task in this Reference has been not only to fashion solutions to legal problems, but also to construct a sturdy foundation of analysis and information for the public debate that is sure to follow.

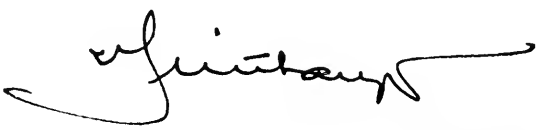
2. ACKNOWLEDGMENTS

For their assistance in this task, we wish to express our sincere appreciation, once again, to Professor Bernard M. Dickens, of the Faculty of Law, University of Toronto, the Consultant to the Project, to the members of our Advisory Board, and to the artificial insemination and *in vitro* fertilization specialists who met with representatives of the Commission. The Commission benefited from their learned guidance during the course of this Reference.

We wish also to express our gratitude to Mr. M.A. Springman, Senior Legal Research Officer, and Mr. Larry M. Fox, Legal Research Officer, for their scholarship and dedication in the writing of this Report and in bringing this

Project to a successful conclusion, and to Ms. M. Patricia Richardson, Counsel to the Commission, for her invaluable assistance in the preparation of this Report.

All of which is respectfully submitted,



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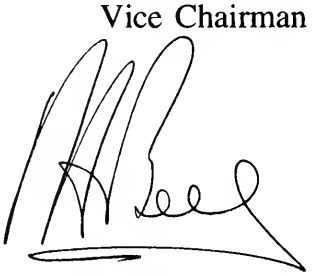

Richard A. Bell
Commissioner

William R. Poole
Commissioner

Barry A. Percival
Commissioner

March 15, 1985

APPENDIX

REFORM AND PROPOSALS FOR REFORM IN OTHER JURISDICTIONS

1. INTRODUCTION

As we have indicated in chapter 5, during the past several years there has been an increasingly avid interest in human artificial reproduction. In addition to a burgeoning literature, legislation and regulatory guidelines have been adopted or proposed in respect of the new technologies.

The material reviewed in this Appendix canvasses the medical, legal, ethical, social, and other issues addressed by reports, legislation, and guidelines from jurisdictions outside Ontario. While we cannot be exhaustive in our review, the material selected represents a broad cross-section of the ways in which informed bodies and legislatures have attempted to deal with the problems generated by the new artificial conception technologies.

2. RESEARCH AND REPORTS

(a) CANADA

(i) British Columbia, Royal Commission on Family and Children's Law

In 1975, with the guidance of a multidisciplinary Working Group, the British Columbia Royal Commission on Family and Children's Law published a Report on artificial insemination.[1] The Commission's main concern was "to safeguard the interests of all the parties involved" by means of "some protective regulation".[2] It did not "[attempt] to judge whether this procedure should be encouraged or discouraged".[3]

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[1] British Columbia, Royal Commission on Family and Children's Law, *Ninth Report of the Royal Commission on Family and Children's Law: Artificial Insemination* (1975) (hereinafter referred to as "British Columbia Royal Commission Report").

[2] *Ibid.*, at 2.

[3] *Ibid.*

The Commission, after cataloguing several situations where legal liability might result from A.I.D.,[4] concluded "that when a child is conceived through AID within marriage, all the legal protections of the marital relationship should be automatically in force".[5] The Commission then continued with a wide-ranging recommendation dealing, *inter alia*, with the need for written consents from the recipient and her spouse, full disclosure, and the absolving of the doctor from liability where he has "carried out a standard level of care".[6] It stated that, where the husband consents to the insemination, and whether the sperm is that of the husband or a donor, the child should have the same legal standing as a child conceived naturally with the husband's sperm. Accordingly, the husband would have responsibility to support the child and the child would have full rights of inheritance. Moreover, the "donor should remain anonymous and should not be held liable for support of the child, nor should he be allowed to claim access or other rights to the child".[7]

The Commission next turned to the "ethical issues" involved in A.I.D. Emphasis was placed on the need to protect certain "human values" as well as the interests of society and those involved in the procedure, while not resisting beneficial technological innovations.[8] In this context, it considered eligibility for participation in A.I.D. The Report assumed, without explanation, that some screening of prospective recipients by physicians was necessary, although it did discuss the standards applicable to such selection.

The Commission began with the assertion that "[i]n principle, rules as to eligibility for AID should be the same as for adoption".[9] In view of the importance of the Commission's assumption that the ability to become a "successful" parent was critical in evaluating a potential A.I.D. recipient, the full discussion is reproduced here:[10]

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[4] *Ibid.*, at 3-5. The Commission stated that some of its concerns would be removed by implementing other Commission proposals respecting the abolition of illegitimacy: see British Columbia, *Fifth Report of the Royal Commission on Family and Children's Law,* Part II, *The Status of Children Born to Unmarried Parents* (1975).

[5] British Columbia Royal Commission Report, *supra*, note 1, at 5.

[6] *Ibid.* Although the Commission believed that, "[i]n terms of AID, the physician at present will probably be held liable only if he fails to exercise reasonable care during the insemination procedure or in the selection of a donor or sperm bank" (*ibid.*, at 21), it expressed some concern that strict liability might be imposed. The Commission's proposal was as follows (*ibid.*, at 25, recommendation 15 (emphasis in original)):

> A new statute should impose a negligence standard on the doctor, and expressly exclude any concepts of implied warranties. However, if the doctor's consent form and counselling did not include a *full disclosure* of the risks involved, this omission should be seen as constituting negligence *per se* in the event of any problems caused by the procedure which are experienced by the baby or the recipient.

[7] *Ibid.*, at 6, recommendation 1.

[8] See *ibid.*, at 9, recommendation 2.

[9] *Ibid.*, at 10.

[10] *Ibid.*, at 10-11. See, also, recommendation 3, *ibid.*, at 11.

> Who, then, should be eligible for AID? One approach to a decision might be the development of a test of 'ability to nurture', which would involve guidelines describing generally the types of emotional and social variables which seem essential to success in parenting a child. The potential recipient would be evaluated on her ability to meet these guidelines and would not be eliminated from consideration just because of her marital status. This 'ability to nurture' test would include the concepts of guidance and a stable home environment as well as the recipient's ability to provide for the child's needs. In our Report on Children's Rights, we suggested that the child's needs can be expressed as a legislative standard. The mother's ability to meet this statement of Children's Rights (see Appendix II) should be the main criterion as to her ability to nurture a child.
>
> The guidelines, moreover, would also involve an evaluation of the physical and mental health of the potential recipient. It is suggested that an attempt to judge the recipient in terms of her conformity to prevailing mores about marriage and lifestyle should be made in the context of their current state of flux and, more importantly, should concentrate on the conduct of the individual which can be shown to relate quite directly to her ability to nurture. As suggested above, the central concern in evaluating the prospective AID recipient should focus directly (and singularly) on her ability to be a successful parent. It is the potential child's interest which must be paramount in this situation.[11]

Notwithstanding, then, that the guidelines would require an evaluation of more than simply the health of the applicant, the Commission recommended that a physician ultimately should use his own professional judgment, on the basis of certain guidelines, to decide whether to accept or refuse a candidate.[12]

With respect to the selection of donors, the Commission offered recommendations designed "to avoid the embarrassment of unintended exposure of the child's origin".[13] For example, except where medically undesirable, "the selection of the prospective donor should allow as far as possible for inheritance of blood characteristics compatible with paternity by the child's presumed father".[14] The desire to preserve the anonymity of the donor was reflected in the further proposal that "[t]he donor and recipient family should remain unidentified to each other" and that "the donor should commit himself to refrain from

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11 With respect to eligibility, the Commission later recommended that "[a] set of guidelines should be developed by which a physician may apply medical and social criteria in deciding whether to provide artificial insemination for an applicant requesting it": *ibid.*, at 20, recommendation 14.

12 *Ibid.*, at 11, recommendation 4. The Commission further stated that "an individual physician has the right to refuse a request for AID": *ibid.*, at 12. The Commission rejected the notion that the physician should be required to have "the backing of a number of colleagues acting as a tribunal", since "sheer numbers in such a body might jeopardize the confidentiality of the situation": *ibid.*, at 11.

In this connection, reference should be made to the recommendation that a rejected A.I.D. applicant should be entitled to appeal to a specially constituted tribunal "representative of medicine, social sciences and appropriate agencies of government": *ibid.*, at 12, recommendation 5.

13 *Ibid.*, at 14, recommendation 8.

14 *Ibid.*

seeking out the recipient family or the child".[15] Moreover, "[n]either the donor, nor a child conceived by artificial insemination, should have any claim over the other, such as inheritance rights".[16]

The psychological and other effects of donation on a donor and his family were also considered in the Report. In addition to the provision of "special counselling", it was proposed that "[t]he donor's signed consent should absolve the physician and the recipient of any liability in the event that there is an allegation that adverse psychological effects have been produced by the procedure".[17] It should be noted that the Report did not suggest that the spouses of donors must give their consent prior to donation.

The Commission then turned to general medical considerations, particularly the "medical, biological, or genetic documentation of the donor". Ordinarily, such documentation would not be of much interest[18] and, therefore, ought to be confidential. Moreover, the Commission had recommended generally that "[t]he child should not have the fact of his origin by artificial insemination divulged to him".[19] However, as an exception, the Report recommended that "[s]ome system should be devised, without susceptibility to breach of confidentiality, whereby appropriate investigation and counselling may be launched if a genetically determined disease should become manifest in the donor or the child conceived by artificial insemination, following the procedure, if in the opinion of a geneticist or genetic counsellor this information may be important to the reproductive planning by the person concerned".[20]

To help avoid the transmission of disease by diseased sperm donors who may be anxious to make a profit from repeated donations, the Commission recommended that "a limit should be placed upon the numbers of successful sperm donations that may be provided by any individual donor. An arbitrary number might be six".[21] In addition, a donor "should receive full and adequate recompense for his time, expenses and the loss of any revenue that he may sustain in making himself available for sperm donations, sufficient to enlist his cooperation"; however, "it would seem inadvisable to pay him a price for the seminal fluid itself".[22]

Concerning the effect of A.I.D. on the registration of births, the Commission expressed the view that "[n]o significant reasons have been advanced for suggesting that the fact of AID should appear on, or be ascertainable from, the

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15 *Ibid.*, at 15, recommendation 9.

16 *Ibid.*, at 19, recommendation 13.

17 *Ibid.*, at 16, recommendation 10.

18 *Ibid.*, at 18.

19 *Ibid.*, at 14, recommendation 7.

20 *Ibid.*, at 27, recommendation 16.

21 *Ibid.*, at 19, recommendation 12.

22 *Ibid.*, at 23.

registration of birth or any related records in the Division of Vital Statistics".[23] Again, the principle of confidentiality was emphasized.

It was noted that, while a married woman living with her husband must register "the particulars of the husband as those of the father of the child", the physician's duty to submit a notice of birth, with the name of the father,[24] may make him reluctant to record the husband as being the father where he is aware of the use of A.I.D. In order to ensure the secrecy of the fact of A.I.D., the Commission recommended that the physician be required to "enter on the notice the name of the husband of the mother as being the name of the father".[25]

The Commission then turned to the accessibility of "confidential information relating to research, quality control of AID services, and, in some instances, to the future health and genetic interests of an individual".[26] The Commission recommended that such information "should be stored for restricted retrieval in the physician's confidential files".[27] The only exception made was in the case of confidential information collected by fertility clinics[28] attached to sperm banks.[29]

The last section of the Report dealt in more detail with sperm banking. The Commission expressed its view that, given "the many unanswered questions"[30] with respect to collection, storage, documentation, and confidentiality, and given the need for further research concerning sperm storage, "a sperm storage facility should be restricted to an institutional base in which there is accountability, both to society through the government,[31] and to the most critical academic and professional authorities, through a university based sponsorship or joint sponsorship".[32] The "institutional base" should "preferably [be] connected with a

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23 *Ibid.*, at 27.

24 See, now, *Vital Statistics Act,* R.S.B.C. 1979, c. 425, ss. 2 and 3(6)(b).

25 British Columbia Royal Commission Report, *supra*, note 1, at 29, recommendation 17.

26 *Ibid.*, at 30.

27 *Ibid.*, at 31, recommendation 18.

28 *Ibid.*

29 *Ibid.*, at 30. The Commission stated that, with respect to information stored in sperm banks, "[p]olicies relating to content, confidentiality, retrievability, and authorization for access could be established to serve the interests of society and the individual" (*ibid.*).

30 *Ibid.*, at 32.

31 The Commission recommended (*ibid.*, at 33, recommendation 21):

> 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.

See *infra*, sec. 2(a)(iii).

32 *Ibid.*, at 32. See, also, *ibid.*, recommendation 19.

research and service component relating to problems of human infertility".[33] To minimize problems, "[p]rivate or commercial sperm banks should not be recommended unless their facilities and services are subjected to close governmental surveillance".[34]

(ii) Alberta, Institute of Law Research and Reform

In 1976, the Alberta Institute of Law Research and Reform published its Report on the *Status of Children.*[35] Chapter XII dealt solely with the question of legitimacy in the context of artificial insemination.[36] The Institute's recommendations were as follows:[37]

> (1) That if a married woman is artificially inseminated with semen all or part of which is donated by a man other than her husband
>
> (i) the donor not be in law the father of the child, and
>
> (ii) the husband be in law the father of the child if he consents to the artificial insemination but not otherwise.
>
> (2) That subsection (1) apply with necessary changes to a woman and a man who without being married cohabit throughout the year preceding the child's birth, but only if the man also consents to assume the responsibilities of parenthood.

The Institute stated that it is "far from clear" that the child's best interests would be advanced by legally obliging a nonconsenting husband to take responsibility for the child, given that his lack of consent evinces an unwillingness to do so.[38]

(iii) Health and Welfare Canada, Advisory Committee on the Storage and Utilization of Human Sperm

In 1981, the federal Advisory Committee on the Storage and Utilization of Human Sperm submitted its Report.[39] Emphasizing the need for provincial legislation,[40] the Committee warned that continuing uncertainty in the law and the "legal risks to donors and physicians"[41] may well lead to a considerable

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33 *Ibid.*, recommendation 19.

34 *Ibid.*, recommendation 20.

35 Alberta, Institute of Law Research and Reform, *Status of Children* (Report No. 20, 1976).

36 "[W]e are not concerned in this Report with regulation of the practice of artificial insemination nor with its ethical, sociological, religious or psychological implications": *ibid.*, at 91.

37 *Ibid.*, at 93. See, also, Draft Bill, s. 8.

38 *Ibid.*, at 92.

39 Canada, Health and Welfare Canada, *Report of the Advisory Committee on the Storage and Utilization of Human Sperm* (1981) (hereinafter referred to as "Health and Welfare Canada Report").

40 *Ibid.*, Letter of Transmittal, at 1.

41 *Ibid.*, at 31.

restriction of the procedure and, perhaps, to an increased use of A.I.D. from "unregulated sources".[42]

After noting that, in Canada, there were fewer A.I.D. births involving congenitally defective children than might have been expected in the same number of births in the general population,[43] and that emotional reactions that might harm the new family appear to be rare,[44] the Committee concluded that "AID is a socially acceptable and beneficial medical procedure".[45] However, the Committee was equally clear that "the bearing of a child by AID is neither a right which should be claimed by anyone nor an obligation which should be imposed upon anyone".[46]

Chapter I dealt with the issue of legitimacy.[47] To rectify the present unsatisfactory state of the law, the Committee recommended the enactment of legislation "extending the definition of legitimacy to include children born through AID to which the husband[48] of the mother has consented in writing".[49] Where such consent has been given, the name of the mother's husband would be entered as the name of the father.[50] Unfortunately, the Committee did not indicate why the status of the child ought to depend on written consent.

In chapter II of the Report, the Committee recommended that federal regulations should establish standards in respect of the acquisition, preservation,

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42 *Ibid.*

43 *Ibid.*, at 12.

44 *Ibid.*, at xi. See text accompanying notes 67-73, *infra*. With respect to the effect of A.I.D. on the marriage, the Committee concluded that, "in principle", A.I.D. need not involve "a violation of the exclusivity and totality characteristic of the structure of the marriage relationship": Health and Welfare Canada Report, *supra*, note 39, at 37. A.I.D., therefore, need not be morally rejected as a matter of principle.

45 *Ibid.*, at xi.

46 *Ibid.*, at xii.

47 It is interesting to observe that, to buttress its view that A.I.D. children should be considered legitimate, the Committee stated categorically that, "[i]f parents wish to have a child by AID they must surely be prepared to accept that child as a full member of the family unit and to provide for his or her needs and protection": *ibid.*, at 2. See, also, *ibid.*, at 42: "There is explicit acceptance ... of [the couple's] joint responsibility for any children conceived through AID perhaps even more responsibility than is felt by many couples conceiving 'normally'."

48 "The committee was not able in the time available to discuss the subject [of the use of A.I.D. for the fertilization of a woman without a 'male partner'] in sufficient depth to form recommendations": *ibid.*, at 46.

In chapter IV, the Committee listed several vital questions "that direct attention to some of the principal conditions which have to be considered in elaborating the ethics of AID": *ibid.*, at 38. For example, one set of questions related to whether the proposed recipients — a homosexual or unmarried couple or person — could give "a sufficient guarantee of stability": *ibid.*, at 38, para. 2.

49 *Ibid.*, at 3, recommendation 1.1. See, also, *ibid.*, at 3, recommendation 1.2.

50 *Ibid.*, at 4, recommendation 1.3.

and importation of sperm.[51] In addition to recommending donor screening in order to ensure medical[52] and psychological suitability,[53] and donor interviews and counselling,[54] the Report discussed the potential problem of propagating genetically defective children on a large scale and of increasing the chances of "inadvertent consanguinity".[55] It proposed that "[d]onor selection procedures should ensure that a limit to the number of pregnancies from any one donor may be set up".[56]

The Committee was particularly concerned with the importation of sperm and the use of commercial sperm banks. It was of the view that, "[u]ntil regulations establishing federal standards of quality are in effect for Canada, the importation of sperm from commercial human sperm banks should be prohibited; and no new human sperm bank should be allowed to operate outside the jurisdiction of a university or other publicly owned agency".[57]

Chapter III of the Report dealt with guidelines for A.I.D. centres. Indeed, the Committee recommended that "AID be available only where guidelines are met to safeguard the interests of donor, recipient and progeny".[58] The guidelines would relate to record keeping, counselling, consents for A.I.D., insemination procedures, and "procedures to be followed if an infant is born with an abnormality".[59]

With respect to whether medical records should link donors and recipients, it was recognized that information concerning congenital defects attributable to a donor's sperm would be valuable to the donor. Yet, there was some concern that the general absence of confidentiality of medical records could prove prejudicial to donors. In addition, it was believed that "it may be impossible to obtain donors if they cannot be assured anonymity".[60]

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51 *Ibid.*, at 5.

52 *Ibid.* See, also, *ibid.*, at xiv, recommendation 2.2. The Committee went into considerable detail with respect to the genetic criteria used to evaluate the donor (and his "first degree relatives"): see *ibid.*, at 7-9. See, also, *ibid.*, at 11-12.

53 *Ibid.*, at 6. The Committee recommended that a psychological evaluation should be made of his wife, if the donor is married: *ibid.*

54 *Ibid.* For example, the donor would be told of "the ethical and legal status of the AID program, record keeping, donor liability and technique of sperm acquisition".

55 *Ibid.*, at 12.

56 *Ibid.*, at xiv, recommendation 2.4. See the suggestions made *ibid.*, at 12.

57 *Ibid.*, at 16 and xiv, recommendation 2.5. With respect to the use of frozen sperm from banks, see *ibid.*, at 29-30. For recent federal developments in this area, see *supra*, ch. 3, sec. 4(b).

58 Health and Welfare Canada Report, *supra*, note 39, at 17.

59 *Ibid.* With respect to the latter issue, see *ibid.*, at 30, where the Committee said that, if an abnormality indicates an appreciably increased risk in respect of the donor's children, "consideration should be given to the donor's right to be informed" of the facts. However, the Committee did not expressly endorse such a right.

60 *Ibid.*, at 20.

On balance, while the Committee endorsed donor anonymity,[61] it advocated the keeping of "linkable records",[62] but only if provincial legislation were enacted to ensure the following:[63]

1) That no legal relationship exists between the donor and the child fathered by his sperm.

2) That the donor has no legal responsibility to anyone arising from the sperm donation if he has given full and accurate answers, to the best of his knowledge and belief, to the questions asked of him by the physician involved, concerning his genetic background and medical history.[64]

3) That the standard of care required by the physician is that of reasonable care and that the physician has no legal responsibility to the child beyond exercising that reasonable care in the obtaining of sperm and the insemination.

In part of chapter III, and in chapter V, the Committee dealt first with the need for comprehensive counselling[65] and clearly written consent forms[66] and then considered the effects of A.I.D. on the family. In the latter connection, the Committee stated, on the one hand, that, "[s]ince the social father accepts his role from the onset of pregnancy, the child is born in accord with the wishes and actions of both parents".[67] On the other hand, the Committee stressed that "[a]n

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61 *Ibid.*, at 21.

62 The Committee recommended as follows (*ibid.*, at 23):

> Thus, if linkable records related to AID are to be maintained, then for the protection of all parties, records should be kept long enough that for practical purposes most genetic defects would be manifest in the child. The committee recommends that records should be maintained which collect all relevant and available information on the donor. A separate record should document the history and the physical, laboratory and follow-up data on the couple and the progeny.

The Report also contained a proposal relating to the discovery and treatment of transmissible genetic defects. The Committee recommended that "routine pooling or mixing of sperm from different donors for artificial insemination should be avoided" (*ibid.*, at 29). The Committee believed, for example, that this procedure "effectively prevents any search for possible cause when a congenital malformation is discovered, or for the identification of patterns of inheritance when a hereditary disorder is discovered" (*ibid.*).

63 *Ibid.*, at 21. See, also, *ibid.*, at 22. Anonymity "could be protected by the statutory establishment of a board with the object of inquiring into any legal claim arising from a genetic or congenital defect in an AID child" (*ibid.*). Where, for example, the donor wilfully gave incorrect information, his name "would be revealed to the parties [but] it would be protected by law from publication" (*ibid.*).

64 The Committee recommended that "provincial legislation be passed to protect the donor from unfounded or frivolous legal action" (*ibid.*, at 25).

65 *Ibid.*, at 26. For details, see *ibid.*, at 25-26.

66 *Ibid.*, at 27. For details, see *ibid.* The information to be given to the couple would be wide-ranging, concerning, for example, the future relationship between the donor, recipient couple, and child.

67 *Ibid.*, at 41. See, also, *supra*, note 47.

immediate and long-term potential for good, and harm,[68] is present",[69] although the measurement of this potential would be exceedingly difficult. For example, there was said to be "no 'marital stability index' to apply to families and no objective techniques for assessing 'successful parents' or 'happy children' ".[70] However, the Committee stated that physicians' reports "are generally positive", and "[q]uestionnaire surveys of the family sometime after the baby arrives have also reported favourably on AID".[71] While stating that, "in truth, no one really knows",[72] the Committee concluded that "[t]he impression gained by the committee is that AID rarely harms and may often strengthen the family".[73]

(iv) Law Reform Commission of Saskatchewan

In 1981, the Law Reform Commission of Saskatchewan published its *Tentative Proposals for a Human Artificial Insemination Act.*[74] The document dealt with pre-insemination issues and the legal position of physicians and others involved in or affected by the procedure. In addition, there was a draft *Human Artificial Insemination Act,* with commentary, appended to the Report.[75]

At the outset, the Report noted the general absence of any "background from which to draw guidance in dealing with" the social, legal, and medical issues connected with the use of artificial insemination.[76] Significantly, the Commission stated that "it is not particularly helpful to adopt conclusions based on analogy to other types of human relationships, legal structures or medical procedures".[77] For example, the fact that the state does not interfere with respect to "natural" procreation does not necessarily mean that no such intervention is reasonable where artificial insemination is contemplated. However, the Commission stated that the "legislation recommended in the report would, if enacted, involve no more intervention in the practice of artificial insemination than

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68 Because, for example, the father may reject the child as not his own, or the mother may reject the husband by "excessive attachment to 'her' child", the child "may be more vulnerable at times of later family stress": Health and Welfare Canada Report, *supra*, note 39, at 43.

69 *Ibid.*, at 41.

70 *Ibid.*, at 41-42. These facts bear on recommendations in several other reports that, for example, prospective couples should be screened as to their suitability for parenthood.

71 *Ibid.*, at 42.

72 *Ibid.*

73 *Ibid.*, at 44.

74 Law Reform Commission of Saskatchewan, *Tentative Proposals for a Human Artificial Insemination Act* (1981) (hereinafter referred to as "Law Reform Commission of Saskatchewan Report").

75 *Ibid.*, at (vi) *et seq.* (hereinafter referred to as "Draft Act").

76 *Ibid.*, at 2.

77 *Ibid.*

appears absolutely necessary to guarantee and protect the basic rights of persons involved".[78]

With respect to pre-insemination issues, the Report stated that one of the most important questions was whether A.I.D. should be restricted to married couples.[79] While the Commission noted the refusal of some physicians to inseminate single women,[80] it stated that such refusal might violate *The Saskatchewan Human Rights Code*.[81] The majority of the Commission recommended that "the social and economic criteria for selection of artificial insemination recipients should, for the time being at least, not be prescribed by law except to the extent that *The Saskatchewan Human Rights Code* now prohibits discrimination".[82] The Report concluded that "[t]he law is not the best vehicle for establishing guidelines for the determination as to who is a good parent and who is not".[83] The Commission stated that, where a married woman seeks artificial insemination, an "important social question ... is whether or not the consent of the recipient's husband should be a prerequisite".[84] A majority of the Commission recommended that "legislation should not specify that a husband's consent be required",[85] although, "as a matter of social policy", the Commission agreed that "physicians should be very reluctant to inseminate a married woman without her husband's consent".[86]

The Commission turned next to a consideration of donor selection, noting the "rather disturbing failure to investigate and screen donors adequately".[87]

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78 *Ibid.*, at 3. For a discussion in this Report of the state's role in the case of artificial conception, see *supra*, ch. 4.

79 Law Reform Commission of Saskatchewan Report, *supra,* note 74, at 1-2.

80 The reason advanced was that the physicians "are not satisfied that a child born into a single parent family will receive the same quality of upbringing and support as a child born to two parents" (*ibid.*).

81 S.S. 1979, c. S-24.1.

82 Law Reform Commission of Saskatchewan Report, *supra*, note 74, at 1-4.

83 *Ibid.*

84 *Ibid.*, at 1-3.

85 *Ibid.*, at 1-4.

86 *Ibid.* While the Commission stated that "[t]he decision as to whether or not to become pregnant is not one in which the law should play a role", and that "[t]he woman who bears a child should be free to make her own choice" (*ibid.*), it should be emphasized that, except insofar as the human rights legislation was involved, the Commission did not comment negatively on the role of the physician in selecting recipients for artificial insemination.

In his dissent, Mr. G.J.D. Taylor, Q.C., responded by saying that he did "not believe that questions of social policy should be left to individual doctors, any more than to individual lawyers" (*ibid.*, at 4-2). Rather, legislation should require the written consent of the husband living with his wife (*ibid.*, at 4-1 to 4-2). His dissent was based on his view that marriage is founded on "mutual trust and respect between spouses" (*ibid.*, at 4-3).

87 *Ibid.*, at 1-8. The Report quoted extensively from Curie-Cohen *et al.*, "Current Practice

This latter fact prompted the Commission to recommend regulations respecting "minimum investigation and screening",[88] at least for the moment: "[o]nce the medical community comes to agreement concerning the minimum requirements, the regulations should be repealed".[89]

The Commission's concern for the health of the participants was reflected in a further proposal that artificial insemination should be carried out only by a licensed physician or by medical personnel acting under the direct control of a licensed physician.[90] However, the Commission did not indicate the nature of the sanction, if any, that should apply where artificial insemination is performed in violation of this injunction.

Turning to the legal position of physicians, the Commission first examined the bases for potential liability to a recipient. While the Commission concluded that the law of negligence and contract should be retained as the basis for setting legal obligations owed by physicians to recipients,[91] some areas were thought to be in need of express regulation. For example, the Commission was concerned with the role of exclusionary clauses in respect of contractual and tortious liability. The Commission stated that "waiver forms" and consent forms "serve a useful purpose and their use should not be prohibited".[92] However, it subsequently recommended that "[a]ny agreement, contractual term or waiver of liability which purports to exonerate a physician or any other person from liability for negligent acts or omissions in connection with artificial insemination or any express warranty or misrepresentation made by the physician or other person should have no legal effect".[93]

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of Artificial Insemination by Donor in the United States" (1979), 300 New England J. Med. 585.

Notwithstanding the Commission's concern respecting the investigation and screening of donors, it stated that "a physician should not be required by law to refuse artificial insemination services after the woman in question has been apprised of the risk and has decided to proceed with the insemination" (Law Reform Commission of Saskatchewan Report, *supra*, note 74, at 1-11). The Commission concluded that, "[i]f the recipient is determined to be inseminated, it is better that the insemination be carried out under medically controlled conditions" (*ibid.*).

88 The Report emphasized that, in some cases, additional investigation and screening may be necessary: *ibid.*, at 1-10 and 1-12 to 1-13, recommendation I(4). See, also, Draft Act, s. 4, and Comment (*ibid.*, at (xix)), and s. 25(a).

89 *Ibid.*, at 1-9. See Draft Act, s. 4, and Comment (*ibid.*, at (xix)). The Commission recommended that "[l]egislation should not specify investigation and screening requirements directed toward ensuring that a donor is matched to a recipient or the husband of a recipient with respect to race, physical characteristics or intelligence" (*ibid.*, at 1-13, recommendation I(5)).

90 *Ibid.*, at 1-12, recommendation I(3). See Draft Act, ss. 3 and 24.

91 *Ibid.*, at 2-5, recommendation II(1). See Draft Act, s. 8.

92 *Ibid.*, at 2-4.

93 *Ibid.*, at 2-5, recommendation II(4). See Draft Act, s. 11. In chapter II, the Commission stated that *The Sale of Goods Act,* R.S.S. 1978, c. S-1, and *The Consumer Products Warranties Act,* R.S.S. 1978, c. C-30, probably did not apply to a contract between an

The Commission then turned to consider the physician's potential liability to a child born as a result of artificial insemination.[94] In the context of prenatal injury actions, the Commission concluded that "[a] physician practising AID would ... be liable to a child born with injuries suffered as a result of damage done to the child while *en ventre sa mere,* if those injuries resulted from his negligence".[95] However, the Report stated that "[a] much more difficult issue concerns the liability of a physician practising AID for damages arising out of the conception itself",[96] where the injuries arise "from the fact that negligence occurred prior to or during insemination".[97] In such a case, the Commission recommended as follows:[98]

> [The child should] be able to recover pecuniary and non-pecuniary damages for losses to which he has been subjected or will, in the future, be subjected, as a result of the fact that he was born with abnormalities which an AID child would not have if the negligence had not occurred. The claimant should be able to recover damages of the kind and in the amount recoverable by a person who initially did not suffer the abnormalities of the claimant, but who suffered abnormalities identical to those of the claimant as a result of the negligent acts or omissions of the defendant.[99]

A.I.D. physician and a recipient: Law Reform Commission of Saskatchewan Report, *supra*, note 74, at 2-3. However, to remove any doubt, the Commission recommended that these statutes should not apply to a contract between a physician or hospital and an A.I.D. recipient: *ibid.*, at 2-5, recommendation II(2). See Draft Act, s. 9.

The Commission also dealt with the applicability of any implied warranty of reasonable fitness, particularly where defects in the semen "could not have been discovered upon reasonable investigation and screening of the donor by an expert": *ibid.*, at 2-4 (footnote reference deleted). The Commission noted that the courts might well apply the warranty even though a contract for professional services was involved. Accordingly, the Commission recommended that "[t]here should not be implied in a contract of service between a physician practising artificial insemination and a recipient any implied warranties as to the semen used in the insemination": *ibid.*, at 2-5, recommendation II(3). See Draft Act, s. 10.

For analogous proposals that deal with the applicability of the implied warranties where a donor is paid for his semen, see *ibid.*, at 3-14 and 3-16, recommendation III(9). See, also, Draft Act, s. 10.

94 It also discussed "wrongful life" actions, that is, those brought by a child — usually mentally or physically impaired — where it is alleged that, but for the wrongful act of the defendant, the child would not have been conceived or, if already conceived, would not have been born alive. However, "wrongful life" actions were not the subject of a specific proposal.

95 *Ibid.*, at 2-8.

96 *Ibid.*

97 *Ibid.*

98 *Ibid.*, at 2-16, recommendation III(6).

99 The rationale for the last portion of this proposal was "to avoid the need to develop an entirely new body of damages law to deal with any perceived peculiarities arising in this context" (*ibid.*, at 2-14). "In other words", the Report explained, "even though an AID child is not in existence when the negligent acts or omissions which caused his injury

A further issue concerned "the physician's duty to report genetic defects later appearing in the donor to the child or the child's parents".[100] The Commission proposals appeared to recognize the difficulties in imposing a duty to inform children and parents of defects discovered after insemination. However, it also accepted the need to keep records:[101]

> Legislation should not be enacted to require a physician who has performed artificial insemination to inform children born as a result thereof, or their parents, of genetic defects in donors of the semen used, where such defects come to the attention of the physician after artificial insemination has been performed.
>
> All physicians practising artificial insemination and hospitals or other medical organizations which provide facilities for artificial insemination should keep such records of all instances of artificial insemination as are prescribed in regulations.[102]

The Commission next considered the statutory standards for civil liability of doctors, hospitals, or others to A.I.D. recipients, their husbands, and children. It first reemphasized its view that, "where possible, medical experts [should] formulate minimum standards of general application, and that generally, physicians in charge of the process of artificial insemination [should] ensure that the investigation and screening necessary in the circumstances is conducted".[103] The Commission then offered several proposals relating to the specific circumstances where a doctor or other person may be held liable.[104]

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occurred, he should be able to recover damages of the kind and in the amount normally recovered by someone who is negligently injured" (*ibid.*). See Draft Act, s. 12.

100 *Ibid.*, at 2-14.

101 *Ibid.*, at 2-16, recommendations II(7) and (8). With respect to the proposed requirement to keep records, see Draft Act, ss. 6, 24, and 25(b).

102 The Commission went on to say, however, that "requirements as to records should not force physicians to abandon the practice of inseminating with sperm from more than one donor per cycle" (*ibid.*, at 2-15), even though the Commission noted earlier that this practice is prompted to some extent by the wish of doctors "to ensure that ... tracing is, if not impossible, extremely difficult" (*ibid.*, at 2-14).

103 *Ibid.*, at 2-17. With respect to proving negligence, the Report noted that "the injury may well have occurred even if the physician had not been negligent": *ibid.*, at 2-21. For example, a donor may conceal indications of transmissible genetic disorders. Since the identity of the donor is unknown to the plaintiff, the former cannot be called as a witness in any litigation to prove that he was, in fact, truthful in his responses to the physician's inquiries prior to donation.

In view of the plaintiff's difficulties, but without seeking to attach liability in all cases where the physician's conduct may have caused the injuries, the Commission "concluded that it is not unfair or unreasonable to place an onus on the physician to establish that he did conduct the necessary investigation and screening": *ibid.*, at 2-22. The reverse onus would serve "to induce physicians to conduct" such tests: *ibid.*, at 2-23. For the recommendations, see *ibid.*, at 2-24 to 2-25, recommendations II(10) and (11). See Draft Act, ss. 14-16. See, also, Draft Act, s. 8.

104 *Ibid.*, at 2-19 to 2-20, recommendation II(9). See Draft Act, s. 13. See, also, Draft Act, s. 8.

The Commission further proposed that, "[w]here the semen used in artificial insemination is exclusively that of the husband of the recipient, the physician should not be required to comply with investigation and screening requirements, although he may decide to do so".[105] The Commission reasoned that "[t]he decision as to whether or not a woman should be inseminated with the semen of her husband is not ... a matter for regulation, but should be a matter of choice for the couple, made in consultation with a physician".[106]

The last section dealing with the legal position of physicians concerned the anonymity of semen donors not specifically chosen by the recipient. The Commission was of the view that disclosure of the identity of donors would discourage donations. Moreover, it stated that the identities of donors, recipients, and resulting children should not be known to each other, to avoid disrupting the lives of the families rearing A.I.D. children.

In view of what the Commission thought was the potential for these identities to become known — for example, in court proceedings — it recommended stricter regulation of the use of information contained in medical records. The Commission offered proposals designed to protect the confidentiality of anonymous donors, recipients, and A.I.D. children, without effectively precluding litigation by denying access to records that indicate the fact of artificial insemination. The Commission was of the view that, where records are admissible, the identity of an anonymous donor must not be disclosed.[107]

The final substantive portion of the Report dealt with the legal position of the recipient,[108] her husband, and the donor.

With regard to the husband, the Report first examined the law respecting child maintenance. Unlike the position under Ontario law, there is no obligation in Saskatchewan to maintain a child to whom one stands *in loco parentis*.[109] In order to "regularize" the relationship between the A.I.D. child and the recipient's husband, the Report recommended that "[w]hen a married woman is artificially inseminated with a donor's semen or with her husband's semen mixed with that of a donor, the resulting child should be treated in law for all purposes

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105 *Ibid.*, at 2-18. See Comment to Draft Act, s. 4.

106 *Ibid.* However, the Commission's statement did not really explain why, even though the actual decision to use A.I.H. might be that of the couple alone, the physician should not be required to comply with the investigation and screening requirements proposed in the case of A.I.D.

107 *Ibid.*, at 2-27 to 2-28, recommendation II(12). See Draft Act, ss. 7 and 24. While the Commission acknowledged that "[s]ituations will arise ... in which the plaintiff or defendant's case would be facilitated if the semen donor were called as a witness", it concluded that "on balance, it is more important to protect the anonymity of semen donors than to facilitate judicial proceedings in those few cases where negligence is alleged": *ibid.*, at 2-26 to 2-27.

108 With respect to whether A.I.D. constitutes adultery, see *infra*, note 111.

109 See *Family Law Reform Act*, R.S.O. 1980, c. 152, ss. 16 and 1(e) (definition of "parent").

as a child of the husband if the husband has given prior consent to the artificial insemination".[110]

With respect to the maintenance obligation of a non-consenting husband, the Commission analogized to the position of a husband *vis-à-vis* the child of his adulterous wife or a child born as a result of sexual intercourse between his wife and another man prior to marriage. The Commission therefore recommended that the same child maintenance obligation should apply in these situations.[111]

Turning to the legal position of the donor, the Commission recommended that, "[e]xcept as provided in the following recommendation, a donor of semen should be deemed not to be a parent of a child born as a result of artificial insemination of a woman with his semen".[112] The Commission's following recommendation, dealing with the status of a donor who was not anonymous, provided that "[a] man who has supplied his own semen for use in inseminating a woman under an arrangement with the woman should be treated in law as the parent" of the resulting child if the donor knew or had reasonable cause to know that the mother was unmarried or was separated from her husband, or that the mother was married and her husband did not consent to the artificial insemination with the donor's semen. This support obligation would terminate when "an unmarried woman marries and her husband has legal support obligations to the child", or "the husband of a married woman has legal support obligations to the child".[113]

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110 Law Reform Commission of Saskatchewan Report, *supra*, note 74, at 3-8, recommendation III(1). See Draft Act, s. 19.

111 *Ibid.*, at 3-8, recommendations III(2) and (3). See Draft Act, s. 21(a) and (b).

While the Commission stated that A.I.D. was "not likely" adultery, even without the husband's consent (*ibid.*, at 3-1), it was of the view that a declaration respecting this matter could have the effect of ensuring the retention of certain provincial rights that depend on whether a woman has committed adultery (*ibid.*, at 2-7). Accordingly, the Commission recommended that "[a]rtificial insemination through the use of a donor's semen should not constitute adultery": *ibid.*, recommendation II(5). See Draft Act, s. 18.

112 *Ibid.*, at 3-14, recommendation III(4). See Draft Act, s. 22(1). See, also, Draft Act, s. 19(a), which provides that, where the recipient's husband has consented to A.I.D., "the donor other than her husband [in the case of a mixed donation] has no legal rights in respect of the child and has no legal obligations and duties as to the maintenance of the child".

113 *Ibid.*, at 3-14 to 3-15, recommendation III(5). See Draft Act, s. 22(2) and (3). See, also, *ibid.*, at 3-15, recommendation III(6), and Draft Act, s. 23.

The Commission's rationale for drawing a distinction between the case where the recipient was unmarried or separated or where her husband did not consent, and the case where the recipient marries and her husband has a legal support obligation or a married recipient has a husband with such an obligation, was as follows (*ibid.*, at 3-9):

> If the recipient is married and her husband has consented to the AID, the donor should have no support obligations toward the resulting child since he can assume that the child will receive adequate financial support from the recipient and her husband. But, if he knowingly supplies semen to be used to inseminate an unmarried woman, or a woman who has failed to obtain the consent of her husband,

The Commission then turned to consider the liability of a donor for statements made to an examining doctor or recipient. While the Report had earlier advocated certain limitations on the rights of recipients and A.I.D. children against anonymous donors, special considerations were said to apply where an arrangement subsisted between the donor and the recipient. In such a case, the Commission recommended that the recipient and the resulting child should have a right of action against the donor for his negligent or fraudulent misrepresentation concerning his suitability as a supplier of semen, or for his failure to disclose his "knowledge of any disease, genetic condition, or medical condition in him or in blood relatives of his, whether alive or dead, which to his knowledge would or would be likely to render him unsuitable as a supplier of semen ...", so long as the donor's wrongdoing induced the recipient to consent to the insemination and the injury suffered resulted from the use of the semen.[114] The Commission buttressed these proposals by recommending that it should be an offence for a donor to conceal certain medical facts relating to his suitability as a donor.[115]

The last topic covered in the Report concerned the payment of donors. After briefly canvassing the arguments for and against payment — including the view that the prospect of payment might encourage concealment of diseases — the Commission observed that "the practical fact is that, if donors were not paid, the supply would dwindle and possibly disappear altogether"; accordingly, "legislation should seek to control the donor selection process to ensure that the risk of transmission of disease is minimized".[116]

(b) UNITED KINGDOM

(i) United Kingdom, Department of Health and Social Security, Scottish Home and Health Department, and Welsh Office

In 1972, an Advisory Group appointed by the United Kingdom Secretary of State for Social Services and the Secretaries of State for Scotland and Wales issued its report on *The Use of Fetuses and Fetal Material for Research.*[117] At the outset, the Advisory Group noted that "it is often difficult to distinguish between

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he occupies a position not unlike that of a man who has inseminated the woman by sexual intercourse. The fact that the semen was administered artificially provides a very weak basis upon which to draw a distinction. He has had direct control over the circumstances of the birth of the child, and therefore, should bear support obligations of a parent until some other person in addition to the mother is legally obligated to support the child.

114 *Ibid.*, at 3-15, recommendation III(7). See Draft Act, s. 17.

115 *Ibid.*, at 3-16, recommendation III(8). See Draft Act, ss. 5 and 24.

116 *Ibid.*, at 3-13 to 3-14.

117 United Kingdom, Department of Health and Social Security, Scottish Home and Health Department, and Welsh Office, *The Use of Fetuses and Fetal Material for Research: Report of the Advisory Group* (1972).

research uses and the diagnostic or therapeutic uses of the work which is being done".[118]

Much of the Report was not directly related to the subject of human artificial conception, since it dealt in large measure with research on the fetus *in utero*, viable fetuses, and dead fetuses. However, the Report also discussed research on the pre-viable fetus[119] and on fetal tissues and material.

Given its importance, the Advisory Group gave its *imprimatur* to research on pre-viable fetuses, under certain conditions. For example, such research should be conducted in hospitals and with the approval of their ethical committees; each ethical committee should first "satisfy itself: (a) on the validity of the research; (b) that the required information cannot be obtained in any other way; and (c) that the investigators have the necessary facilities and skill".[120] In addition, "no member of staff should be under any duty to participate in research on the fetus, fetal tissue or fetal material if he or she has a conscientious objection".[121]

With respect to payments, the Report stated that, aside from charges made to meet the "necessary costs incurred in administering" research facilities, no monetary exchange should be permitted.[122] The Report also proposed that "the relevant institutions should ensure that a record is kept of all ... material supplied or received and of its source and destination".[123]

When it turned to the future control of research, the Advisory Group reiterated its proposal that all research on pre-viable fetuses should be carried out only in hospital departments;[124] in addition, it should be approved by a

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118 *Ibid.*, para. 8, at 2.

119 While the Report appeared to be concerned mainly with a more fully developed pre-viable state than that represented by, for example, an ovum just fertilized, the broad definition of "fetus" to mean "the human embryo from conception to delivery" (*ibid.*, para. 6, at 2) would seem to make the proposals of the Advisory Group at least theoretically germane to our discussion.

120 *Ibid.*, para. 35(3) and (4), at 8.

121 *Ibid.*, para. 43, at 9.

122 *Ibid.*, para. 44, at 9.

123 *Ibid.*, para. 45, at 9.

124 *Ibid.*, para. 47, at 10.

committee of doctors with experience in clinical investigation.[125] The "committee should accept responsibility for ensuring that such investigations are ethical".[126]

Finally, the Advisory Group considered whether research personnel ought to be specially licensed. The Report rejected such a system as "unnecessarily cumbersome". Instead, an easily amended "code of ethical practice would be an adequate safeguard".[127]

(ii) British Medical Association, Board of Science and Education, Panel on Human Artificial Insemination

In 1973, a Panel appointed by the British Medical Association reported on the legal and ethical issues respecting A.I.D.[128] With regard to these issues, the Panel noted that legitimacy and registration of births was first dealt with in the United Kingdom in 1960 by the Departmental Committee on Human Artificial Insemination, chaired by the Earl of Feversham.[129] A majority of the Feversham Committee had recommended that the law respecting these matters ought not to be altered, lest there be an increase in the practice of A.I.D. However, two dissenting members proposed that a child born as a result of A.I.D. to which the husband of the mother had consented should be legitimate, and that, for the purposes of birth registration, the husband should be deemed to be the father of

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125 *Ibid.* The Report indicated that, in Hospital Memorandum (68)33, the Ministry of Health asked hospital authorities in England and Wales to arrange with the medical staff of their hospitals for a proposal of this type to be put in effect. See *supra*, note 117, para. 46, at 10.

It was suggested that, given the medical profession's code of practice, the disciplinary control over the profession, the general safeguards in the law, and the many purely medical factors involved, it was not necessary to have a lay member appointed to the ethical committees. Moreover, the Advisory Group did not believe it was necessary to establish a permanent, central body to deal with the limited number of cases that might arise where the hospital committee was uncertain of the ethics of a particular investigation: *ibid.*, paras. 48 and 50, at 10-11. In lieu of such a body, the Report recommended that "arrangements should be made for a small informal advisory body with legal representation and including members drawn from the Medical Research Council, the Royal College of Obstetricians and Gynaecologists, the General Medical Council and the British Paediatric Association to be convened when the need for central advice arises": *ibid.*, para. 50, at 11.

126 *Ibid.*, para. 47, at 10.

127 *Ibid.*, para. 49, at 10.

128 British Medical Association, Board of Science and Education, "Appendix V: Report of Panel on Human Artificial Insemination", Brit. Med. J. Supplement 3, Vol. II, April 7, 1973, at 3 (hereinafter referred to as "B.M.A. Panel Report").

129 United Kingdom, Home Office and Scottish Home Department, Departmental Committee on Human Artificial Insemination, *Report* (Cmnd. 1105, 1960). See B.M.A. Panel Report, *supra*, note 128, para. (5), at 3.

that child.[130] The B.M.A. Panel wholeheartedly endorsed the dissenting position.[131]

Whereas the majority of the Feversham Committee had recommended that the practice of A.I.D. not be regulated by law, the B.M.A. Panel stated that "[d]anger could arise from its widespread use without proper safeguards".[132]

While the Panel noted the steady increase in A.I.D. since the Feversham Committee Report,[133] it stated that "it is important not to exaggerate the justification for A.I.D.":[134] relatively few people would be suitable candidates. The Panel concluded that, before couples were accepted for A.I.D., there must be no way that couples could be helped other than by this procedure.[135] For such couples, "A.I.D. should be generally available within the National Health Service" (N.H.S.).[136]

Insofar as the provision of A.I.D. services was concerned, the Panel recommended that accredited centres should be set up within the N.H.S.,[137] although A.I.D. should not be limited to the N.H.S.[138]

Turning to the notion of licensing for A.I.D. doctors, the Panel was concerned that the relatively simple nature of the procedure would encourage "a too ready resort" to A.I.D. without adequate medical safeguards. However, the Panel rejected a system of licensing A.I.D. practitioners. It stated that existing investigatory and disciplinary machinery was sufficient to regulate the conduct of doctors.[139]

With respect to the selection of semen donors, the Panel endorsed the general practice of recruiting potential donors from the medical student population,[140] although it was stated that directors of accredited A.I.D. centres could

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130 See *ibid.*, para. (8), at 3-4.

131 *Ibid.*, para. (8), at 4. See, also, *ibid.*, para. (34), at 5. This endorsement was later reaffirmed by the B.M.A.: see text accompanying notes 164-65, *infra*.

The only other legal aspect of A.I.D. considered in the Report related to the law of negligence. The Panel concluded that the law of negligence would apply to A.I.D. and that it was "unlikely that a court would find any reason for distinguishing between this [A.I.D.] and any other medical or surgical technique": B.M.A. Panel Report, *supra*, note 128, para. (9), at 4.

132 *Ibid.*, para. (13), at 4.

133 *Ibid.*, paras. (12)-(19), at 4.

134 *Ibid.*, para. (18), at 4.

135 *Ibid.*, para. (19), at 4.

136 *Ibid.*

137 *Ibid.*, para. (24), at 4.

138 *Ibid.*

139 *Ibid.*, para. (25), at 4.

140 *Ibid.*, para. (26), at 5.

choose any suitable donor, so long as he was prepared to have his medical and genetic history investigated.[141] The Panel also was of the view that such directors could authorize the use of fresh or frozen semen. Frozen semen should be stored in "the minimum possible number of banks".[142] To preserve anonymity, information concerning donors would be sent to accredited centres and to physicians in coded form, although "the banks would maintain complete records of their identity and medical history".[143] In order to preserve A.I.D. recipient anonymity, the Panel recommended that "[a] similar code of practice to that in operation for the maintenance of confidentiality of hospital records generally should be followed in the case of records of patients treated at accredited centres for A.I.D.".[144]

Finally, the Panel dealt with the monitoring of A.I.D. children. While it acknowledged the view that there should be no follow-up of such children, it did not entirely agree with this view. In order to obtain valuable genetic information and to learn the effects of A.I.D. on family life, the Panel recommended that "there should be properly conducted long-term follow-up of these families though it appreciates that there will be difficulties in instituting methods of follow-up which are effective and acceptable".[145]

(iii) British Medical Association, Working Group on In Vitro Fertilisation

In 1982, the British Medical Association Council established a Working Group to consider the social and ethical aspects of *in vitro* fertilization. The Working Group published its Interim Report in 1983.[146] This Report was amended, in part, in the Council's Annual Report for 1983-84.[147]

The 1983 Report first concluded that, given the rather low success rate of I.V.F., "these procedures should be carried out only in a few special centres in the United Kingdom, each providing the necessary special medical and backup scientific expertise supported by appropriate facilities, clinical and otherwise".[148]

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141 *Ibid.*, para. (27), at 5. Payment of a fee for the time spent at such an examination was considered to be a possibility, again at the directors' discretion: *ibid.* The Panel also suggested that, as a matter of practice, the prior consent of the donor's wife should be obtained: *ibid.*, para. (28), at 5.

142 *Ibid.*, para. (31), at 5.

143 *Ibid.*

144 *Ibid.*, para. (35)(iv), at 5.

145 *Ibid.*, para. (33), at 5.

146 British Medical Association, Working Group on In Vitro Fertilisation, "Appendix VI: Interim report on human in vitro fertilisation and embryo replacement and transfer" (1983), 286 Brit. Med. J. 1594 (hereinafter referred to as "B.M.A. Working Group Report").

147 British Medical Association, "Annual Report of Council 1983-4" (1984), 288 Brit. Med. J. 25 (special insert) (hereinafter referred to as "B.M.A. Annual Report").

148 B.M.A. Working Group Report, *supra*, note 146, para. (14), at 1594.

The Report also stated that I.V.F. records should be kept confidential in the same way as the confidentiality of all other medical records is preserved.[149] However, while, for example, the names of patients and donors would be kept confidential, the details of any congenital abnormalities and numerical summaries for statistical purposes were recommended to be kept by the various Health Departments, "which, under the direct control of the chief medical officers, would hold the confidential central [I.V.F.] registers".[150]

With respect to the selection of couples for treatment, nonmedical criteria were stressed: "[t]he treatment of infertility by in vitro fertilisation and embryo replacement should be preceded by assessment of the stability of the family relationship of the couple concerned and of the sincerity of their intention to accept the duties and obligations of parenthood".[151] However, no mention was made of who was to make such an assessment.

In addition to giving its *imprimatur* to I.V.F. involving the gametes of both husband and wife,[152] the Working Group stated that, "[g]iven informed consent by all parties concerned", it was "not unethical" to use the procedure where a donor was involved.[153] The Report stated further that, while "rare", it "may be ethically acceptable" to use donated sperm and donated ova for I.V.F. where neither wife nor husband can produce viable gametes.[154]

The B.M.A. Report then turned to the use and disposition of embryos in excess of those needed to create a pregnancy. The Working Group recognized that, by observing such embryos, medical knowledge might be advanced and important genetic information, potentially helpful to the couple involved, might be obtained.[155] However, the Working Group first stated that the necessary observations of surplus embryos "should normally be completed within five to 10 days and always within a maximum of 14 days of fertilisation of the ovum by in vitro fertilisation".[156] It then proposed that "[t]he donors' wishes in relation to the ultimate disposal should, as far as possible, be respected".[157] With respect to

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149 *Ibid.*, para. (5), at 1594.

150 *Ibid.*

151 *Ibid.*, para. (6), at 1594.

152 *Ibid.*, para. (8), at 1594.

153 *Ibid.*, para. (9), at 1594.

154 *Ibid.* However, the Working Group did not indicate what persons were included in the phrase "all parties concerned". Would the spouse of a married donor have to consent? In addition, the Working Group did not explain why I.V.F. involving the donation of both semen and ovum "may" be ethically acceptable.

155 *Ibid.*, para. (10), at 1594.

156 *Ibid.* In the B.M.A. Annual Report, *supra*, note 147, para. (38.17)(i), at 25, the Council added the requirement that "[c]onsent to observation of fertilised ova in excess of those needed for embryo replacement or transfer should always be *obtained* ..." (emphasis in original).

157 B.M.A. Working Group Report, *supra*, note 146, para. (10), at 1594.

frozen surplus embryos, "[s]torage should not exceed 12 months, and the couple's wishes in relation to ultimate disposal should, as far as possible, be respected".[158] The Working Group did not indicate why, in the case of non-frozen embryos, the "donors' " wishes should be taken into account, whereas, in the case of frozen embryos, the "couple's" wishes were to be consulted.[159]

The Working Group also addressed very briefly another controversial topic, namely, surrogate motherhood. Without any explanation, the Interim Report simply stated that "[t]he working group has yet to be satisfied that to undertake in vitro fertilisation with the sperm and ova of a couple and to transfer the embryo to the uterus of another woman who might carry the embryo to term on behalf of the couple will ever be acceptable".[160] In its Annual Report for 1983-84, the B.M.A. Council echoed this view. The Council stated that, "in consideration of the difficulties, anxieties, and uncertainties to all the individuals concerned, [the B.M.A. Council] considers that it is unethical for a doctor to become involved in techniques and procedures leading to surrogate motherhood".[161]

A further subject considered in the B.M.A. Report concerned genetic experimentation and research not specifically designed to deal directly with the problem of infertility. Again, the Working Group dealt with the matter summarily:[162]

> It is not ethically acceptable for medical practitioners to be involved in in vitro fertilisation and embryo replacement procedures in which the gametes (sperm or ova), embryos, or parts thereof are subjected to manipulations, including procedures designed to change their genetic make up or to induce the formation of multiple progeny ('cloning') if there is any intent to transfer the resulting embryos to a uterus.[163]

In an Addendum to the B.M.A. Interim Report, the Working Group offered

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158 *Ibid.*, para. (11), at 1594. In the B.M.A. Annual Report, *supra*, note 147, para. (38.17)(ii), at 25, the Council added that "if a period of observation is intended after unfreezing and before disposal, consent for this should be obtained".

159 A further control respecting surplus embryos was that "proposed programmes of observations on fertilised ova in excess of those needed for embryo replacement should be approved by the local ethical committee": B.M.A. Working Group Report, *supra*, note 146, para. (12), at 1594. Presumably, if the donor or the couple refused to allow such observation, these wishes would have to be respected, but this conclusion is not made clear.

160 *Ibid.*, para. (13), at 1594.

161 B.M.A. Annual Report, *supra*, note 147, para. (38.15), at 25.

162 B.M.A. Working Group Report, *supra*, note 146, para. (14), at 1594.

163 The implication appears to be that this type of experimentation would be ethically acceptable where the intent was "pure" research, and not embryo transfer. With respect to such research, the Working Group endorsed (*ibid.*, para. (15), at 1594-95) the guidance given by the Medical Research Council in "Research Related to Human Fertilisation and Embryology" (1982), 285 Brit. Med. J. 1480 (hereinafter referred to as "Medical Research Council Statement"), discussed in the following section of this chapter.

some comments on A.I.D., although the topic was not within its formal terms of reference. It noted that an A.I.D. child is usually registered as if it were the natural child of the couple — a registration, it added, that was "contrary to English law", although "condoned as part of the present social scene".[164] It proposed that an A.I.D. child should be considered legitimate.[165]

(iv) Medical Research Council

In 1978, the Medical Research Council set up an Advisory Group to review research involving I.V.F. and embryo transfer. The Advisory Group "advised the council that scientifically sound research involving in vitro fertilisation — where there was no intent to transfer the embryo to the uterus — should be allowed to proceed if its aim were clearly defined and acceptable". It also concluded that, where medically necessary, I.V.F. "should be regarded as a therapeutic procedure covered by the normal ethics of the doctor/patient relationship".[166] The Council endorsed these views.

In May 1982, an expanded Advisory Group was convened, and its conclusions, accepted by the Council, were published.[167] First, the Advisory Group essentially reiterated the earlier views on experimentation. It then expressed the opinion that donor consent, and the approval of the local ethics committee, should be obtained. Excess fertilized ova might be used for research, again with the consent of both donors. Finally, it was stated that fertilized ova "should not be cultured in vitro beyond the implantation stage; and should not be stored for unspecified research use".[168]

(v) Royal College of Obstetricians and Gynaecologists, Ethics Committee on In Vitro Fertilisation and Embryo Replacement or Transfer

In 1983, the Royal College of Obstetricians and Gynaecologists published a Report of its Ethics Committee on I.V.F.[169] The Report stated that it was "ethically acceptable"[170] to use I.V.F. in the context of a "marriage", defined as "a hetero-sexual couple cohabiting on a stable basis, whether or not legally

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164 B.M.A. Working Group Report, *supra*, note 146, Addendum, para. (2), at 1595.

165 *Ibid.*, paras. (3) and (5), at 1595. The Working Group also noted that "changes in the law in connection with artificial insemination from a donor might also provide protection in the analogous field of ovum donation" (*ibid.*, para. (6), at 1595).

166 Medical Research Council Statement, *supra*, note 163, at 1480.

167 Medical Research Council Statement, *supra*, note 163.

168 *Ibid.*, at 1480. As indicated earlier, these guidelines received the endorsement of the British Medical Association in the B.M.A. Working Group Report, *supra*, note 146.

169 United Kingdom, Royal College of Obstetricians and Gynaecologists, *Report of the RCOG Ethics Committee on In Vitro Fertilisation and Embryo Replacement or Transfer* (1983) (hereinafter referred to as "RCOG Report").

170 *Ibid.*, para. 3.3, at 3.

married".[171] However, the Ethics Committee expressed "grave reservations" about the use of I.V.F. in other situations,[172] although it did not rule out the treatment of single women.[173] The rationale for the Committee's position related to the need for the resulting child to be in a "natural" two parent family.[174] The Report stated:[175]

> IVF and ER differs from other forms of treatment for infertility and puts extra strain not only on patients but also on doctors. The latter are not acting only as 'enablers'; in IVF and ER they are taking part in the formation of the embryo itself. That role brings a special sense of responsibility for the welfare of the child thus conceived. The Committee believes that most practitioners will intuitively feel that IVF and ER should be performed in the most 'natural' of family environments.

The Committee was categorical in its view that the decision to use I.V.F. is not for the couple alone; nor is it to be based exclusively on medical considerations:[176]

> A notional distinction may be drawn between parents who are unsuitable on medical grounds, whether physical, genetic or psychiatric, and those who may be considered unsuitable as parents on other grounds. There may be strong adverse indications of a social nature, or in the history of the marriage, which would seriously jeopardise the interests of the child to be born from the procedure, and hence outweigh the desires of the couple themselves. It remains the province of the doctor, in consultation with appropriate counsellors, to decide whether or not he should agree to their request. In so doing he would do nothing unusual. It is his normal procedure in other areas of practice; in abortion, for instance, within the loosely defined criteria set by the law; or in sterilisation, where yardsticks are applied which vary from doctor to doctor. Similarly it will remain the task of the doctor practising IVF and ER to assess and guide a couple as to their suitability for the procedure; and no doctor will wish, or can be compelled, to surrender his duty to make these judgments. Even under the NHS, where patients may claim consultation and advice, and seek alternative opinion as of right, they have no such right to any particular procedure if in the practitioner's reasonable judgment it ought not to

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171 *Ibid.*, para. 3.1, at 3. It is interesting that, in respect of A.I.D., Dr. B. Mason, a participant in an earlier RCOG forum, stated that the "couples that select themselves for A.I.D. are more stable than average": Brudenell *et al.* (eds.), *Artificial Insemination: Proceedings of the Fourth Study Group of the Royal College of Obstetricians and Gynaecologists* (1976) (hereinafter referred to as "Fourth Study Group"), at 57. With respect to the selection and counselling of A.I.D. recipients, see *ibid.*, at 80-96. The discussion dealt with, *inter alia*, the assessment of suitability for parenthood and whether doctors have the "right" or "responsibility" to select recipient couples. In the latter connection, reference was made to the doctor's role in protecting the interests of the future child.

172 RCOG Report, *supra*, note 169, para. 6.1, at 6.

173 *Ibid.*, para. 6.2, at 6. The Committee stated that, "in a society where a variety of family forms now exists and where adoption by single people, though rare, is possible it is felt that it would be wrong arbitrarily to exclude all single women from IVF and ER without consideration of their individual circumstances" (*ibid.*, para. 6.3, at 7).

174 *Ibid.*, para. 6.4, at 7.

175 *Ibid.*, para. 6.1, at 6. See, also, *ibid.*, para. 6.4, at 7.

176 *Ibid.*, para. 3.5, at 4.

be provided for them. The advice given, and its outcome, will reflect the integrity of those who counsel and the quality of their relationship with their patients; and this will remain true, whether resources remain limited and constricting or not.

The Ethics Committee saw "no legal or ethical difference" between I.V.F., using donor sperm or donor ova, and A.I.D.[177] In all cases, it recommended that the resulting children should be legitimized by deeming either the husband or the wife, as the case may be, to be the father or mother of the child.[178]

In connection with the legitimization of I.V.F. children, the Report recommended that "[t]he ovum donor should surrender all interests relating to her ovum in just the same way as the donor in AID does in regard to his sperm".[179] By implication, it appears that the sperm donor would also surrender his interests in the sperm. The Report stated further that the anonymity of donors must be maintained, and neither donors nor recipients should know of each other's identity.[180]

The RCOG Report then dealt with embryo donation where both the ovum and sperm are donated. The Ethics Committee saw the process as "analogous to adoption".[181] Accordingly, counselling would be required.[182] Indeed, the Report stated that, "[p]rovided that the appropriate administrative and counselling framework has been established, the Committee believes this form of adoption is ethically acceptable".[183]

With respect to surrogate motherhood, the Committee, while indirectly acknowledging that there might be thought to be "medical indications for surrogate motherhood in the case of a 'bad reproducer' ",[184] rejected the use of medical technology in this manner. The Committee was of the view that surrogate motherhood "carries important legal and psychological difficulties especially in relation to the child".[185]

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177 *Ibid.*, paras. 5.1-5.2, at 5.

178 See *ibid.*, para. 5.2, at 5, and para. 14.2.2, at 15. But see Dunstan, in Fourth Study Group, *supra*, note 171, at 186.

179 RCOG Report, *supra*, note 169, para. 5.3, at 5.

180 *Ibid.*, para. 5.3, at 5, and para. 5.9, at 6. Accordingly, donation by a sibling or other relative or friend of the patient "is an undesirable practice and ... this form of donation would rarely be justified": *ibid.*, para. 5.9, at 6.

181 *Ibid.*, para. 5.5, at 6.

182 *Ibid.*

183 *Ibid.*, para. 5.8, at 6. The reference to the "administrative" framework was not explained. With respect to the status of the resulting child, presumably, by extension, the previously mentioned deeming provision would legitimize him or her: see text accompanying notes 177-78, *supra.*

184 RCOG Report, *supra*, note 169, para. 7.1, at 7.

185 *Ibid.*, para. 7.2, at 7. See, also, *ibid.*, para. 7.6, at 8. The Report did not indicate what "legal and psychological difficulties" were envisaged.

The Report also focused on the surrogate mother. The Committee stated that "[a] change in her attitude and intentions [between implantation and birth] would create emotional stress in herself if she gives up the child or to the potential parents if she does not".[186] However, the Report later indicated that, with respect to surrogate motherhood agreements in the United States, "[t]he psychological impact on the surrogate is not known although no detrimental effect has been reported".[187]

After dealing with surrogate motherhood, the Ethics Committee turned its attention to record keeping. The Committee recommended the creation of a register, "with due regard to confidentiality", to include, for example, the details of parentage, a record of success or failure with different procedures, and information regarding the development of the child.[188] Even an "international register" was contemplated.[189]

With respect to the monitoring of the child, the Committee was "unanimous in its view that the physical follow up of babies resulting from IVF and ER is important".[190] However, at the time, it was "not considered practicable to follow up these babies from a psychological point of view or to compare them with a control series in any meaningful way".[191] This conclusion should be viewed in the light of the Committee's general wish to ensure that the children not be told of how they were conceived.[192]

Another matter canvassed in the RCOG Report concerned the freezing of embryos. The Committee stated that, while justifiable "in the hope of improving the success rate of IVF and ER",[193] "[i]t would be wise at first to limit the storage time to that required for a foreseeable and specific purpose e.g. a second pregnancy to the same couple".[194] "Such an arbitrary time limit", the Report continued, "is recommended on social rather than on scientific grounds and to avoid unpredictable legal hazards".[195] The Committee also recommended that,

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186 *Ibid.*, para. 7.3, at 7.

187 *Ibid.*, para. 7.5, at 8.

188 *Ibid.*, paras. 8.2-8.3, at 8.

189 *Ibid.*, para. 8.4, at 9.

190 *Ibid.*, para. 10.1, at 9.

191 *Ibid.*, para. 10.4, at 9.

192 *Ibid.*, para. 10.3, at 9.

193 *Ibid.*, para. 11.3, at 11.

194 *Ibid.*

195 *Ibid.* The implication of the phrase "at first", and its relationship to the social and legal reasons why a time limit was suggested, were not examined; nor did the Report specify the "social ... grounds" for a time limit or the "unpredictable legal hazards" to be avoided.

"[t]o avoid the possibility of creating siblings unknown to one another, [the 'spare embryos'] should not be used for donor purposes".[196]

The Committee stated that "[g]uidelines or rules governing research investigations conducted on human embryos must reflect the status of the embryo in our scale of values".[197] It found that the view that life begins at conception, so that there is "a duty to respect the absolute inviolability of the embryo," is "difficult to sustain".[198] The Committee supported the views on research of the Medical Research Council,[199] and added that "[h]uman embryos employed in this way should not be allowed to develop beyond the stage of early neural development, (Day 17 after conception: Carnegie Stage 8) and such research should be subject to informed consent of the donor or donors".[200]

The final portion of the RCOG Report considered "the possible interface between the law and the practice of IVF and ET",[201] as well as problems relating to A.I.D. The Report dealt with the registration of persons carrying out these procedures and the licensing of premises where they are carried out. The Report acknowledged both the need to avoid placing unwarranted limits on infertility research and the need to preclude "commercial exploitation" of such research. Accordingly, the Committee recommended that "[a] statutory body should be established to advise the Secretaries of State on matters relating to in vitro fertilisation and embryo replacement".[202] On the advice of that body, the Secretaries of State would be given power to make the regulations relating, for example, to the licensing and inspecting of I.V.F. centres and practitioners and to experimentation.[203]

Several paragraphs were also devoted to a discussion of the legal status of semen, embryos, fetuses, and babies. The Committee recommended that "[w]hen sperm, ova or embryos are donated the donor should surrender all

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196 *Ibid.*, para. 11.4, at 11. See, also, *ibid.*, para. 13.1, at 13.

197 *Ibid.*, para. 13.3, at 13.

198 *Ibid.*

199 See Medical Research Council Statement, *supra*, note 163, para. (i), at 1480. See *supra*, this ch., sec. 2(b)(iv).

200 RCOG Report, *supra*, note 169, para. 13.8, at 14. The Committee also dealt with "embryo division", that is, the "asexual reproduction aimed at producing multiple, genetically identical groups of cells and hence potentially viable off-spring": *ibid.*, para. 12.1, at 12. The Committee stated that it "accepts that attempts to detect defects by the above techniques are ethical, but sees no other indication for embryo division at the present time": *ibid.*, para. 12.4, at 12.

201 *Ibid.*, para. 14.1, at 14. The term "embryo transfer" (ET) was used to refer to the case where an embryo is "implanted into a recipient other than the donor of the ovum": *ibid.*, para. 1.4, at 1.

202 *Ibid.*, para. 14.3.4, at 16.

203 *Ibid.*, para. 14.3.5, at 16.

rights to interest or ownership".[204] Apart from "reasonable expenses", payment of donors would be forbidden.[205] The Commission proposed as follows:[206]

> Stored semen (other than that produced for donor purposes) remains the property of the man until he requests its destruction. In the event of his death it remains part of his estate and is subject to the conditions of his will or, should he die intestate, would form part of his chattels and would pass to his widow. The possibility that she might subsequently wish to conceive a child using this semen might arise. Its use in other circumstances would have no justification.

The Committee stated that "[f]rozen embryos remain the property of the parents, who may wish and should be permitted to donate them anonymously subject to consideration of ethical use and public policy ...".[207]

With respect to storage, it was said that "clear guidelines should be established".[208] While a firm opinion could not yet be given, "[i]n the meantime [the ethics committee] advises doctors maintaining sperm banks to enter into a formal contract with those individuals 'banking' sperm so that all possible eventualities are covered".[209]

The final conclusions and recommendations of the Committee included the following:

> 6. The Committee does not consider that the question of research on or experimentation with early human embryonic material is a matter for the law. That problem is strictly an ethical one, in which it is necessary to be sensitive to public sentiment.[210]
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> 7. The legal status of babies born following IVF and ER where the gametes are derived from the parents presents no problems.[211]
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> 11. [T]he identity of donors should not be revealed and indeed the donor arrangements should be such that anonymity is inviolable .... [T]he decision to disclose to the child the nature of its parentage should at the present time remain with the 'legal' parents. This should apply equally to children resulting from AID or from IVF and ER. In the event of the parents making such disclosure the child should have access to the same information regarding the genetic background of the donor as was available to its parents without

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204 *Ibid.*, para. 14.4.1, at 16. See, also, text accompanying note 179, *supra*.

205 RCOG Report, *supra*, note 169, para. 14.4.1, at 16.

206 *Ibid.*, para. 14.4.3, at 16-17. It should be noted that, whereas "[s]tored semen ... remains the property of the man", and "no justification" arises for its use other than (perhaps) by his widow to conceive a child, frozen embryos, not to be transferred to the uterus of a woman, may be used for certain research purposes: see *ibid.*, para. 11.4, at 11, and para. 13.8, at 14. See, also, *ibid.*, para. 14.4.4, at 17.

207 *Ibid.*, para. 14.4.4, at 17.

208 *Ibid.*, para. 14.4.5, at 17.

209 *Ibid.*

210 *Ibid.*, para. 14.4.6, at 17.

211 *Ibid.*, para. 14.4.7, at 17.

breaching anonymity. If AID or IVF has been employed to avoid transmission of a genetic defect the parents should consider how this information can be conveyed to the child in the event of their premature deaths.[212]

(vi) The Law Commission

In 1979, the English Law Commission published its Working Paper on illegitimacy,[213] followed in 1982 by its final Report,[214] to which was appended a Draft Family Law Reform Bill.[215] The Commission dealt with A.I.D. only in its relationship to illegitimacy.[216]

The Law Commission Working Paper began with a basic statement that, under the present law, an A.I.D. child is illegitimate,[217] the donor being the legal father.[218] The "question therefore arises whether the law should be so framed that, in proper cases, it gives effect to the social reality (that is, that the child is the offspring of the husband and wife) rather than the genetic truth (that is, that he is the offspring of the wife and donor)".[219]

The Working Paper discussed the present practice of a majority of A.I.D. mothers of registering the husband as father. The Law Commission thought it was "unrealistic" to expect couples to resist the temptation to cover up the fact of A.I.D. in this manner. Accordingly, the Law Commission recommended in its final Report that "where a married woman has recieved A.I.D. treatment with her husband's consent, the husband rather than the donor should, for all legal purposes, be regarded as the father of a child conceived as the result; and that such a child should therefore not be 'illegitimate' ".[220] The Commission rejected as unreal and cumbersome the alternative of a special form of adoption to deal with the A.I.D. child.[221]

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212 *Ibid.*, para. 14.4.11, at 18.

213 The Law Commission, *Family Law — Illegitimacy,* Working Paper No. 74 (1979) (hereinafter referred to as "Law Comm. W.P.").

214 The Law Commission, *Family Law — Illegitimacy,* Law Com. No. 118 (1982) (hereinafter referred to as "Law Comm. Report").

215 *Ibid.*, Appendix A, at 193 *et seq.* See s. 34, which covered the A.I.D. proposals.

216 Law Comm. W.P., *supra*, note 213, para. 10.4, at 133.

217 *Ibid.*, para. 10.1, at 132.

218 *Ibid.*, para. 10.3, at 132.

219 *Ibid.*, para. 10.3, at 133.

220 Law Comm. Report, *supra*, note 214, para. 12.9, at 173 (footnote reference deleted). See, also, Law Comm. W.P., *supra*, note 213, para. 10.9, at 137. The Law Commission recommended "that the A.I.D. child should be treated as a child of the marriage and of the mother's husband unless it is proved to the satisfaction of any court which has to decide the issue that the husband did not consent to the A.I.D.": Law Comm. Report, *supra*, note 214, para. 12.24, at 178.

221 *Ibid.*, para. 12.12, at 174, and Law Comm. W.P., *supra*, note 213, paras. 10.18-10.20, at 140-43.

Fundamental to the above proposal was the consent of the husband to the insemination. Two approaches were canvassed with respect to this issue, one requiring written consent, and the other adopting a presumption of consent.[222]

The first approach, focusing on the "legal consequences of the husband's consent", was animated by the principle that, if the consent "were to be effective, [it] would have to be in writing, in a prescribed form, and perhaps formally attested".[223] However, it was said that such a scheme would create a timing problem for the consent. Three possibilities were considered with respect to when consent could be effective: (1) whenever given; (2) only if given before the child's birth; or (3) only if given before the start of the treatment resulting in conception.[224] The Law Commission stated that the last alternative "is clearly desirable in the interests of fairness to the husband, but we doubt if it is sufficiently important in the interests of society as a whole to justify elevating it into a positive rule of law".[225]

Accordingly, the second approach was endorsed.[226] The Law Commission was concerned that hardship would be caused to the child where the husband had consented, but had neglected to meet the required formalities. Accordingly, "[i]t would be presumed that the husband had consented unless he (or anyone else with a sufficient interest) satisfied the court that he had not done so".[227] The Report continued by stating that, "although we believe that the practice of the Royal College, of requiring that consent be obtained before treatment is started, is a desirable rule of practice, we think it should not be mandatory".[228]

With respect to the preservation of the biological "integrity of the births register", the Law Commission considered whether "it should be provided that a husband should be deemed to be the father of an A.I.D. child if, but only if, a stipulated procedure for recording the A.I.D. conception were followed".[229] The Commission, in rejecting the annotation of the births register, noted two objections. First, the annotation would have to appear only where the husband of the recipient was clearly not the father. Secondly, many A.I.D. mothers would simply not use the procedure; rather, they would state that the husband was in fact the father.[230]

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222 See, generally, Law Comm. W.P., *ibid.*, paras. 10.12-10.16, at 138-40, and Law Comm. Report, *supra*, note 214, paras. 12.13-12.17, at 174-75.

223 *Ibid.*, para. 12.14, at 174.

224 The last alternative was said to represent the practice of the Royal College of Obstetricians and Gynaecologists: *ibid.*, para. 12.15, at 175.

225 *Ibid.*, para. 12.15, at 175.

226 *Ibid.*, para. 12.16, at 175. See, also, Law Comm. W.P., *supra*, note 213, para. 10.16, at 140.

227 Law Comm. Report, *supra*, note 214, para. 12.16, at 175 (footnote reference deleted).

228 *Ibid.*, para. 12.17, at 175.

229 *Ibid.*, para. 12.18, at 176.

230 *Ibid.*, paras. 12.19 and 12.21, at 177.

The Law Commission next dealt with the question "whether or not legal provision should be made so that the child would be entitled to ascertain the facts about his parentage".[231] It noted that, since the identity of the A.I.D. donor is confidential, access to any records by the child might not be of any real use to him. And to divulge the name of the donor would involve a substantial change of policy. The Law Commission concluded that, although the matter was outside the terms of reference, "[i]t may be that in time, if and when A.I.D. practice is regulated by statute, some right of disclosure may be thought appropriate".[232]

(vii) England, The Law Society, Standing Committee on Family Law, Human Fertilisation and Embryology

In 1983, the Law Society of England submitted a Memorandum[233] to a Departmental Inquiry chaired by Dame Mary Warnock.[234] Animating much of the discussion in the Memorandum was the need to regulate A.I.D.[235] For example, the Law Society noted the possibility of keeping a register of A.I.D. donors[236] and recommended a "system of recording the use of AID and of births resulting from it".[237] These suggestions would help to inhibit genetic incest and to bring A.I.D. "under some statutory control".[238]

When the Law Society turned to surrogate motherhood, it stated that "[i]t is by no means clear ... that the courts (which are not disposed to enlarge the existing fields of public policy) would necessarily hold that a contract based on AI was unenforceable — so far at least as it related to incidents other than those governing the destiny of the resulting child".[239] While what would be enforceable was not made clear,[240] the whole notion of such agreements was ultimately rejected. The Law Society stated that some way must be found to "[limit] a

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231 *Ibid.*, para. 12.22, at 177.

232 *Ibid.*, para. 12.23, at 177-78 (footnote reference deleted).

233 England, The Law Society, *Memorandum by the Society's Standing Committee on Family Law: Human Fertilisation and Embryology* (1983).

234 See discussion *infra*, sec. 2(b)(ix).

235 *Supra*, note 233, para. 1.1, at 1.

236 *Ibid.*, para. 2.2, at 2.

237 *Ibid.*, para. 2.4, at 2. In passing, the Law Society stated that it did not favour any proposal that "AID children should be subject to some special form of adoption procedure" (*ibid.*).

238 *Ibid.*, para. 2.5, at 3.

239 *Ibid.*, para. 2.6, at 3.

240 What if the child were given up to the couple, and the surrogate mother sued the couple for payment under the contract? Or what if, in the latter case, the surrogate mother breached a contractual term prohibiting smoking or consuming alcohol during pregnancy? Could such terms be enforced? See the English case of *A. v. C.*, unreported (June 20, 1978, H.C.J., Fam. Div.), where, in his *obiter* remarks, Mr. Justice Comyn stated that he regarded the surrogate motherhood agreement as "pernicious", as a purported contract for the purchase and sale of a child, and therefore void as against public policy.

phenomenon which we consider thoroughly undesirable — womb leasing for which payment is made".[241] Indeed, the Society stated that "it is worth considering whether the time has come when it should become criminal for"

> (a) a woman to offer, for reward of any kind, to bear a child for another person;
>
> (b) a man or a woman to offer such a reward to a woman;
>
> (c) a person to act as an agent or intermediary in such a transaction.[242]

The Law Society then commented that, "[w]hile the criminal law may require strengthening, the existing civil and family law is probably effective in making provision for any children that result ...".[243]

The final substantive section of the Memorandum dealt with the "manipulation of human genetic material". Once again, the emphasis of the Law Society was on the need for control.[244] The Memorandum considered whether genetic engineering should be prohibited, permitted, or permitted with controls.[245] The governing "best interests of the child" principle was said to preclude the "artificial creation of children" except in conformity with such interests,[246] and to preclude purely "scientific enquiry or investigation" except where, if carried full term into the generation of a child, "it would have been permitted as being in the best interests of the child".[247] This principle was also said "probably" to forbid "any other exercise of the [genetic] option (which clearly involves the use of human genetic and embryological material for experimental and possibly commercial purposes and raises profound legal problems which inter-relate with moral and social problems) ...".[248]

The Law Society stated that "all modern knowledge seems to point to the need of the child to establish wherever possible a clear identity for both its parents — that being the key to its own identity".[249] The Law Society then observed that, "applying the 'best interests' test, it would seem that any use of modern techniques that allows husbands and wives (and presumably also those permanently living together as such) to give birth by natural processes to

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241 *Supra*, note 233, para. 2.6, at 3.

242 *Ibid.*, para. 2.7, at 3.

243 *Ibid.*, para. 2.8, at 3. With respect to the legal status of the child, the Law Society mentioned, without comment, the Law Commission's proposal deeming the mother's husband to be the father of an A.I.D. child and the present general practice of registering the child as that of the mother and her husband: *ibid.*, para. 2.9, at 4.

244 *Ibid.*, paras. 3.2 and 3.4, at 4.

245 *Ibid.*, para. 3.5, at 5.

246 *Ibid.*, para. 3.7(a), at 5.

247 *Ibid.*, para. 3.7(b), at 5.

248 *Ibid.*, para. 3.7(c), at 6.

249 *Ibid.*, para. 3.9, at 6. The Memorandum cited the example of the right of adopted children in England to discover their natural parentage.

children of their *own* which they *want* is consistent with the interest of the child and should be permitted".[250]

The Law Society then dealt with the use of modern techniques other than those that would allow couples to give birth to "their *own*" children:[251]

> Anything else, it would seem, should *NOT* be permitted for quite simply it savours of the *deliberate* creation of children to satisfy the demands of adoptive relationships — which tend to be less than ideal for the child and should not be encouraged. The fact that under our proposals it would be disallowed in the fields of genetic manipulation where high technical skills are required, though still feasible in the natural childbirth and AID field, should not gainsay the principle. It is probably undesirable from the child's point of view in the other fields — but not amenable to the same control.

The final paragraph in the Memorandum dealt with experimentation. The Law Society raised the possibility that experimentation might serve to benefit some future life, but then focused on cloning and related experimental work in its final discussion.[252]

(viii) Law Society of Scotland

In a response to a request by the Warnock Committee,[253] the Law Society of Scotland submitted its *Draft Submission on Government Inquiry into Human Fertilisation and Embryology.*[254]

While A.I.H. did not cause the Law Society any particular concern — since "any child so born must be a legitimate child of the two parties" — it did recommend that, where "there is consensual A.I.D., the child so born should be a legitimate child of the spouses".[255] With respect to unmarried women, the Law

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250 *Ibid.*, para. 3.10, at 6 (emphasis in original).

251 *Ibid.*, para. 3.11, at 7 (emphasis in original).

252 *Ibid.*, para. 3.12, at 7.

253 See *infra*, sec. 2(b)(ix).

254 Law Society of Scotland, *Draft Submission on Government Inquiry into Human Fertilisation and Embryology* (1983) (hereinafter referred to as "Law Society of Scotland Report").

255 *Ibid.*, at 4 and 5. "If the husband does not consent any child so born would be illegitimate, but should be alimentable by the husband if he has accepted that child 'en famille' ": *ibid.*, at 5. The Report did not deal with the mechanics of the husband's consent. However, it did state that "[t]he question of the position of the medical practitioner where there was non-consensual A.I.D. is not one of law and although it has been raised in discussion at meetings of the working party, it is the view of the working party that this is a matter of ethics which should be referred to the General Medical Council": *ibid.*, at 6. It should be noted that the Report expanded the class of non-consensual A.I.D. to include the case where semen is used by the donor's wife after his death: *ibid.*, at 9.

Society stated that access to the procedure was "a matter of ethics"[256] — presumably, then, to be left to the medical profession.

The Report then turned to the issue concerning who ought to be authorized to carry out inseminations. The Law Society recommended that "insemination should be carried out by a registered medical practitioner or by a suitably qualified member of his staff, under his direct supervision".[257] The Law Society expressly declined to make any recommendation "regarding artificial insemination carried out in any other manner", although it did state that it would be "unnecessary and undesirable" to criminalize such activity.[258]

While the Law Society was willing to countenance control of the new technologies by the medical profession, it stood opposed to the importation of semen.[259] For example, where semen is stored, the storage should be only in "authorized" or "official" semen banks and "subject to statutory control".[260]

Like other bodies, the Law Society believed that confidentiality was "of paramount importance".[261] This view was related to the further proposal that "[t]he donor, if other than the husband, should have no rights in the child subsequently born, nor should the child have any rights in or claim to the 'father' or his estate".[262]

Another related issue concerned the consent of the relevant parties to the procedure. The Law Society endorsed the proposal of the Law Commission[263] that such consent should be presumed and "that anyone seeking to challenge such consent should have to satisfy a very high burden of proof".[264]

Insofar as I.V.F. was concerned, the Law Society generally saw "no additional problems ... beyond those already discussed in relation to A.I.H. and A.I.D."[265] However, the submission did expend some time considering the disposition of surplus embryos. After discussing the question whether they are "human matter or laboratory artifacts",[266] the submission supported the use of

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256 *Ibid.*, at 8.

257 *Ibid.*, at 6. While the Law Society was "opposed to indiscriminate use" of A.I.D. (*ibid.*, at 8), it did not see fit to interfere with control by the medical profession (*ibid.*).

258 *Ibid.*, at 6.

259 *Ibid.*, at 8.

260 *Ibid.*, at 9.

261 *Ibid.*, at 6.

262 *Ibid.*

263 Law Comm. Report, *supra*, note 214.

264 Law Society of Scotland Report, *supra*, note 254, at 7.

265 *Ibid.*, at 9.

266 *Ibid.*, at 10.

surplus embryos for research that would help to detect genetic defects in the child and so contribute to "the well being of the child".[267]

At a later stage, the Law Society stated that it "[makes] no comments" on the "experimental use of human embryos"[268] (although it had earlier said that it was opposed to "any form of genetic engineering"[269]). The Law Society then commented that "[a]ny extension of experimentation on [a] pre-viable foetus should be subject to the normal laws regarding human experimentation, and in the view of the working party would require to form the subject of a special review".[270]

Also in the context of its discussion of "experimental matters", the Law Society stated unequivocally that it was "totally opposed to any proposal that artificial inseminatory techniques should be used for the purpose of cloning".[271] In addition, it was "opposed to any proposal that I.V.F. cloning or freezing techniques could be used to determine the sex of an embryo prior to its transfer to the uterus of the mother ...".[272] Indeed, the Law Society was "opposed to any proposed development of a technique to allow couples to choose the sex of their off-spring".[273] "Except for good medical grounds", the Report stated, "the working party are opposed to the killing of a foetus because of its sex".[274]

The Report also examined what it called "womb leasing",[275] that is,

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267 *Ibid.* With respect to the time limits on the use of surplus embryos, the Law Society stated as follows (*ibid.*):

> The working party are persuaded that an embryo derives its humanity only after having established normal unity with its human mother. Prior to this, the working party would consider the embryo as no more than a laboratory artifact .... From a purely legal stand point ... it is submitted that it is essential that there should be legally defined terms to differentiate between a state prior to 'infusion with humanity' and that thereafter .... The dividing line is exceeding fine, but this must not be seen as a deterrent from drawing it. Undoubtedly this is a matter which must be kept under constant review.

268 *Ibid.*, at 13.

269 *Ibid.*, at 8.

270 *Ibid.*, at 13.

271 *Ibid.*, at 12.

272 *Ibid.*

273 *Ibid.*

274 *Ibid.* In this connection, the Law Society said that "the provisions of Section 11(b) of the Abortion Act relevant to sex linked hereditary disease are sufficient ..." (*ibid.*).

> The Law Society also referred to "certain studies [that] have been undertaken using human sperm and hamster eggs to differentiate between unexplained cases of male human infertility" (*ibid.*, at 13). The Law Society stated that it "[accepted] the limits on which this experimental technique has been used, but would be opposed to any extension thereof" (*ibid.*). Unfortunately, no reasons were advanced for restricting experimentation in this area.

275 For the Law Society's definition of "womb leasing", see *ibid.*, at 2.

surrogate motherhood. The Law Society isolated three considerations respecting this matter.[276] First, there must be medical reasons for using this procedure. Secondly, the gestatory mother is the legal mother for all purposes.[277] Thirdly:

> (c) The 'sponsoring' parents must have a right of adoption. Here the Committee would differentiate between the circumstances where a woman is unable to bear a child and where she is both unable to bear a child and sterile. In the former case, because the fertilised ovum will be that of the wife, the 'sponsoring' parents should have an absolute right to adopt the child. This absolute right should only be available to the husband and wife jointly. If for any reason the right is exercised only by one parent it is no longer absolute but merely presumptive. In the latter case since the fertilised ovum will be that of the woman bearing the child, the 'sponsoring' parents should only have a presumptive and rebuttable right to adopt the child so born.

With respect to payment to the biological mother, the Law Society stated that, prior to birth, the mother "should only receive reasonable expenses to cover her pregnancy, including, where appropriate, compensation for loss of employment".[278] In addition, "[t]here should be a rebuttable presumption that all payments made during the pregnancy were made in support of the pregnancy".[279] After birth, however, payments should be required to be made "only ... when the baby is handed over".[280]

(ix) Department of Health and Social Security, Committee of Inquiry into Human Fertilisation and Embryology

In July 1984, a major study conducted by the Committee of Inquiry into Human Fertilisation and Embryology was published in the United Kingdom.[281] In light of the Committee's broad mandate to examine the social, ethical, and legal implications of the new reproductive technologies, it is understandable that it found considerable disagreement, both in the public at large and within the Committee, concerning many of the issues it addressed. Indeed, three formal expressions of dissent, one on surrogate motherhood and two on the use of human embryos in research, were included in the Report.

Yet, notwithstanding the controversial nature of the subject, the Committee found that "[w]hat is common ... is that people generally want *some principles or*

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276 *Ibid.*, at 11.

277 The Report proposed that "the woman who gives birth to the child should be regarded in law as the mother, regardless of whether she was involved in the initial conception: *ibid.*, at 3.

278 *Ibid.*, at 12.

279 *Ibid.*

280 *Ibid.* Presumably, such payments would still be related to "reasonable expenses to cover her pregnancy", although this is somewhat unclear.

281 United Kingdom, Department of Health and Social Security, *Report of the Committee of Inquiry into Human Fertilisation and Embryology* (1984) (hereinafter referred to as "Warnock Report").

other to govern the development and use of the new techniques".[282] The Committee attempted to gauge the community sentiment and determine what it considered to be the public good, setting forth the arguments for and against various alternative approaches to reform. In doing so, however, the Committee clearly recognized that its conclusions could not reflect the diverse views held by all members of society.

The Report was divided into several chapters dealing with, *inter alia*, the Committee's general approach, the problem of infertility and its alleviation by such techniques as artificial insemination, I.V.F., egg and embryo donation, and surrogate motherhood, the storage of gametes and embryos, and embryo research.

In the main, the Committee was willing to leave many of the details involved in its proposals to be worked out later. Its recommendations were framed in more general terms, indicating, for example, where the law should intervene to regulate one practice or another. In this latter connection, it bears mentioning that the Committee foresaw "real dangers in the law intervening too fast and too extensively in areas where there is no clear public consensus".[283] With regard, however, to the fundamental question concerning the ethical status of artificial conception programmes, the Committee's basic view was that "actions taken with the intention of overcoming infertility can, as a rule, be regarded as acceptable substitutes for natural fertilisation".[284]

With respect to those persons who would be eligible to participate in an artificial reproduction programme, the Committee, while acknowledging the arguments of single men and women and those persons in homosexual or lesbian relationships, expressed the view that, "as a general rule it is better for children to be born into a two-parent family, with both father and mother, although we recognize that it is impossible to predict with any certainty how lasting such a relationship will be".[285] Insofar as the marital status of heterosexual couples was concerned, the Committee stated as follows:[286]

> It is sometimes suggested that infertility treatment should be available only to married couples, in the interests of any child that may be born as a result. While we are vitally aware of the need to protect these interests, we are not prepared to recommend that access to treatment should be based exclusively on the legal status of marriage.

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282 *Ibid.*, para. 5, at 2 (emphasis in original).

283 *Ibid.*, para. 1.9, at 7.

284 *Ibid.*, para. 2.4, at 9.

285 *Ibid.*, para. 2.11, at 11-12. It is interesting to note that the Committee mentioned in passing the discrepancy between the proposed restrictions on artificial procreation expressed in the evidence presented to it — and reflected, in part, in its own recommendation — and the absence of any such restrictions in respect of fertile couples. "It has been argued", the Committee stated, "that the greater the degree of intervention in the creation of a child, the more responsibility must be taken for that child" (*ibid.*, para. 2.7, at 10). The Committee did not elaborate.

286 *Ibid.*, paras. 2.5-2.6, at 10 (emphasis in original).

> In discussing treatment for infertility, this report takes the term *couple* to mean a heterosexual couple living together in a stable relationship, whether married or not. We use the words *husband* and *wife* to denote a relationship, not a legal status (except where the context makes differentiation necessary, for example in relation to legitimacy).

Not only would the Committee restrict eligibility, as a general principle, to married couples or to couples living in a stable union, but it also countenanced the rejection of certain otherwise eligible couples. In part, scarcity of services was said to impose on medical practitioners the need to grant priority to some persons over others, having regard to several factors, such as the patient's age. Indeed, the Committee seemed to go further; it stated that a practitioner may "consider that there are valid reasons why infertility treatment would not be in the best interests of the patient, the child that may be born following treatment, or the patient's immediate family".[287] The implications of this statement were made clear at a later juncture:[288]

> We recognize that this will place a heavy burden of responsibility on the individual consultant who must make social judgments that go beyond the purely medical ....

However, the Committee said that it was not possible to set out "the wider social criteria" to guide practitioners; each case must be decided on its own merits.[289]

Beginning with chapter 3, the Committee dealt with techniques for the alleviation of infertility. The Report first considered certain common threads running through all such techniques. For example, it was stressed that treatment should be undertaken "under the supervision of a registered medical practitioner".[290] With respect to the position of a gamete donor *vis-à-vis* the recipient couple, the Committee recommended anonymity at all times "as a matter of good practice".[291] All parties should be able to receive adequate counselling[292] and should be required to give their fully informed consent.[293]

In chapter 4, the Committee turned to artificial insemination. Except where a widow wished to use the semen of her deceased husband — which was

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287 *Ibid.*, para. 2.12, at 12.

288 *Ibid.*, para. 2.13, at 12.

289 *Ibid.*

290 *Ibid.*, para. 3.1, at 15.

291 *Ibid.*, para. 3.2, at 15.

292 *Ibid.*, paras. 3.3-3.4., at 15-16.

293 *Ibid.*, para. 3.5, at 16. It appears that, "as a matter of good practice", the need for consent *in writing*, on "an appropriate consent form", would apply only "in the case of more specialized forms of infertility treatment" (*ibid.*). Precisely what was intended to be covered by this characterization was not made clear. See, also, *ibid.*, para. 4.23, at 25. As a matter of law, however, the husband's consent would be rebuttably presumed: see *ibid.*, para. 4.24, at 25-26.

considered in more detail in chapter 10 — the Committee saw no moral objection to A.I.H.[294]

In the case of A.I.D., more arguments could be marshalled against the practice. For example, the Committee noted that many persons believe that A.I.D. is violative of the marriage relationship, a threat to the family, and harmful to the child. The Committee accepted the notion that it would be detrimental to a child if he or she were to learn accidentally of the nature of the conception. The Committee opposed secrecy in this sense, but did not regard the potential for deception as an argument against A.I.D. itself.[295]

Moreover, and as a general principle, the Committee rejected the view that A.I.D. was necessarily disruptive of family and marital life. Indeed, at one point the Committee stated that "[i]t will often be true that A.I.D. with the consent of the husband is a mark of stability in a marriage ...".[296] The Report noted further that "those engaging in AID are, in their own view, involved in a positive affirmation of the value of the family".[297] Finally, it was said that "[a]n AID child is a child very much wanted ...".[298]

Not surprisingly, then, the Committee favoured the use of A.I.D. for infertile couples in appropriate cases, subject to its subsequent recommendations concerning licensing and other arrangements, described later.[299] The Committee recommended that the A.I.D. child should be treated in law as the legitimate child of the mother and her husband[300] where they have both consented to the insemination.[301] The husband's consent should be presumed, although the presumption should be rebuttable by the husband.[302] The Committee stated that, where "the mother is married and the husband consents to AID ... the law should be changed so as to permit the husband to be registered as the father".[303] The

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294 *Ibid.*, paras. 4.4-4.5, at 18.

295 *Ibid.*, para. 4.12, at 21.

296 *Ibid.*, para. 4.10, at 21.

297 *Ibid.*, para. 4.14, at 22.

298 *Ibid.*, para. 4.15, at 22.

299 *Ibid.*, para. 4.16, at 23. The "provision of AID services without a licence for the purpose should be an offense" (*ibid.*).

300 It bears repeating here that in this and other proposals, the terms "couple", "wife", and "husband" were given extended definitions unless otherwise indicated. See *ibid.*, paras. 2.5-2.6, at 10, reproduced in text following note 286, *supra.*

301 Warnock Report, *supra*, note 281, para. 4.17, at 23-24.

302 *Ibid.*, para. 4.24, at 25-26.

303 *Ibid.*, para. 4.25, at 26. It should be noted that this recommendation applies only in the case of legally married persons.

The Committee added that, given the resulting effect on the births register (in England, hitherto envisaged as a true genetic record), "consideration should be given as a matter of urgency to making it possible for the parents in registering the birth to add 'by donation' after the man's name" (*ibid.*).

semen donor — who should remain unknown to the couple[304] — should have no parental rights or duties in relation to the child.[305]

The Report further recommended that semen donors should be restricted as to the number of children that they may father. An arbitrary limit of ten children was suggested, to be monitored by a system of checking donors' National Health Service numbers against a proposed new centrally maintained list of N.H.S. numbers of existing donors.[306] With respect to the payment of donors, the Committee was concerned that payment of a fee would tempt some donors to withhold essential medical or other information. Accordingly, it recommended that "there should be a gradual move towards a system where semen donors should be given only their expenses".[307]

Chapter 5 of the Report dealt briefly with *in vitro* fertilization involving no donor gametes. While some of the arguments for and against I.V.F. were identical to those used in the context of artificial insemination, other arguments were unique to I.V.F. For example, the Report stated that many people are concerned about the ultimate disposition of embryos not transferred to a woman receiving artificial conception treatment.

The Committee's conclusion respecting I.V.F. mirrored that given in respect of A.I.D.: the practice "should continue to be available subject to the same type of licensing and inspection as ... recommended [in chapter 4] with regard to the regulation of AID".[308]

Chapters 6 and 7 considered, respectively, egg donation and embryo donation, the first involving I.V.F., the second involving either I.V.F. using donor gametes or *in vivo* fertilization and lavage. With respect to egg donation, the Committee thought it would be illogical not to accept the practice in light of its A.I.D. and I.V.F. proposals. The recommendation was as follows:[309]

> We recommend that egg donation be accepted as a recognized technique in the treatment of infertility subject to the same type of licensing and controls as we have recommended for the regulation of AID and IVF. The principles of good practice we have already considered in relation to these other techniques should apply, including

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304 Except where a man has donated semen, for example, specifically to provide for the artificial insemination of his brother's wife: see *ibid.*, para. 4.22, at 25. However, it was also recommended that, "on reaching the age of eighteen the child should have access to the basic information about the donor's ethnic origin and genetic health and that [non-retrospective] legislation be enacted to provide the right of access to this" (*ibid.*, para. 4.21, at 24-25).

305 *Ibid.*, para. 4.22, at 25.

306 *Ibid.*, para. 4.26, at 26-27. The proposed list would be held separately from the N.H.S. central register, to protect donor anonymity.

307 *Ibid.*, para. 4.27, at 28.

308 *Ibid.*, para. 5.10, at 32.

309 *Ibid.*, para. 6.6, at 37.

> the anonymity of the donor,[310] limitation of the number of children born from the eggs of any one donor to ten, openness with the child about his genetic origins, the availability of counselling for all parties and informed consent.

The Committee further recommended that legislation should provide that the "woman giving birth should, for all purposes, be regarded in law as the mother of [the] child, and that the egg donor should have no rights or obligations in respect of the child".[311]

Embryo donation was regarded by the Committee as "probably the least satisfactory form of donation".[312] However, the Committee was prepared to accept this practice where it involved donated semen and ova brought together *in vitro*, again subject to the same type of controls recommended in respect of A.I.D., I.V.F., and egg donation.[313] On the other hand, the Committee recommended that "the technique of embryo donation by lavage should not be used at the present time",[314] although it would be acceptable once the risks of donation by this method have been overcome.[315]

Where a child is born by means of an embryo donation, the Committee recommended that the child should be treated in law as the child of the gestating mother.[316] With respect to the mother's husband, the Committee's proposal made applicable an earlier recommendation to the effect that "the law should be changed so as to permit the [consenting] husband to be registered as the father".[317] However, it is clear that the Committee also intended that a consenting husband should be the child's legal father. In its commentary following the proposal, the Committee expressed the view that "a child following embryo donation to a married couple will, in the eyes of the law, have that couple as parents".[318]

Chapter 8 of the Report considered the highly controversial question of surrogate motherhood. The Committee assumed that surrogate motherhood agreements would likely be treated by the courts as contrary to public policy and, therefore, unenforceable.[319] It was said that the weight of public opinion was in

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310 Except where this is not possible in practice, such as where the egg was donated by a sister or a close friend (*ibid.*, para. 6.7, at 37).

311 *Ibid.*, para. 6.8, at 38. While the Committee did not make a specific proposal in respect of birth registration, it was clearly assumed that the gestating woman would be registered as the mother. However, as in the case of A.I.D., it was said that the parents should be permitted to use the words "by donation" after the mother's name: *ibid.*

312 *Ibid.*, para. 7.4, at 40.

313 *Ibid.*

314 *Ibid.*, para. 7.5, at 40.

315 *Ibid.*, para. 7.6, at 40.

316 *Ibid.* Again, the words "by donation" could be appended: *ibid.*, para. 7.6, at 41.

317 *Ibid.*, para. 4.25, at 26.

318 *Ibid.*, para. 7.6, at 40.

319 *Ibid.*, para. 8.5, at 43.

line with this likely legal treatment of such agreements. Once again, the Committee noted the argument that the practice was a violation of marital and familial bonds and was inconsistent with human dignity. Moreover, the potential harm to the resulting child was stressed.

While the issue of surrogacy raised some of the most troublesome questions for the Committee, on one point it was unanimous: "surrogacy for convenience alone, that is, where a woman is physically capable of bearing a child but does not wish to undergo pregnancy, is totally ethically unacceptable". But, even where necessary to alleviate the consequences of infertility, the Committee raised moral objections to the practice, largely because of the "commercial exploitation of surrogacy".[320] The majority of the Committee even rejected the creation of a "limited, non-profit making surrogacy service, subject to licensing and inspection", for it was of the view that the existence of such a service would in itself encourage the growth of surrogacy.[321]

The Committee's main recommendations respecting surrogate motherhood were as follows:[322]

> We recommend that legislation be introduced to render criminal the creation or operation in the United Kingdom of agencies whose purposes include the recruitment of women for surrogate pregnancy or making arrangements for individuals or couples who wish to utilise the services of a carrying mother; such legislation should be wide enough to include both profit and non-profit making organisations. We further recommend that the legislation be sufficiently wide to render criminally liable the actions of professionals and others who knowingly assist in the establishment of a surrogate pregnancy.

While it was not envisaged that private persons entering into a surrogacy agreement would be liable to prosecution, a majority of the Committee proposed recommendations to ensure that all surrogate motherhood agreements remained illegal and unenforceable.[323]

The Committee then turned to consider the position of a child where, in a surrogacy situation, "the egg or embryo has not been donated but has been provided by the commissioning mother or parents with the intention that they

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320 *Ibid.*, para. 8.17, at 46.

321 *Ibid.*, para. 8.18, at 46-47.

322 *Ibid.*, para. 8.18, at 47.

323 *Ibid.*, para. 8.19, at 47. Two members of the Committee dissented. They were of the view that, on "rare occasions", surrogacy could be justified "as a last resort" and, therefore, should be permitted (*ibid.*, para. 1, at 87). However, the proposed licensing authority should regulate and monitor such a practice; for example, it should license non-profit agencies that assist in making surrogacy arrangements (*ibid*). Courts should be empowered to consider individual surrogate motherhood agreements on their own merits (*ibid.*, para. 8, at 89). Payments to the surrogate mother in respect of her "services" "should not be a barrier to the child being adopted by the commissioning couple" (*ibid.*, para. 7, at 89). (In this latter connection, it appears that the dissenting Committee members envisaged that the acquisition of parental status would be by adoption only.)

should bring up the resultant child".[324] The Committee stated that, in such a case, the earlier proposals dealing with donated eggs and embryos should be made to apply. Accordingly, the woman giving birth, and not the prospective social mother, would be treated in law as the mother.

With respect to the question concerning who would be the legal father, the Committee referred to an earlier proposal that "the law should be changed so as to permit the [consenting] husband to be registered as the father".[325] Presumably, then, adapting this recommendation to the surrogacy context, as envisaged by the Committee, the husband of the surrogate mother could — but need not — be registered as the father of the child.

One final point should be mentioned in the present context. The Committee stated that, "[i]f experience shows that [the proposals, just described, respecting who is to be the legal mother and father, give] rise to an injustice for children who live with their genetic mother rather than the mother who bore them then in our view the remedy is to make the adoption laws more flexible so as to enable the genetic mother to adopt".[326] Given the legal consequences of the Committee's earlier proposals, and their potential effect on such matters as support obligations, inheritance rights, and custody, it is not too difficult to foresee some "injustice" in many cases. Moreover, the Committee's proposals seem to run counter to its general predisposition in favour of certainty — particularly insofar as the welfare of the child is concerned — although the surrogacy proposal may have been regarded by the Committee as a necessary exception to the rule in light of its antipathy to the practice.

Whereas hitherto the Committee had dealt with the use of the new reproductive technologies to alleviate infertility, in chapter 9 the Committee considered the "wider use" of such technologies. For example, it recommended that "it should be accepted practice to offer donated gametes and embryos to those at risk of transmitting hereditary disorders".[327]

Another area canvassed was sex selection, where such practice could be of benefit in avoiding sex-linked genetic disorders, or where there were other sound medical reasons for choosing the sex of the child. The possibility that couples would seek sex selection for purely social reasons made the Committee "dubious about the use of sex selection techniques on a wide scale".[328] However, no firm proposal was made in this regard. The Committee restricted its one recommendation to "do-it-yourself" sex selection kits, stating that all such kits "should be brought within the ambit of control provided by the Medicines Act with the aim

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324 *Ibid.*, para. 8.20, at 47.

325 *Ibid.*, para. 4.25, at 26, incorporated expressly in the recommendation contained in para. 8.20, at 47.

326 *Ibid.*, para. 8.20, at 47.

327 *Ibid.*, para. 9.3, at 49.

328 *Ibid.*, para. 9.11, at 51.

of ensuring that such products are safe, efficacious and of acceptable standard for use".[329]

Chapter 10 of the Warnock Report dealt with the freezing and storage of human semen, eggs, and embryos. While the Committee recommended that "the use of frozen semen in artificial insemination should continue",[330] it proposed that "the use of frozen eggs in therapeutic procedures should not be undertaken until research has shown that no unacceptable risk is involved".[331] The Committee also recommended that "the clinical use of frozen embryos may continue to be developed under review by the licensing body".[332]

The Committee then turned to consider nonmedical problems that might arise in respect of the storage, use, and disposal of frozen gametes or embryos. Reference was made to earlier proposals that would place the responsibility for disposing of the material on the storage authority, bearing in mind any express wish of the donor (for example, where storage was for the personal use of the man, woman, or couple). The Committee recommended as follows:[333]

> We recommend that there should be automatic five-yearly reviews of semen and egg deposits. We recommend that legislation provide that where a person dies during the storage period or cannot be traced at a review date the right of use or disposal of his or her frozen gametes should pass to the storage authority [bearing in mind any wishes of the donor].

In order to avoid inheritance and succession problems associated with posthumous fertilization, the Committee also proposed that "any child born by AIH who was not *in utero* at the date of the death of its father [should] be disregarded for the purposes of succession to and inheritance from the latter".[334] A similar proposal was made in connection with I.V.F. where a frozen embryo was used.[335]

With respect to embryo storage, the Committee also recommended a five-yearly review. In addition, because of medical, legal, and ethical considerations, it stated that there should be "a maximum of ten years for storage of embryos after which time the right to use or disposal should pass to the storage authority".[336] While the donor couple should have the right to the use and

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329 *Ibid.*, para. 9.12, at 52.

330 *Ibid.*, para. 10.1, at 53.

331 *Ibid.*, para. 10.2, at 53. This last matter would be reviewed by the licensing body proposed in chapter 13.

332 *Ibid.*, para. 10.3, at 54.

333 *Ibid.*, para. 10.8, at 55.

334 *Ibid.*, para. 10.9, at 55.

335 *Ibid.*, para. 10.15, at 57.

336 *Ibid.*, para. 10.10, at 56. The Committee was concerned, for example, with the disposal of embryos whose "parents" had died or divorced.

disposal of the embryo prior to the end of the ten year period, neither the couple nor anyone else should have a right of ownership in a human embryo.[337]

The Committee went on to propose that, where one of a couple dies, the right to use or dispose of a stored embryo should pass to the survivor; if both should die, the right should pass to the storage authority.[338] Where "there is no agreement between the couple the right to determine the use or disposal of an embryo should pass to the storage authority as though the ten year period had expired".[339]

In chapter 11, the Committee discussed the ethical and other arguments for and against the use of human embryos for either pure or applied research purposes — where, for example, such research was on embryos brought into existence by I.V.F. but not transferred to a uterus.

While the Committee accepted the notion that the embryo did not, and should not, have the same status as a living child or adult, it did state that no research should be undertaken on it where animals or other methods could serve the same purpose. Some legal protection should be afforded the human embryo.[340] While the majority of the Committee did not wish, then, to endorse a total prohibition on embryo research, such research and the handling of embryos would be permitted only under licence, with any unauthorized use of an embryo constituting a criminal offence.[341] The statutory licensing body would monitor the research and ensure compliance with the Committee's proposals.

A controversial area in respect of research concerns the time limit on keeping embryos alive *in vitro*. The Committee selected fourteen days after fertilization — excluding any time when the embryo was frozen — as the appropriate limit, based on what was thought to be the beginning of individual development of the embryo, which was said to occur at about fifteen days after fertilization. The Committee recommended that research on, or handling of, an embryo beyond this period should be a criminal offence. No embryo used for research purposes should be transferred to a woman.[342] Finally, the Committee stressed the need to obtain consent with respect to the method of use or disposal

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337 *Ibid.*, para. 10.11, at 56.

338 *Ibid.*, para. 10.12, at 56.

339 *Ibid.*, para. 10.13, at 56-57.

340 *Ibid.*, para. 11.17, at 63.

341 *Ibid.*, para. 11.18, at 64. Three members of the Committee dissented. They recommended that "nothing should be done that would reduce the chance of successful implantation of the embryo": *ibid.*, para. 3, at 90. More specifically, they would prohibit any experimentation on human embryos: *ibid.*, para. 5, at 91. Surplus embryos should be frozen, with a view to future implantation, or "allowed to die": *ibid.* The dissenting members justified their view mainly on the ground that an embryo has a potential to become a human being and, therefore, has a special status. See, also, *infra*, note 344.

342 Warnock Report, *supra*, note 281, para. 11.22, at 66.

of surplus embryos. As a matter of good practice, no research should be carried out without informed consent, "whenever this is possible".[343]

The final issue in chapter 11 was concerned with the difficult question whether research should be undertaken on embryos deliberately brought into existence for this purpose. The Committee canvassed the arguments for and against such research, including the argument that this practice would open the door to the creation of embryos for less valid purposes. Not all members believed that a distinction could be drawn between surplus and deliberately generated embryos. In some cases, a particular kind of research would effectively be precluded where reliance was placed on spare embryos alone. Despite a lack of consensus on all points, the Committee did agree that legislation, rather than the proposed licensing body, should deal with the issue. A majority recommended further that "the legislation should provide that research may be carried out on any embryo resulting from *in vitro* fertilisation, whatever its provenance, up to the end of the fourteenth day after fertilisation, but subject to all other restrictions as may be imposed by the licensing body".[344]

In chapter 12, some specific future research developments were canvassed, many of which were said to have caused public concern. In the case of trans-species fertilization, for example, the fear that a hybrid half-human creature might be created prompted the recommendation that such research be permitted by licence and only where the research was part of a recognized programme respecting infertility or subfertility. In no case should the embryo be allowed to develop beyond the two cell stage.[345]

Another area of concern was the use of human embryos to test drugs. While the Committee generally rejected the validity of such research — since it would require the creation of large numbers of embryos — it did accept the view that the proposed licensing body might endorse particular projects of this sort.[346]

Most of the remaining developments discussed by the Committee — such as cloning — were believed to be too speculative in nature to warrant specific proposals.[347] Moreover, several earlier recommendations, such as the proposal that would prevent research on embryos more than fourteen days after fertilization, would effectively prevent certain kinds of ethically unacceptable or suspect research. However, as a further safeguard, it was recommended that "the proposed licensing body [should provide] ... guidance on what types of research,

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343 *Ibid.*, para. 11.24, at 66-67.

344 *Ibid.*, para. 11.30, at 69. Four Committee members dissented from the view that research should be permitted on embryos deliberately created for this purpose or coming into existence as a result of other research (*ibid.*, at 94).

345 *Ibid.*, para. 12.3, at 71.

346 *Ibid.*, paras. 12.5-12.6, at 71.

347 Although the Report did recommend, for example, that "the placing of a human embryo in the uterus of another species for gestation should be a criminal offence" (*ibid.*, para. 12.9, at 72).

apart from those precluded by law, would be unlikely to be considered ethically acceptable in any circumstances and therefore would not be licensed".[348]

The last chapter — chapter 13 — dealt with the actual regulation and monitoring of infertility services and research. The Committee recommended the creation of a new, independent statutory licensing authority, with lay representation and a lay chairperson, to regulate and monitor practice in the sensitive areas described in the Report.[349] The new body would have an advisory and an executive function, advising government, issuing guidance on good practice, publishing relevant information, granting licences, and overseeing inspections of licensed facilities.[350]

With respect to the licensing of infertility services — which should be supervised by "a qualified medical practitioner"[351] — the Committee recommended that "all practitioners offering the services that we have recommended should only be provided under licence, and all premises used as part of any such provision, including the provision of fresh semen and banks for the storage of frozen human eggs, semen and embryos should be licensed by the licensing body".[352] In addition to the functions described earlier, it was proposed that "the licensing body be asked to consider the need for follow-up studies of children born as a result of the new techniques, including consideration of the need for a centrally maintained register of such births".[353]

With respect to the licensing of research, the Committee stated that licences should be granted for individual projects for specified research in the field, with the licence to expire on the completion of the project. The licensing body would require "local ethical clearance" from the research institution and support for the work "by peer review undertaken by appropriate academic referees". Also proposed were tight controls on staffing and the reporting, for example, of the source and number of embryos used.[354]

The last topic considered by the Committee was the risk of commercial exploitation through the uncontrolled purchase and sale of human gametes and embryos. The Committee proposed that such purchase or sale "should be permitted only under licence from, and subject to, conditions prescribed by the licensing body and therefore unauthorized sale or purchase should be made a criminal offence".[355]

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348 *Ibid.*, para. 12.16, at 74.

349 *Ibid.*, paras. 13.3-13.4, at 75-76.

350 *Ibid.*, paras. 13.5-13.6, at 76.

351 *Ibid.*, para. 13.8, at 77.

352 *Ibid.*, para. 13.7, at 77.

353 *Ibid.*, para. 13.9, at 78. Such a register would permit children to discover their origins and any information to which they are entitled. See, also, *ibid.*, para. 4.21, at 24-25; para. 6.6, at 37; and para. 7.7, at 41.

354 *Ibid.*, paras. 13.10-13.12, at 78-79.

355 *Ibid.*, para. 13.13, at 79.

(c) AUSTRALIA

(i) Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization

a. In Vitro Fertilization, Artificial Insemination, and Donor Gametes

In the early 1980's, the Victoria Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization published the *Report on Donor Gametes in IVF,*[356] as well as the prior *Interim Report*[357] and *Issues Paper on Donor Gametes in IVF.*[358] It should be noted at the outset that many important issues were identified, but not dealt with, by the Committee in these Reports — for example, the freezing and storage of embryos and the use of donated ova and sperm, surrogate motherhood, the fertilization of embryos for research and experimentation or for therapeutic purposes, and genetic engineering.[359]

The *Interim Report* concentrated its attention solely on I.V.F. using the gametes of the husband and wife. The Committee stated that it "considers this form of the procedure to be acceptable to the Victorian community and accordingly recommends that it be recognized in those terms".[360]

The subsequent Issues Paper dealt with A.I.D. and I.V.F. involving donor gametes. After reviewing the history and practice of I.V.F. and artificial insemination, the Issues Paper recanvassed the place of these procedures in Victoria. For example, the paper stated that "[t]hese techniques offer a better opportunity for establishing bonds between parents and child than does adoption, and they also offer greater scope than adoption for matching characteristics of parents and child".[361] In addition, the Committee suggested that "the child born as the result of sperm or ovum donation is likely to be especially well nurtured, since it is especially wanted".[362]

However, the Committee recognized that the tension involved in keeping the child's origins a secret, or the feeling that the child is a "foreign" person, may

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356 Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Report on Donor Gametes in IVF* (1983) (hereinafter referred to as "Victoria Report on Donor Gametes").

357 Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Interim Report* (1982) (hereinafter referred to as "Victoria Interim Report").

358 Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Issues Paper on Donor Gametes in IVF* (1983) (hereinafter referred to as "Victoria Issues Paper").

359 Victoria Interim Report, *supra*, note 357, paras. 5.2-5.4, at 19-20.

360 *Ibid.*, para. 5.6, at 20 (emphasis deleted).

361 Victoria Issues Paper, *supra*, note 358, para. 3.2.6, at 14.

362 *Ibid.*, para. 3.2.7, at 16.

disrupt family life.[363] Moreover, "whether or not they [the couple] agree, their action is a denial of true sexual order.... It [A.I.D.] certainly is difficult to reconcile with the understanding of the unitive (as distinct from the contractual) nature of marriage".[364] Finally, the paper stated that "AID and ova donation are seen by some as departures from the age-old principle that the interests of the child are paramount, since they are not child-orientated but geared to satisfy the maternal and paternal instincts of the couple".[365]

Finally, in relation to the child, the Committee noted the argument that "children have a right to be brought into the world in the context which tends best to promote their individuality and responsibility and to promote their sense of identity ...".[366] This "sense of identity" might be impaired where the child's biological parents are not identical with its social parents. In this connection, the Committee stated that the "legislator may talk easily about erasing the legal link between genetic parent and child, but he cannot ignore the ethical right of the child to know its genetic antecedent".[367]

The Committee's *Report on Donor Gametes in IVF* did not review in any detail the matters raised in the *Interim Report* and Issues Paper. After a brief discussion, a majority of the Committee endorsed the use of donor sperm and donor ova in I.V.F.,[368] despite recognized differences between A.I.D. and

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363 *Ibid.*, para. 3.2.6, at 14.

364 *Ibid.*, para. 3.2.5, at 14.

365 *Ibid.*, para. 3.2.7, at 15. In this connection, the Committee commented that, in the legitimacy proposal in the English Law Commission Working Paper on illegitimacy, *supra*, note 213, "[t]he child is not mentioned": Victoria Issues Paper, *supra*, note 358, para. 3.2.7, at 15. The Committee's comment arguably reflects a rather narrow reading of one passage of the Working Paper. The point made in the latter document was that a mother using A.I.D. generally registers her husband as the father of the child. The Law Commission sought to recognize the social reality that the couple wants to treat the child as its own — generally not for the personal gratification of the husband and wife, but because they want to create a family unit, which presumably is in the best interests of the child.

Moreover, it seems somewhat myopic to view the proposal as essentially being related to anything other than the best interests of the child. The wish to remove any stigma of illegitimacy and regularize the status of the A.I.D. child is clearly an orientation in favour of the child.

366 *Ibid.*

367 *Ibid.*

368 Victoria Report on Donor Gametes, *supra*, note 356, para. 2.6, at 10-11, and para. 2.9, at 12. The Rev. Dr. Francis Harman dissented with respect to the use of donor gametes (*ibid.*, Appendix A, at 49 *et seq.*). Having regard to the principle that the interests of the child are paramount, he stated that there were "higher-than-normal risks deriving from the trauma of [the child] discovering" his origins (*ibid.*, Appendix A, para. 8, at 54). In addition, he noted the "deception" practised by attempting to conceal origins. In his view, "IVF should be confined to the husband-wife dyad" (*ibid.*, Appendix A, para. 13, at 57).

I.V.F.[369] and despite special medical, surgical, social, and psychological problems associated with ova donation.[370]

However, in the *Interim Report,* it had been said that "[s]afeguards were needed to protect the interests of the community and the individuals involved in the programme, including the embryo formed in the laboratory".[371] For example, it was proposed that specially trained counsellors should advise couples on all matters relating to the treatment of infertility,[372] and should warn them that, in some cases, artificial conception procedures may involve some risk and may be traumatic, even where successful.[373] Such advice "will then permit each couple to express in writing their free and informed consent to participate in the programme".[374]

An important topic considered by the Committee was the selection of participants. The *Interim Report* was "of the view that the procedure should be available, at present, only to married couples",[375] although the door may have been left open for the future use of I.V.F. in the case of "de facto relationships".[376] This issue was not canvassed directly in the *Report on Donor Gametes in IVF.*

While many other bodies have recommended or assumed that an inquiry should be made into the suitability of the candidates for parenthood, the Committee was not clear on this point. It did insist that selection "should not be

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369 For example, unlike in the A.I.D. case, where there is time for counselling, "[c]ouples in an IVF programme ... may be asked to make quick decisions, with little or no prior counselling on that subject, whether to accept the use of donor sperm, when fertilisation using the husband's sperm has failed to occur" (*ibid.*, para. 2.5, at 10).

370 The Committee was "very conscious of the need to avoid any adverse discrimination against those couples whose infertility may only be managed through the use of donor ova" (*ibid.*, para. 2.9, at 12).

371 Victoria Interim Report, *supra*, note 357, para. 5.8, at 21.

372 *Ibid.*, para. 5.8.2, at 22-23, and Victoria Report on Donor Gametes, *supra*, note 356, para. 3.2, at 13-14. The two Reports also recommended the initiation by the government of a programme of information and education concerning infertility and "artificial" means of conception: see Victoria Interim Report, *supra*, note 357, para. 5.8.4, at 23-24, and Victoria Report on Donor Gametes, *supra*, note 356, para. 3.1, at 13.

373 Victoria Interim Report, *supra*, note 357, para. 5.8.2, at 22-23, and Victoria Report on Donor Gametes, *supra*, note 356, paras. 3.3-3.4, at 14-15.

374 Victoria Interim Report, *supra*, note 357, para. 5.8.3, at 23. The Committee elaborated on this point in the Victoria Report on Donor Gametes, *supra*, note 356, para. 6.8, at 43:

> Consent to the use of donor gametes in IVF should be given, and recorded in a document, by the couple before they begin to participate in the procedures. A copy of the consent document should be given to the partners, and the original retained by the hospital.

See, also, discussion *ibid.*, para. 3.5, at 15-16.

375 Victoria Interim Report, *supra*, note 357, para. 5.8.5, at 24.

376 *Ibid.*

solely made on the basis of first in line or the capacity to pay".[377] But, by suggesting that selection "should be made on the basis of defined priorities relating to individual *needs*",[378] the *Interim Report* seemed to focus attention on matters other than the more amorphous ones relating to suitability for parenthood. In the *Report on Donor Gametes in IVF,* the Committee indicated that, in assessing the "need" of the couple, account should be taken of "not only medical but also social and psychological considerations".[379] Unfortunately, there was no further discussion of this important issue.

With respect to the person or body authorized to make a final decision concerning the screening of prospective recipients, it is interesting to observe that, in the Issues Paper, the Committee attempted to go beyond an uncritical approval of the medical profession's regulation of A.I.D. and I.V.F. The Committee's concerns deserve mention:[380]

> The Committee understands that the medical profession's regulation of insemination procedures extends to such fundamental social questions as the selection and screening of both donors and recipients, the maintenance of records (if any), and counselling (if any). It also extends to the destruction of records. There is a social interest in some form of regulation more comprehensive than that provided by individual members of the profession, or even by the ethics committees of specific hospitals. Medical ethics are not separate from but are part of the general moral and ethical order by which the whole community lives. Decisions as to what doctors ought to do must be tested against the ethical principles of society. They have no special dispensation to depart from our moral and ethical standards.

The Issues Paper, however, did not indicate the type of "more comprehensive" regulation suggested above or under whose aegis such regulation would take place.

In the *Interim Report,* the Committee attempted to protect the interests of the community and the persons involved in I.V.F. by recommending that "IVF should only be conducted in hospitals authorized to do so by, and responsible to, the Health Commission of Victoria".[381] The *Report on Donor Gametes in IVF* further suggested that the Health Commission establish procedures to monitor the authorized hospitals.[382] The Committee also made it clear that "the hospitals providing donor gametes in IVF programmes [should] ... retain a final responsibility for the admission of any patients to those programmes".[383]

The *Report on Donor Gametes in IVF* then turned to the donation of

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377 *Ibid.* See, also, Victoria Report on Donor Gametes, *supra*, note 356, para. 3.6, at 16.

378 Victoria Interim Report, *supra*, note 357, para. 5.8.5, at 24 (emphasis added).

379 Victoria Report on Donor Gametes, *supra*, note 356, para. 3.6, at 16.

380 Victoria Issues Paper, *supra*, note 358, para. 3.2.8, at 16.

381 Victoria Interim Report, *supra*, note 357, para. 5.8.1, at 82.

382 Victoria Report on Donor Gametes, *supra*, note 356, paras. 3.40-3.41, at 30.

383 *Ibid.*, para. 3.6, at 16.

gametes. In view of the potentially unsettling effects of a donation, the Committee recommended that "the selection of donors shall be based not only on medical, but also on social and psychological considerations".[384] Prior to donation, prospective donors should be given "comprehensive information" on I.V.F. and the implications of gamete donation. In addition, donors should be told that, while they will have no legal relationship to the child and no duties or rights in respect of the child, there can be no guarantee of permanent, total anonymity.[385]

With respect to the collection of gametes, the Committee stated that, prior to the donor's written consent, "it shall be unlawful for any gametes to be recovered".[386] In addition, a donor should be entitled to withdraw his or her consent upon "[f]ormal notice of withdrawal in writing" to the hospital.[387] On receipt of such notice, the hospital should "immediately dispose of those gametes, and make an appropriate record of that disposition".[388]

The Committee further recommended that "it [should] be unlawful to buy or to sell, or to agree to buy or to sell, any gametes",[389] although donors may be reimbursed "for any costs, including medical expenses they incur, in making the donation".[390] Moreover, "it [should] be unlawful to recover, or receive, any gametes from a child", that is, an unmarried person under eighteen years of age.[391]

The Committee had "reservations" about the use of known donors, having regard to the potentially harmful effect on the resulting child. But, given that some groups would not permit the use of gametes from unknown persons, the Committee recommended that "the use of known donors in IVF [should] be permitted where both partners specifically request that that be done".[392]

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384 *Ibid.*, para. 3.13, at 19.

385 *Ibid.*, para. 3.14, at 19-20. In the penultimate section of the Victoria Issues Paper, the Committee dealt with the "uncertainty about the powers of donors of ova and sperm in respect of the use and disposition of gametes" (Victoria Issues Paper, *supra*, note 358, para. 3.4.8, at 26). The question whether, upon donating the gametes, the donor surrenders all rights to them — a matter that might arise where the donor wants the gametes back or applies for custody of the resulting child (see *ibid.*) — was identified, but not answered, by the Committee.

386 Victoria Report on Donor Gametes, *supra*, note 356, para. 3.15, at 20.

387 *Ibid.*, para. 3.17, at 21. See, also, Victoria Issues Paper, *supra*, note 358, para. 3.4.8, at 26, noted *supra*, note 385.

388 Victoria Report on Donor Gametes, *supra*, note 356, para. 3.17, at 21. If the gametes have already been used, legislation should absolve the hospital and recipients of any criminal or civil liability as a result of such use: *ibid.*, para. 3.18, at 21.

389 *Ibid.*, para. 3.10, at 18.

390 *Ibid.*, para. 3.11, at 18.

391 *Ibid.*, para. 3.12, at 18.

392 *Ibid.*, para. 3.21, at 22. The donor should be subject to the same screening proposed

The Committee next turned to special matters respecting ova donation. In order to avoid pressure being placed on women participating in an I.V.F. programme to donate their surplus ova, the Committee recommended that "it [should] be unlawful to seek, or to use, ova ... soon after discovery that more have been recovered" than are necessary.[393] Further, "[c]onsent to the use of ova recovered must ... follow counselling and be obtained before any operation or other procedure for the recovery of those gametes".[394]

Several sections of the *Report on Donor Gametes in IVF* then proceeded to deal with the identification or anonymity of donors and recipients. This important matter was touched upon in the Issues Paper, where the Committee stated:[395]

> Donors should be helped to appreciate that records will be kept and subsequently details may be made available in certain cases. Records should be kept to include identity, health and social details. But the need to protect privacy remains. Accordingly certain records, it may be argued, should only be available to the people most affected, say, the child, the donor, and the recipients.

The details of what information could be given to these selected persons were not, however, disclosed.

In the *Report on Donor Gametes in IVF*, the Committee stated that donors and recipients should be provided with information thought to be important to them, without sacrificing anonymity. Accordingly, the Committee proposed that the hospital should offer "non-identifying" recipient information, including the results of the use of the gametes,[396] to the donor, and similar donor information to the recipient.[397]

With respect to anonymity *vis-à-vis* the resulting child, the Committee noted the tension between the need for secrecy and the "strong interest in being able to discover some information about [one's] origin".[398]

The Issues Paper considered the "psychological and social implications" of A.I.D. and I.V.F. from the perspective of both the couple and the child, whose interests were said to be paramount.[399] The Committee said that, "[i]n AID,

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earlier in the Report, and "special counselling" should be given, with a separate document recording this fact: *ibid.*, para. 3.22, at 23.

393 *Ibid.*, para. 3.25, at 24.

394 *Ibid.*

395 Victoria Issues Paper, *supra*, note 358, para. 3.3.6, at 21.

396 Victoria Report on Donor Gametes, *supra*, note 356, para. 3.28, at 25.

397 *Ibid.*, paras. 3.26-3.27, at 24-25. But see the dissent of Rev. Dr. Francis Harman (*ibid.*, Appendix A, at 49 *et seq.*), where he stated (para. 11, at 56) that "identifying information re donors should be available to the IVF/donor gamete product on attaining majority ...".

398 *Ibid.*, para. 3.29, at 26.

399 Victoria Issues Paper, *supra*, note 358, para. 3.3.1, at 17.

secrecy is being maintained, with possible tensions and conflicts between the parents, and between them and the child or children".[400]

In the *Report on Donor Gametes in IVF*, the Committee stated that "children born as a result of the successful use of donor gametes in IVF, should be able to discover some information about their origins".[401] However, while reference was made to the present view that, under certain circumstances, adopted children should be permitted to discover their natural parentage, "it is recognized that the considerations are not exactly the same as in adoption".[402] The Committee was concerned that emotional injury might result from overexposure to the facts.

The Committee proposed that the Health Commission should establish a central registry containing "comprehensive information". In addition, each authorized I.V.F. hospital should maintain its own register of donors, and should provide the Health Commission with information concerning successful pregnancies and any abnormalities found in I.V.F. children.[403] The Committee also proposed[404] that the "information in the registries [should] be exempt from the provisions of the *Freedom of Information Act* 1982[405]".

The Committee acknowledged that it had "not sought finally to determine ... what kinds of information, beyond that which is non-identifying, shall be provided by way of an entitlement to any person who enquires about her or his own genetic background".[406] Indeed, even the notion of "entitlement" appeared to be somewhat circumscribed, for the Committee stated earlier that any *request* for information should be made "on such terms and in such circumstances as the [Health] Commission from time to time shall determine".[407] However, it was recognized that the nature and scope of the information released would depend on the developing views of the Victorian community.[408]

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400 *Ibid.*, para. 3.3.4, at 19.

401 Victoria Report on Donor Gametes, *supra*, note 356, para. 3.29, at 26.

402 *Ibid.*, para. 3.30, at 26.

403 *Ibid.*, para. 3.32, at 27.

404 *Ibid.*, para. 3.36, at 28.

405 No. 9859.

406 Victoria Report on Donor Gametes, *supra*, note 356, para. 3.34, at 28.

407 *Ibid.*, para. 3.33, at 27.

408 *Ibid.*, para. 3.34, at 28. A further recommendation, related to the Committee's concern for "honesty and integrity in the family", was that "it [should] be unlawful to use donor gametes in IVF in such a way as to confuse those concerned about the genetic background of any child born": *ibid.*, para. 3.37, at 29. For example, "procedures such as the mixing of donor sperm, or the transfer of several embryos from different sources, should be prohibited": *ibid.*

The emphasis on the "integrity of the family" and the need to avoid genetic confusion prompted the Committee to deal with the possibility of incestuous relationships and sibling marriages arising from the indiscriminate use of donor gametes. It was thought

The next major portion of the *Report on Donor Gametes in IVF* dealt with the status of, and obligations to, I.V.F. children, matters considered briefly in both the *Interim Report* and the Issues Paper.

Where married couples used their own genetic material, the situation was said to be clear: the child was the legitimate issue of the marriage.[409] Where donor gametes were involved, the Committee rejected the possibility of using the cumbersome and expensive procedure of adoption to overcome the status of illegitimacy.[410]

In the *Report on Donor Gametes in IVF,* it was noted that, in July 1983, the Standing Committee of Commonwealth and State Attorneys-General respecting the status of A.I.D. children had considered a draft Artificial Conception Bill, prepared for the Attorney-General of Victoria. Section 4 provided that a consenting husband or common law partner was irrebuttably presumed to be the father of an A.I.D. child, and section 5 provided that the semen donor was irrebuttably presumed not to be the father. The Committee endorsed these principles, but stated that they should also apply where donor sperm or donor ova were used in I.V.F.[411]

The last section[412] of the *Report on Donor Gametes in IVF* dealt with a

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that the existence and use of a central registry would significantly reduce these possibilities. For example, the Health Commission would be able to monitor the successful use of a donor's gametes in more than one I.V.F. programme, and to advise the hospitals accordingly: *ibid.*, paras. 3.38-3.39, at 29.

409 Victoria Interim Report, *supra*, note 357, para. 5.9, at 26.

410 Victoria Issues Paper, *supra*, note 358, para. 3.4.3, at 23, and Victoria Report on Donor Gametes, *supra*, note 356, para. 4.2, at 32.

411 *Ibid.*, paras. 4.9 and 4.11, at 36. It should be noted that the Committee was of the view that, under the present law, the "mother of a child born as a result of the use of donor ova is the donor of the ova" (*ibid.*, para. 4.1, at 31). For a contrary view of the status of the gestating mother, see Law Society of Scotland Report, *supra*, note 254, at 11, para. (b).

The Victoria Issues Paper, *supra*, note 358, para. 3.4.11, at 27-28, also referred to recently proposed — although now lapsed — legislation in Australia to amend the federal *Family Law Act* 1975, No. 53. Section 5A(1) of the 1981 *Family Law Amendment Bill* provided, *inter alia*, that the consenting husband of a woman who was an A.I.D. or I.V.F. recipient shall be the father of the resulting child. The Committee noted that the language of clause (a) "[seems] to mean that consent must be given before AID or AID-in-IVF is carried out": Victoria Issues Paper, *supra*, note 358, para. 3.4.11, at 28.

We shall return to the legislation in Victoria at a later juncture: see *infra*, sec. 3(d)(i).

412 Prior to this, the Committee completed its discussion concerning the status of I.V.F. children by indicating that it had not considered other matters of law identified in the Issues Paper: Victoria Report on Donor Gametes, *supra*, note 356, para. 4.13, at 37. For example, the Committee discussed briefly prenatal and other personal injury actions against medical personnel and donors. Further study was said to be necessary in respect of many of these matters: *ibid.*

matter thought to demand special attention, that is, the use of donor embryos, as opposed to donor sperm or donor ova.

The issue was considered briefly in the *Interim Report,* but there was no clear statement by the Committee. A minority believed that, "until the Committee has had time to consider fully the implications of alternatives such as freeze thawing of embryos, donation of embryos, and surrogate motherhood, ... these procedures should not be employed in IVF programmes in Victoria".[413] However, the majority endorsed the process of freeze thawing "while this is being considered".[414] Moreover, it was of the view that, where there were surplus embryos, "the wishes of the couple concerning handling of such excess embryos should be respected".[415]

In the *Report on Donor Gametes in IVF,* the Committee stated that its examination of the issues relating to the freezing of embryos had not been completed. However, it recognized that, given the potentially unsettling effect on the child and couple, embryo donation was of more concern than the donation of sperm or ova alone. While, initially, the Committee said that the statements in the *Interim Report* represented its only observations to date,[416] a majority of the Committee nonetheless recommended that the use of donor embryos should be permitted. In particular, the majority was "conscious of the need to avoid discrimination against those couples whose infertility may only be managed through the use of donor embryos".[417]

In addition to recommending that its previous proposals concerning the regulation of the use of donor sperm and donor ova should apply to the use of donor embryos,[418] the Committee made several other recommendations with respect to the latter.[419] For example, the Committee said that "[i]t should be unlawful for donor embryos to be used except in the case of couples whose infertility cannot be overcome by other means, or where the couple may transmit undesirable hereditary disorders".[420]

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413 Victoria Interim Report, *supra*, note 357, para. 5.8.6, at 26.

414 *Ibid.*

415 *Ibid.*, para. 5.8.6, at 25.

416 Victoria Report on Donor Gametes, *supra*, note 356, para. 5.3, at 39.

417 *Ibid.*, para. 5.5, at 40. It will be recalled that this was the rationale used to justify the proposal respecting the use of donor ova: see *supra*, note 370.

Rev. Dr. Francis Harman and Mrs. Jasna Hay dissented. Both expressed concern for the welfare of the child whose genetic makeup did not come from either of the social parents.

418 Victoria Report on Donor Gametes, *supra*, note 356, para. 5.6, at 41.

419 *Ibid.*, paras. 6.32-6.35, at 47-48.

420 *Ibid.*, para. 6.32, at 47.

b. In Vitro Fertilization and "Surplus" Embryos

In its *Interim Report,* the Victoria Committee had identified certain matters relating to the disposition of embryos in the context of I.V.F. It decided that, subsequent to its *Report on Donor Gametes in IVF,* it would consider the cryopreservation of embryos, experiments on embryos, and surrogate motherhood using I.V.F. Accordingly, in 1984, the Committee published its *Report on the Disposition of Embryos Produced by In Vitro Fertilization.*[421]

After first discussing generally the freezing of gametes and embryos, the Committee noted that it was divided concerning developments in genetic manipulation, particularly those that would permit the treatment and cure of embryos *in vitro* so that they might be transferred to recipients. However, the Committee was unanimously of the view that the subject of genetic manipulation of untransferred embryos deserved further study.[422]

When the Committee returned to the topic of embryo freezing, it noted the arguments both for and against the process. For example, one member of the Committee believed that the embryo, unlike the individual gamete, represented human life, and that freezing and storing it "is to derogate, grossly, from [its] intrinsic worth".[423] In addition, it was suggested that the physical risks of freezing and thawing, and the effect on the future child who learns that, for a time, he or she was in "suspended animation", also militated against cryopreservation.[424]

The main argument marshalled in favour of the process was a simple one: "the procedure is successful and it does presently facilitate the operations of [an I.V.F.] programme".[425] Indeed, the Report noted that, for some persons, cryopreservation is essential, where, for example, it is impossible or medically undesirable or impracticable to transfer an *in vitro* embryo immediately to the intended recipient. To permit the embryo to be wasted might necessitate, among other things, a further laparoscopy under general anesthetic. In this connection, the Committee stated, it must be borne in mind that most transfers do not, in fact, result in a pregnancy; accordingly, cryopreservation reduces the economic and emotional burdens involved in I.V.F. treatment. Moreover, embryo freezing may permit couples to have children subsequent to radiation therapy or chemotherapy undergone by one of them, since such therapy usually results in sterility.

The Committee, by a majority, recommended that "the freezing of embryos formed in an IVF programme should be permitted in Victoria at present", in

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421 Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Report on the Disposition of Embryos Produced by In Vitro Fertilization* (1984) (hereinafter referred to as "Victoria Report on Embryos").

422 *Ibid.*, para. 1.17, at 14.

423 *Ibid.*, para. 1.28, at 18. See, also, *ibid.*, Appendix A, at 62.

424 *Ibid.*, para. 1.30, at 18-19.

425 *Ibid.*, para. 1.31, at 19.

accordance with further proposals made in the next part of its Report.[426] As indicated, there was one dissent.[427] Moreover, one Committee member was in favour of freezing only where the health of the intended recipient did not permit an immediate embryo transfer.[428] In order to reduce the need to freeze embryos, all members of the Committee were of the opinion that "research on and development of techniques for the freezing and storage of human ova should be warmly encouraged".[429] Should such techniques be perfected, the question of embryo freezing "should appear as an item on the agenda of a standing review and advisory body on human fertility, reproduction and related subjects",[430] proposed in Part 5 of the Report.

Since the Committee took the position that embryo freezing was still experimental,[431] it was of the view that "the greatest caution must be exercised in the management and control of that programme".[432] More specifically, it stated that "the overriding consideration must be to restrict as far as possible the period of cryopreservation", while bearing in mind the needs of infertile couples.[433] However, it was not made entirely clear why the majority of the Committee believed that a time limitation was necessary, once freezing had taken place, particularly since the majority thought that "[f]reezing is not inimical to the interests of the embryo".[434] One rationale, discussed earlier,[435] related to the psychological effect of cryopreservation on the future child. But it was not stated why the actual duration of cryopreservation, as opposed to cryopreservation itself, was relevant to the child's attitude to the facts of its origin. Another reason for imposing a time restriction was, apparently, that short term storage would reduce the risk of problems that might occur where, for example, the couple died or ceased to cohabit.[436]

With respect to the "management and control" of embryo cryopreservation, the Committee recommended that freezing and storage of embryos should be carried out only "if the couple whose gametes have been used in its formation" agreed in writing to the procedure;[437] moreover, it should "only be undertaken

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426 *Ibid.*, para. 1.40, at 22.

427 See *supra*, note 423 and accompanying text.

428 Victoria Report on Embryos, *supra*, note 421, para. 1.38, at 21-22. See, also, *ibid.*, Appendix B, at 72.

429 *Ibid.*, para. 1.43, at 23.

430 *Ibid.*

431 *Ibid.*, para. 2.1, at 24.

432 *Ibid.*

433 *Ibid.*

434 *Ibid.*, para. 1.32, at 19.

435 *Ibid.*, para. 1.30, at 19. See text accompanying note 424, *supra*.

436 Victoria Report on Embryos, *supra*, note 421, para. 2.14, at 30-31. See discussion *infra*, this sec.

437 Victoria Report on Embryos, *supra*, note 421, para. 2.7, at 26. The agreement could be

in a hospital already approved to conduct an IVF programme, which is specially authorized by the Minister of Health to conduct such activities".[438] Moreover, "no hospital authorised to conduct a cryopreservation programme shall maintain a bank or store of large numbers of frozen embryos from which embryos may be disposed of as the hospital thinks fit";[439] rather, "[e]ach embryo which is frozen shall be retained for a couple, to be used in the course of the treatment of their infertility".[440]

However, the Committee did "not regard the couple whose embryo is stored as owning or having dominion over that embryo",[441] although it did say that the couple should have rights over the embryo analogous to parental rights.[442] Nevertheless, these rights of disposition, which should be indicated prior to cryopreservation,[443] would not be absolute. For example, the couple could not "sell or casually dispose of the embryo".[444] But the couple might donate the embryo for an I.V.F. programme or for I.V.F. research or experimentation,[445] or might simply decide that the storage should cease.

Where the couple exercised its rights of disposition in any one of these ways, "the embryo shall be removed from storage as soon as possible".[446] If storage was simply to cease, the embryo "should not be destroyed in any deliberate fashion", but, like a terminally ill person whose life-support systems have been removed, should be allowed to die.[447]

Ordinarily, it was said, storage should be for a very short time. However, cases might arise where longer term cryopreservation was necessary, for example, where the intended recipient was undergoing chemotherapy. Where "a couple consents to long term storage, the consent shall be reviewed after 5 years, and may then be renewed".[448]

Long term storage was said to increase the risk of problems that might occur, for example, where one or both of the gamete donors died or disappeared,

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made only after the couple has been given adequate information concerning the procedure and has received "expert counselling": *ibid.* See, also, *ibid.*, paras. 2.4-2.6, at 25-26.

438 *Ibid.*, para. 2.2, at 24.

439 *Ibid.*, para. 2.3, at 24-25.

440 *Ibid.*, para. 2.3, at 25.

441 *Ibid.*, para. 2.8, at 27.

442 *Ibid.*

443 *Ibid.*, para. 2.9, at 28.

444 *Ibid.*, para. 2.8, at 27-28.

445 *Ibid.*, para. 2.8, at 28. See, also, *ibid.*, paras. 2.10-2.11, at 28-29.

446 *Ibid.*, para. 2.12, at 29.

447 *Ibid.* "This does seem to accord the embryo a measure of that respect which is so often spoken of in relation to it": *ibid.*

448 *Ibid.*, para. 2.13, at 30.

or where the parties ceased to cohabit.[449] The Committee decided that the disposition of the stored embryo should not be determined by the hospital holding it, since this might lead to the undesirable establishment of a hospital embryo bank.[450] The Committee further recommended that "the couple who agree to storage shall be required to determine at that time what disposition shall be made if any of the events mentioned occur".[451] Where, for some reason, the intended disposition could not proceed, or no provision had in fact been made, "the embryo shall be removed from storage"[452] (and, therefore, permitted to die).

The Committee next turned to consider embryo research, which was said to be essential to the success of I.V.F. The Committee mentioned several areas, relating, for example, to the treatment of infertility and congenital defects and other diseases, that depended on embryo research.

The members of the Committee were divided regarding such research. A minority was of the view that "any research on embryos which prevents implantation, or reduces the success rate of such implantation, is unacceptable, as is the creation of embryos specifically for research where there is no intention that the embryo created should be transferred to a recipient uterus".[453]

A majority of the Committee, however, concluded that, if regularly scrutinized, embryo research was acceptable in order to improve I.V.F. procedures and evaluate genetic research. For example, the successful development of ovum freezing would help to reduce substantially the ethically difficult questions respecting the use of surplus embryos. The majority recommended that the "use of any embryo for research [should] be immediate, and in an approved and current project in which the embryo [should] not be allowed to develop beyond the stage of implantation, which is completed 14 days after fertilization".[454]

Several Committee members would limit embryo research "to the excess embryos produced by patients in an IVF programme",[455] for example, where abnormal embryos are not transferred to a woman; embryos should not be created solely for research or experimentation.[456] Others recommended that research should not be limited to surplus embryos, but could encompass embryos created purely for research purposes, in order to facilitate certain kinds of study.[457]

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449 *Ibid.*, para. 2.14, at 30-31.

450 *Ibid.*, para. 2.16, at 31-32.

451 *Ibid.*, para. 2.17, at 32.

452 *Ibid.*, para. 2.18, at 32.

453 *Ibid.*, para. 3.24, at 45.

454 *Ibid.*, para. 3.29, at 47.

455 *Ibid.*, para. 3.26, at 46.

456 *Ibid.*, para. 3.27, at 46.

457 *Ibid.*, para. 3.30, at 47-48.

The Committee next turned to consider surrogate motherhood in the context of I.V.F. The Committee came to the conclusion that "surrogate mother arrangements where fees are paid are, in reality, agreements for the purchase of a child, and should not be countenanced".[458] Characterizing commercial surrogacy arrangements, involving payment of a fee to the surrogate mother, as more "inhuman" than the sale of gametes, the Committee stated that a "hospital licensed to conduct an IVF programme [should] not be permitted to make any commercial surrogacy arrangements as part of that programme".[459]

On the other hand, the Committee noted that "surrogacy in IVF [presumably using the gametes of the intended social parents] may commend itself more than the use of donor gametes in IVF to some couples", since a "child born would be genetically theirs, and ethical problems about disclosure and identity would be avoided".[460] In the end, however, the Committee recommended that "surrogacy arrangements [should] in no circumstances be made at present as part of an IVF programme in Victoria",[461] even where the surrogate mother is not paid a fee. The Committee recognized the utility of such arrangements and that the surrogate mother might be acting altruistically. However, its concern for the child, the potential discord where a handicapped child is born, and the problems associated with the failure to surrender the child convinced the Committee that surrogate motherhood arrangements of any kind should be prohibited.

The last substantive part of the Report dealt with future developments and further issues, some of which had not been considered by the Committee in detail, although identified in the *Interim Report.* In addition, the Committee emphasized that advances in research and practice would have a substantial effect on how the various issues in its Reports would be received and resolved. To anticipate such developments and to help monitor activities in the field, the Committee stated that "it would be in the best interests of the Victorian community if the Government established a standing review and advisory body which would continue and broaden the work it has already done". This body "should be empowered to examine and report on all matters in the field of the scientific and medical management of infertility, and related issues".[462] For example, the "question of embryo flushing or in vivo fertilization should be one matter considered by such a body, and should not be permitted unless the body so recommends".[463]

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458 *Ibid.*, para. 4.6, at 50.

459 *Ibid.*, para. 4.11, at 52-53.

460 *Ibid.*, para. 4.10, at 52. However, one would have thought that the ethical problems about disclosure of the child's origins — the fact of surrogacy itself, with the gestating mother different than the genetically related mother — would remain a very significant issue.

461 *Ibid.*, para. 4.17, at 54.

462 *Ibid.*, para. 5.4, at 56.

463 *Ibid.* The body should also consider embryo cleavage, embryo surgery, and genetic manipulation: *ibid.*

(ii) Queensland, Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters

In 1984, a Special Committee on artificial conception, under the chairmanship of Mr. Justice A.G. Demack, published its *Report of the Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters.*[464] Aside from artificial insemination and I.V.F., the Queensland Report dealt with surrogate motherhood, counselling and other related services, and the moral, ethical, social, economic, political, legal, and public policy issues raised by the new reproductive technologies.[465]

After describing the causes and treatment of infertility, chapter 3 delineated such basic principles guiding human conduct as the inherent dignity of the person, protection of the family as the natural and fundamental group unit of society, and the imperative to seek knowledge.[466] The Report noted that the advance of medical knowledge was not, in fact, an absolute goal, but must conform to notions of the public good.

With respect to the method or methods by which social control is exercised over medical science, the Report listed the establishment of ethical guidelines, the enactment of legislation, and the refusal of funding or facilities for certain projects.[467] Insofar as the promulgation of ethical norms was concerned, the Committee stated that no consensus existed with respect to several fundamental issues involved in artificial reproduction.[468] Moreover, rapid technological change appeared to be a constant feature.[469] Accordingly, the control of medical science through ethical rules was extremely difficult; such rules would have to be monitored and frequently revised.[470]

While the Committee's general position was that "medical practice should, so far as is possible, consistent with the public interest, be controlled through

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464 Queensland, *Report of the Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters* (1984) (hereinafter referred to as "Queensland Report").

465 Issues of this nature were raised in the Committee's Interim Report of May 31, 1983, and restated in the Queensland Report: *ibid.*, at 10-14.

466 *Ibid.*, at 40-41.

467 *Ibid.*, at 44-45.

468 *Ibid.*, at 45.

469 *Ibid.*, at 51 *et seq.*

470 For example, by an "institutional ethics committee" appointed for each institution in which research is undertaken, and by a proposed new, multidisciplinary Queensland Bioethics Advisory Committee, a general supervisory body established to advise the government and medical bodies: *ibid.*, at 46 *et seq.*

guidelines issued by responsible professional institutions", it was recognized that such regulation was not always possible or sufficient.[471] In some cases, legislation, including sanctions for breach of certain provisions, was required.[472] Significantly, the Committee adopted a type of compromise in respect of the selection of prospective participants in, for example, an I.V.F. programme. While it agreed that such selection should be left to the medical profession, at the same time it countenanced governmental intervention in order to assist "certain categories of persons rather than others", and considered it "proper for ethics committees to control the right of selection of patients to be admitted to an IVF and ET programme".[473]

Among the values to be protected when considering the control of medical science, the Committee included the rights of the child, the rights of the family, the value of human life, and human dignity and integrity.[474] With respect to the rights of the child, the Committee was of the view that artificially conceived children "must be protected by legislation".[475] Such children were said to need:[476]

(a) A name and identity ...;

(b) Access to a reliable medical (genetic) history ...;

(c) A man and a woman who are committed to their nurture, education and support ...;

(d) The right to sue for any deleterious consequences of the artificial means used in conception ....

The preceding requirements led to the following "inferences":[477]

- That the Registration of Births, Deaths, and Marriages Act should be amended to allow the man who is accepting paternal obligation to describe himself as father on the Birth Notification.
- That provision be made for the keeping of sufficient medical and social information about the donor of sperm used to allow the child to have access to a reliable medical and social history.
- That very strict screening procedures be adopted in the selection of donors.
- That legislation ensure that the 'parents' (the people using the programme) shall have all the rights, duties and privileges of parents towards the child, and that the child shall have all the rights of a child to inherit from the 'parents'.

With respect to the rights of the family, the Committee dealt with two major

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471 *Ibid.*, at 49.

472 For example, in respect of the licensing of artificial conception centres: *ibid.*, at 50.

473 *Ibid.*

474 *Ibid.*, at 55 *et seq.*

475 *Ibid.*, at 55.

476 *Ibid.*, at 55-56.

477 *Ibid.*, at 56.

questions: (1) whether artificial conception services should be open only to legally married couples; and (2) whether procedures should be permitted that may create children whose biological and social parentage differ.

The Report stated that, "[t]hough ... stability may not always be found in couples who are within a legal matrimonial relationship, it is assumed that the marriage commitment itself is evidence of stability".[478] However, to the extent that a *de facto* relationship had continued for a sufficient period to indicate a stable environment for the future child, artificial conception services for the couple involved was thought to be "appropriate".[479] No mention was made of single women as recipients.[480]

When the Committee returned to this topic, it stated that it would restrict admission, first, to those who have been unsuccessful in achieving pregnancy for at least two years or who have some genetic disease or "an obvious and otherwise irremediable bar to fertility".[481] Secondly, childless couples would be preferred.

A third factor related to the relationship of the couple in question:[482]

> [W]hile the Committee considers that there should be no legislative restriction on the extension of the process to de facto couples living in a stable relationship, it is of the opinion that at least priority should be given to married couples, and institutions licensed to provide an IVF service should be free to restrict it to married couples. The formal commitment to a stable relationship which is inherent in marriage, and the wider community acceptance of IVF within the framework of a married relationship, are seen as grounds for giving preference to a married couple. The embryo is produced in vitro in the confident expectation that there is a woman who is anxious to receive it and a family unit able to nurture the child into which the embryo may grow.
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> It would be the responsibility of the medical team at an institution licensed to conduct an IVF programme[483] to decide whether or not to admit a particular couple to the programme.

A proposal extending medical services to unmarried, stable couples was also made in the context of A.I.D.[484]

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478 *Ibid.*, at 58-59.

479 *Ibid.*, at 58.

480 When noting that one other right pertinent to the discussion was the "right of access to public services", the Report stated that "access to infertility services should be made generally available" (*ibid.*, at 63). However, it does not appear that this statement was directed to the question whether, for example, single women or lesbian couples might be selected as recipients.

481 *Ibid.*, at 81. See, also, *ibid.*, at 85, para. (vii).

482 *Ibid.*, at 82. In the context of A.I.D., the Committee also stated that "submission to counselling should be a precondition to involvement ..." (*ibid.*, at 110).

483 With respect to such institutions, see *ibid.*, at 82-83.

484 *Ibid.*, at 99 *et seq.* The Committee's conclusions and proposals were as follows (*ibid.*, at 109):

The next chapter, chapter 4, dealt with I.V.F. and embryo transfer. The Report first canvassed the ethical considerations, raising such issues as the separation of procreation and marital love, the destruction of embryonic life, the danger of harm to the child, the freezing of embryos, and the use of donor gametes.[485]

With respect to the use or disposition of "surplus" embryos, the Committee would not countenance unrestricted experimentation.[486] However, it considered the question of the limits on experimentation to be largely beyond its terms of reference, although it would permit I.V.F. services that did not involve the deliberate loss or destruction of embryonic life. The Committee concluded that I.V.F. ought not to be precluded simply because of these ethical concerns. However, it did recommend that any extension of the present programme in Queensland — which, it said, does not involve any destruction of embryos — and any programme involving fetal research should first be approved by the proposed Queensland Bioethics Advisory Committee.[487]

The next concern raised was that of possible danger to the artificially conceived child. The Committee rejected the proposition that the critical fact was the inability of the embryo to consent, given the informed consent of the couple "for the benefit and well being of the future child".[488] Rather, the "real issue is whether IVF constitutes unacceptable experimental medicine".[489] In this connection, the Committee stated that I.V.F. children did not, in fact, exhibit any

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> The Committee considers that the critical matter in this respect must be the position of the child conceived by AID. The interest of the child is best served by birth and development within a stable situation where both parents are responsible for its nurture. A situation where a child may be born to a woman who may not know who is the donor, where the anonymous donor will have no responsibility in caring for his offspring, and where the child will have no possibility of nurture by both his biological parents, is one which it considers should not be permitted to be fostered. We therefore consider that AID should normally only be administered in cases where the mother is married or is living in a stable de facto relationship with a man who consents to the AID.
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> AID should be available only to couples who have an established infertility problem.

See, also, *ibid.*, at 112-13, respecting the availability of A.I.D. services in Queensland. The Committee proposed that A.I.D. should be made available "to public patients in public hospitals ... as part of an infertility service" (*ibid.*, at 112).

485 *Ibid.*, at 65 *et seq.*

486 Although the Committee noted that, of embryos conceived naturally, only approximately 20% survive: *ibid.*, at 67.

487 *Ibid.*, at 72. With respect to research and experimentation, the Committee later stated that "a process which may help in alleviating the problem of infertility should not be banned simply because it may lead to undesirable forms of genetic engineering" (*ibid.*, at 80).

488 *Ibid.*, at 73.

489 *Ibid.*

abnormal levels of the usual disorders, although final conclusions with respect to all potential risks were not yet possible. In any event, the Committee concluded that "the prospect of possible hazard is not such as to require public intervention to ban the process or impose a moratorium on it".[490]

With respect to cryopreservation of embryos not immediately implanted, the process was justified so long as the risk of injury to the embryo was minimal,[491] the donors of the gametes consented,[492] and there was no risk where a subsequent transfer was attempted.[493] The Committee added that, if, later, it appeared that the risk was unacceptable, "IVF programmes should restrict the number of eggs fertilised to those necessary to accomplish a pregnancy".[494]

With respect to the use of donor gametes, the Committee stated that the "basic issue involved is the impact this may have on a family, including both the spouses and their children".[495] Of particular concern was the "possibility of psychological harm to the children who learn that they have been conceived in this way ...".[496]

The Committee perceived the question whether the use of donor gametes ought to be permitted or prohibited as involving a balance between the "public interest" and "private morality". It did not consider that the former required the banning of the use of donor sperm, but was not unanimous with respect to donor ova. However, the Committee agreed that certain restrictions should be imposed on ova donation:[497]

(a) the transfer should be part of treatment within an accepted family relationship;

(b) the recipient couple should intend to accept the duties and obligations of parenthood;

(c) consent should be obtained from the donor and the recipient couple;

(d) there should be no element of commerce between the donor and recipient couple.

It was recommended that the question whether to use donor gametes should be left to institutional ethics committees,[498] subject to certain limitations, including those outlined above. At a later juncture, the Report listed several more

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490 *Ibid.*, at 74.

491 *Ibid.*, at 75.

492 *Ibid.*, at 76.

493 *Ibid.*, at 77. The Committee suggested that cryopreservation should be restricted to 2 years, "except in exceptional circumstances": *ibid.*

494 *Ibid.*, at 76.

495 *Ibid.*, at 78.

496 *Ibid.*

497 *Ibid.*, at 79.

498 *Ibid.* See, also, *ibid.*, at 84-85, paras. (i) and (ii). The Committee also dealt, in passing, with embryo donation. It recommended that safeguards and procedures similar to those

restrictions on the use of donor gametes.[499] For example, the Committee was opposed to the use of gametes from children and to the payment of donors.[500] It also was of the view that "[s]election of donors should be based not only on medical, but also on social and psychological consideration[s]".[501] Donors should be entitled to withdraw their previously given written consent[502] at any time before their gametes have been used.[503]

With respect to medical records, the Committee proposed that each hospital should keep its own register of donors, and non-identifying information should be made available to recipients.[504] In addition, there should be kept a confidential control register containing medical and social information about donors whose gametes have been successfully used.[505]

The Committee then turned to consider the regulation of I.V.F. It began by stating that "it would seem to be ultimately in the public interest that a programme be established publicly, under public authorisation, and under the supervision of persons of guaranteed competence".[506]

The Report discussed the regulation of I.V.F. under several topics. For example, the Committee dealt with admission to an I.V.F. programme, discussed earlier in this section. The Committee also considered such legal issues as (1) the status of the resulting children, (2) liability to the child, and (3) the disposition of genetic materials and embryos.

With regard to the status of the child, the Committee stated that I.V.F. created no special legal problems: the child's status would depend on who

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applied in the case of adoption should be applied in the case of an embryo donation. There was no elaboration on this matter: see *ibid.*, at 79. At a later juncture, the Committee stated that donor embryos should be used only where the couple's infertility could not be overcome by other means or where the couple might transmit undesirable hereditary disorders: see *ibid.*, at 87, para. (xxv). See, also, *ibid.*, at 88. No embryo should be used without express written donor consent and no embryo should be created for experimental purposes: see *ibid.*, at 88, paras. (xxvii) and (xxviii), respectively.

499 *Ibid.*, at 84 *et seq.*

500 *Ibid.*, at 86, paras. (xi) and (x), respectively.

501 *Ibid.*, at 86, para. (xii).

502 *Ibid.*, at 86, para. (xiv).

503 *Ibid.*, at 86, para. (xv).

504 *Ibid.*, at 87, paras. (xx) and (xviii), respectively. See, also, para. (xxii). No mention was made of access by children.

505 *Ibid.*, at 87, paras. (xix) and (xxi).

506 *Ibid.*, at 81.

supplied the sperm and ovum.[507] In this connection, the Committee recommended that "the provisions suggested in the case where a child is born as a result of donor sperm should be extended to the case of donor ova".[508]

With regard to liability to the child, the Committee concluded that the ordinary law respecting the liability of professionals would apply in the case of I.V.F., so that no special legislation was required.

Finally, with regard to the disposition of genetic materials and embryos, the Committee stated that gamete donors should be viewed as guardians of the gametes and, therefore, "able to make decisions about [their] use and even disposal" prior to the collection of the gametes.[509] Where the gamete donors disagreed, the issue should be determined by means of the procedure applicable in custody proceedings.[510] However, where this was not possible — for example, where the biological parents of a frozen embryo had died, giving no directions concerning disposition[511] — the procedure to be used should be that applicable in the case of adoption. Some, but not all, Committee members would have prohibited any disposition that would involve the deliberate destruction or injury to an embryo.[512]

Chapter 5 of the Queensland Report dealt with artificial insemination. The discussion was confined to A.I.D., since it was believed that A.I.H. did not appear to give rise to moral or social issues necessitating regulation in the public interest. Moreover, children born of A.I.H. would have the status of children of the marriage.[513]

As in the case of I.V.F., the Report canvassed the moral, ethical, social, and legal issues involved and, after deciding that some control of A.I.D. was necessary, discussed the form that such regulation should take. The moral issue focused in large measure on the objection that A.I.D. involved the illegitimate creation of a child outside marriage and, therefore, destroyed the integrity of the family. Another objection concerned the psychological impact of A.I.D. on the child.

The Report acknowledged that the community was deeply divided on the morality of A.I.D. Indeed, the Committee, after reciting the usual objections, did no more than describe the equally frequent responses — relating, for

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507 *Ibid.*, at 88.

508 *Ibid.*, at 88-89. Status in the case of A.I.D. was considered *ibid.*, ch. 5, to be discussed below.

509 *Ibid.*, at 91.

510 *Ibid.*, at 91-92.

511 On June 19, 1984, both the Toronto *Globe and Mail* (at 11) and *The Toronto Star* (at A3) reported the death of the parents of 2 human embryos frozen in Australia, leaving an estate worth approximately $1 million.

512 Queensland Report, *supra*, note 464, at 92.

513 *Ibid.*, at 93.

example, to the love expressed for each other and the future child in the couple's desire to have a child. It then turned its attention to the legal issues.

The Committee began by stating that the A.I.D. "child should be treated in law as the legitimate child of the parties to that marriage, and should not be treated as the child of any person other than the parties to that marriage".[514] With respect to the husband's or partner's consent, the Committee concluded that, for the sake of certainty, the consent should be formally given and evidenced in writing, preferably before treatment, rather than rebuttably presumed.[515] Where consent is given, the "Registrar-General should register that man as the father of the child upon the production to him of the consent form or a certified copy thereof".[516]

The final legal issue canvassed concerned the disposition of sperm stored at a sperm bank or clinic. The Committee's proposal was as follows:[517]

> It is suggested that an appropriate rule would be that sperm provided for AID purposes will be at the disposition of the person or institution which operates the sperm bank or clinic, but that it will be required to carry out any undertakings it may have given the sperm donor as to its use and disposition. In other cases, the right of disposition of the sperm including post-mortem disposition will remain with the person who has supplied the sperm.

Subsequently, the Committee also recommended the enactment of legislation dealing with the operation of sperm banks and clinics.[518] Such institutions should be licensed and should be administered under proper medical supervision. Ethical guidelines should limit the number of inseminations from a particular donor, with semen from different donors to be kept separate. Donors should not be paid, although "travel expenses and loss of wages may be refunded ...".[519] Commercial exploitation respecting the procurement, collection, and disposition of semen should be prohibited. The use of A.I.D. for eugenic, selective purposes should also be prohibited, although the Committee appeared implicitly to adopt the view that the couple could, for example, choose the race or physical characteristics of the child; nor would the above proposal preclude the attempt to avoid harmful genetic traits. Finally, the Committee recommended the adoption of detailed guidelines, to be established by ethics committees and other qualified bodies and persons, dealing with the selection and screening of donors, the documentation of infertility investigations, the duration of sperm freezing, and sperm storage.[520]

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514 *Ibid.*, at 97.

515 *Ibid.*, at 99.

516 *Ibid.*, at 104.

517 *Ibid.*

518 *Ibid.*, at 110-11.

519 *Ibid.*, at 110.

520 *Ibid.*, at 111.

The Committee then turned to consider the regulation of A.I.D. While the Committee rejected the statutory rule, common in the United States,[521] that would legitimize the child only where the procedure was performed by a licensed physician,[522] it did acknowledge the "need for medical supervision and control over the technique" in order to protect both the recipient and her child.[523] But it also noted that, given the relatively simple nature of the procedure, it would be difficult to enforce any general prohibition against performance by laypersons not under the supervision and control of a doctor.

In this context, the Committee stated in chapter 5 that "control must be exercised over the persons who are permitted to administer" A.I.D.[524] However, in the summary of recommendations in chapter 8 it was recommended expressly that "[it] should be made an offence for any person to administer AID unless he is a registered medical practitioner or acts subject to the direction and under the supervision or control of a registered medical practitioner".[525]

In addition, the Committee favoured ethical guidelines, rather than legislation, to regulate matters other than those relating to the persons who should be permitted to administer the procedure.[526] A doctor who administers A.I.D. would be required to keep a history of the donor, a copy of which would have to be sent to the Department of Health. The identity of the donor would be confidential, except where a court ordered otherwise. Doctors would have access to the record, since, for example, information respecting the donor might be necessary to treat the child.[527]

Chapter 6 of the Queensland Report dealt with surrogate motherhood. The Report first reviewed the usual objections to surrogate motherhood: the depersonalization of reproduction; possible exploitation of paid surrogates; potential emotional harm to the child, any children of the surrogate, and the surrogate mother herself; and problems where there is a refusal to accept or keep a defective child, or where the prospective social parents die or divorce prior to the birth of the child. In addition, the Report stated that there was widespread opposition in the community and by professional bodies to any sanctioning of surrogate motherhood arrangements on moral and ethical grounds, with the spectre of "baby buying" used in many submissions to the Committee.

The Committee did not, however, believe it was necessary to criminalize

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521 See *infra*, this ch., sec. 3(c)(i)b(5).

522 Queensland Report, *supra*, note 464, at 105.

523 *Ibid.*

524 *Ibid.*, at 108.

525 *Ibid.*, at 143. See, also, *ibid.*, at 106-07. In order to ensure that a conscientious objection to participating in an A.I.D. procedure is respected, the Report recommended the legislative adoption of a "conscience clause" applicable to both physicians and institutions (*ibid.*, at 111-12).

526 *Ibid.*, at 108.

527 *Ibid.*

surrogate motherhood arrangements, at least at present. But it was of the view that the problems were "such that the most prudent course would seem to be to leave such agreements unenforceable, at least until experience demonstrates whether regulation of such agreement[s] is required in the interest of society and of the parties involved".[528] Moreover, it was proposed that "it should be made illegal to advertise to recruit women to undergo surrogate pregnancy, or to provide facilities for persons who wish to make use of the services of such women".[529]

With respect to the medical, ethical, and social issues faced by doctors, the Committee recommended that guidelines should be adopted for the medical profession. With respect to the legal issues, the Committee believed that its proposal to keep surrogate motherhood arrangements void and unenforceable rendered it unnecessary to canvass such matters. Accordingly, questions of parental rights and obligations and custody would be settled by the application of the general law. However, the Committee did recommend "that any doubt which may exist that the woman who gives birth to a child is considered to be its mother, should be removed by legislation which so provides as an irrebuttable presumption".[530]

The final substantive chapter, chapter 7, dealt with counselling and related "support, communication and education" services, viewed by the Committee as "a crucial part of any infertility service".[531] For example, after identifying the potentially competing interests of all persons involved in artificial conception, the Report stated that an independent, comprehensive counselling service, focusing on social, psychological, and spiritual matters as well as physical and medical ones, would facilitate resolution of these interests in a manner that protects the child and permits decisions to be made by persons directly affected by infertility.[532] Counselling would normally be conducted by specially trained social workers, as well as other professionals, and not left solely to scientists and doctors.[533]

(iii) South Australia, Working Party on In Vitro Fertilization and Artificial Insemination by Donor

In 1983, the South Australian Minister of Health established a Working Party to study the legal issues relating to I.V.F. and A.I.D. The Working Party submitted its Report to the Health Commission in 1984.[534]

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528 *Ibid.*, at 116.

529 *Ibid.*, at 118.

530 *Ibid.*

531 *Ibid.*, at 119.

532 *Ibid.*, at 122.

533 *Ibid.*, at 129.

534 South Australia, *Report of the Working Party on In Vitro Fertilization and Artificial Insemination by Donor* (1984) (hereinafter referred to as "South Australia Report").

The Report began by emphasizing the view of the Working Party that, hitherto, insufficient attention had been paid to the interests of artificially conceived children. It was said that such interests should be given primary consideration.[535]

The first major portion of the Report was concerned with the legal status of artificially conceived children. The Working Party strongly endorsed proposed South Australian legislation[536] that would deem I.V.F. and A.I.D. children to be children of a marriage or a stable *bona fide* domestic relationship, and would give donors no legal status *vis-à-vis* the children.[537] The Working Party was of the view that adoption, which was necessary to legitimize a child born using donor gametes, was "neither practical for the couple nor sensitive to the needs of the child".[538]

In the next section, the Working Party addressed the standards of practice for A.I.D. and I.V.F. For example, the Report noted that, where donated gametes were involved, the "total anonymity of donors is maintained".[539] However, doctors responsible for the treatment did have access to donor records, to be used where it was medically necessary to identify individual donors.[540] The Working Party was of the view that the present practice justifiably protected the donor, the couple involved, and the artificially conceived child. The possibility that the couple might wish to maintain secrecy in respect of the child's origins was recognized without critical comment. Indeed, the Working Party "[considered] that it would be inadvisable to change present practices in this respect because of the potential effects on the family unit and the possible adverse effects on the future availability of male donors".[541] The Working Party, expressly disagreeing with the views given in the Victoria *Report on Donor Gametes in IVF* concerning the flow of information between the donor and the child,[542] stated that "total anonymity must be preserved to ensure that the best interests of the child and the donor are upheld".[543] Furthermore, the Working Party, rejecting the proposal of the Victoria *Report on Donor Gametes in IVF*,[544] recommended that "relatives, friends or known donors should not be selected to participate in an A.I.D. or I.V.F. procedure", having regard to "the likely sociological

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535 *Ibid.*, at 2.

536 *Family Relationships Act Amendment Act, 1984,* Bill No. 4, 1984, s. 6, adding, *inter alia*, Part IIA to the *Family Relationships Act, 1975.*

537 South Australia Report, *supra*, note 534, at 4.

538 *Ibid.*, at 5.

539 *Ibid.*, at 12.

540 *Ibid.*

541 *Ibid.* See, also, *ibid.*, at 19.

542 Victoria Report on Donor Gametes, *supra*, note 356, paras. 3.29 *et seq.*, at 26 *et seq.*

543 South Australia Report, *supra*, note 534, at 24.

544 Victoria Report on Donor Gametes, *supra*, note 356, paras. 3.19-3.22, at 21-23.

consequences for the child within the family unit";[545] in other words, only anonymous donors should be used.

With respect to I.V.F., the Working Party recommended that this procedure, which "should now be regarded as another routine procedure",[546] "should only take place in South Australia in recognized hospitals approved for that purpose by the South Australian Health Commission".[547] It was further proposed that the Health Commission should adopt the set of I.V.F. guidelines appended to the Working Party's Report.[548] Moreover, to ensure greater anonymity and better results where ovum donation was used, "funding should be made available to enable research to continue to find a safe method of freezing fertilized female gametes".[549]

In order to monitor I.V.F. programmes, and particularly the effects on children of using frozen embryos, the Report recommended that all I.V.F. pregnancies should be registered in a central repository, the National Perinatal Statistics Unit.[550] It was noted that, with respect to I.V.F., "the current incidence of congenital malformation based on international reports is less than occurs in the population as a whole".[551]

Insofar as eligibility for artificial conception treatment was concerned, the Report stated that availability for such services was limited by the number of professionals in the field, the size of the waiting lists, and budgetary constraints. The Report did not deal with the method by which persons should be selected for participation; it simply recommended that the Health Commission should review existing selection procedures in order "to rationalize priorities".[552]

After discussing the need for informed consent by a sperm or ovum donor,[553] the Report proposed that "[c]onsent once given should be able to be revoked prior to the donation".[554] It expressly rejected the approach of the Victoria *Report on Donor Gametes in IVF,* which would allow revocation even after donation.[555]

The Working Paper then turned to the use of gametes. With respect to

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545 South Australia Report, *supra*, note 534, at 28.

546 *Ibid.*, at 21.

547 *Ibid.*, at 14.

548 *Ibid.*, Appendix 6, at 50-51.

549 *Ibid.*, at 17.

550 *Ibid.*, at 14 and 18.

551 *Ibid.*, at 17.

552 *Ibid.*, at 21-22.

553 *Ibid.*, at 25.

554 *Ibid.*

555 Victoria Report on Donor Gametes, *supra*, note 356, paras. 3.17-3.18, at 21.

research, it recommended that "fertilized gametes of human beings should never be used for scientific or genetic experimentation".[556] It had earlier proposed that fertilized gametes should not be maintained in a laboratory culture medium beyond the physiological stage at which implantation occurred.[557]

Where surplus frozen fertilized ova, not to be used by the couple, were involved, they should be disposed of on the written request of the couple; the couple "should not be entitled to donate those surplus fertilized gametes to any other person".[558] Moreover, where the marital or nonmarital relationship terminated, through death or divorce, for example, the fertilized ova should be disposed of.[559] The Working Paper went on to recommend that, "[i]n any event they should be disposed of at the expiration of an agreed period of time but in any event no longer than ten years from the date of commencing storage".[560]

The Report next considered the question of surrogate motherhood. Citing inevitable "social complications", where, for example, the surrogate mother refused to give up the child, the Working Party noted that the "community in general regards surrogacy as unacceptable".[561] Accordingly, it recommended that "there should be no change to the law to enable surrogacy to be practised in this State and that a policy should be formally adopted by the Government in relation to the *Adoption of Children Act* to prevent surrogacy being practised in South Australia".[562]

The last section of the Report dealt, *inter alia*, with the need to set priorities for participation in I.V.F. programmes, given the cost of medical care and the problems associated with multiple pregnancies (because of the transfer of multiple embryos to a woman). In respect of the latter, the Working Party advocated the freezing of embryos so that, if one transferred embryo did not result in a pregnancy, another could be transferred.[563]

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556 South Australia Report, *supra*, note 534, at 26.

557 *Ibid.*, at 11.

558 *Ibid.*, at 27. Again, the Working Party rejected the proposal in the Victoria Report on Donor Gametes, *supra*, note 356, para. 5.5, at 40, which would permit embryo donation. See, also, Victoria Report on Embryos, *supra*, note 421, paras. 2.8-2.10, at 27-28.

559 South Australia Report, *supra*, note 534, at 27.

560 *Ibid.*

561 *Ibid.*, at 29.

562 *Ibid.*

563 *Ibid.*, at 32. The Report noted that a frozen embryo may also be wanted in order to have another child.

(d) UNITED STATES

(i) The American College of Obstetricians and Gynecologists

In 1983, the Executive Board of The American College of Obstetricians and Gynecologists approved a Statement of Policy respecting ethical issues in surrogate motherhood.[564] The College first delineated those ethical issues shared with "its logical counterpart", A.I.D. — for example, the tendency toward depersonalizing reproduction (particularly where the procedure is used to avoid interrupting careers), the potential creation of stress in a marriage, the risk of psychological stress in the sperm donor and surrogate mother, the possible adverse psychological effects on resulting children, the question of donor and surrogate mother anonymity, and the legal status of the children.[565]

However, the College also noted several issues that were unique to surrogate motherhood. For example, the surrogate mother must undertake both physical risks respecting the pregnancy and delivery, and psychological risks when the child is separated from her. Or, the surrogate mother may breach her agreement and decide to abort the fetus, or may keep the child after delivery. Or, for some reason, custody of the child may return to her by default.[566]

In addition to the issues raised above, financial arrangements were said to complicate the ethical picture. In particular, according to the College, the buying and selling of children is both illegal and immoral, and "[i]t is difficult to differentiate between payment for the service of carrying the child and payment for the child".[567] Moreover, payment to surrogate mothers beyond out-of-pocket expenses was said to raise the spectre of exploitation by potential social parents and by physicians who might recruit potential surrogates and parents.

Not surprisingly, the College stated that "[s]imple, clear conclusions cannot be anticipated" with respect to the issues raised by surrogate motherhood, even "in the most uncomplicated situation involving an infertile married couple and no financial transactions".[568] The College had "significant reservations"[569] about the procedure — although the decision to participate in it was left to the individual doctor — and offered several recommendations. Aside, for example, from those dealing with the need for counselling and the requirement that the surrogate be treated as any other obstetric patient,[570] the College considered the

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564 The American College of Obstetricians and Gynecologists, "Ethical Issues in Surrogate Motherhood", in ACOG Statement of Policy (May, 1983).

565 *Ibid.*, at 1.

566 *Ibid.*, para. 4, at 2.

567 *Ibid.*, para. 1, at 2.

568 *Ibid.*, at 2.

569 *Ibid.*

570 See *ibid.*, para. II.B, at 2:

> The surrogate mother should be considered the source of consent with respect to

screening of the surrogate mother and the couple. But it stated only that "[s]uch screening may include appropriate fertility studies and genetic screening".[571] There was no mention of screening in respect of nonmedical matters.

(ii) The American Fertility Society

In 1980, the Board of Directors of The American Fertility Society approved guidelines on artificial insemination, set forth in the *Report of the Ad Hoc Committee on Artificial Insemination.*[572] The Report dealt with the selection of donors, the selection and management of recipients, and cryopreservation. It also recommended model legislation and suggested forms to be used in the procedure.

Since the attempt of the Committee was "to provide minimal but feasible guidelines for practitioners",[573] much of the Report dealt with technical, medical matters that need not be discussed here. But the Committee also considered other issues. With respect to semen donors, reference was made, for example, to limiting the use of donors — a limit of fifteen successful pregnancies was suggested — and to avoiding the matching of donors and recipients from the "same area of family origin".[574] Perhaps to preclude payment being made for a body part, the Report recommended that the donation agreement should "indicate that any payment to the donor is to provide for transportation, inconvenience, and other incidental expenses incurred in donating the sample, rather than direct payment for the semen".[575]

Insofar as the selection of recipients was concerned, the Committee countenanced the use of A.I.D. (A.I.H. was not mentioned) in a specified number of cases, including where the husband was sterile, or had a genetic disorder or paraplegia, or had been exposed to environmental mutagens. Otherwise, it appears, A.I.D. would be proper only where there was "[a] history of infertility of at least one year duration, absence of contributing female factors (after proper evaluation), and abnormal sperm count and quality ...".[576]

Record keeping was also briefly addressed. In respect of the recipient, the "usual record" should be maintained, excluding the donor's name. In respect of the donor, a "coded record" should be kept.[577] The Report stated that the

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clinical intervention and management of the pregnancy. Confidentiality between the physician and patient should be maintained. If other parties, such as the adoptive parents, are to play a role in decision making, the parameters should be clearly delineated, with the agreement of the patient.

571 *Ibid.*, para. I.C.1, at 2.

572 The American Fertility Society, *Report of the Ad Hoc Committee on Artificial Insemination* (1980).

573 *Ibid.*, at 1.

574 *Ibid.*, para. 9, at 5.

575 *Ibid.*, para. 12, at 5.

576 *Ibid.*, para. 1, at 8.

577 *Ibid.*, para. 4, at 9.

attending physician or sperm bank "may consider biannual review and upgrading of donor records, and elimination of out-of-date records".[578] However, no indication was given concerning when records become obsolete.

A final section suggested that "other physicians involved in the care of the recipient" need not be, and "relatives, friends, ministers and the offspring" should not be, informed of the procedure.[579]

The model legislation in the Report dealt with A.I.D. alone. We need consider only a few of its provisions here.

The legislation provided that the procedure must be performed by a "licensed physician" or a "health practitioner under the direct supervision of a licensed practitioner".[580] However, even if this requirement is not met, "[n]o penalty shall accrue to any other party and the legal status of the parties, including any resulting child, shall not be affected".[581] In the model legislation, the artificially conceived child was deemed to be the legitimate child of the recipient and her consenting spouse, with all the rights of a child conceived naturally.[582] Moreover, the child would not be the donor's child "unless the donor is the husband of the mother".[583] The model legislation also provided that "[t]he donor shall have no rights in or liability to any child conceived through artificial insemination with donor semen, whether or not the donor's identity is known to the recipient".[584]

3. LEGISLATION

(a) INTRODUCTION

The growth in the practice of artificial conception has forced legislators to have regard to its implications and, in particular, to rethink traditional approaches to legitimacy and parenthood. Two Canadian jurisdictions, Quebec[585]

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578 *Ibid.*, para. 11, at 5.

579 *Ibid.*, para. 5, at 9.

580 Model legislation, "Qualified Practitioners", ss. 1 and 2.

581 *Ibid.*

582 *Ibid.*, "Resultant Child", s. 1.

583 *Ibid.*, s. 2. It bears mentioning that the definition section states, in part, that "[n]o provisions of this act are intended to apply to artificial insemination with husband's semen". Of course, the donor could marry an unmarried recipient subsequent to the insemination.

584 *Ibid.*, "Donor", s. 4. In addition, a provision (*ibid.*, "Practitioner", s. 2) exonerates the physician from liability where he "has complied with the provisions of this statute and has carried out a standard level of practice in the selection of donor or sperm bank, and in the processing and administration of the semen".

585 *An Act to establish a new Civil Code and to reform family law,* S.Q. 1980, c. 39, s. 1, enacting, *inter alia*, arts. 586 and 588, dealing with artificial insemination.

and the Yukon Territory,[586] and at least twenty-five American states,[587] have responded by enacting artificial conception legislation. Several of the American statutes are based on the Uniform Parentage Act,[588] and a Uniform Child Status Act has been proposed in Canada and adopted in the Yukon Territory.[589] In addition, federal regulations in the United States deal, in part, with I.V.F. research or programmes conducted or funded by the Department of Health and Human Services.[590]

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586 *Children's Act*, S.Y.T. 1984, c. 2, s. 14.

587 See, for example: Ala. Code §§26-17-1 to 26-17-21; Alaska Stat. §25.20.045; Ark. Stat. Ann. §61-141 (1971); Cal. Civ. Code §7005 (West 1980); Colo. Rev. Stat. §19-6-106 (1978); Conn. Gen. Stat. Ann. §45-69-f-n (West Supp. 1980); Del. Code Ann., tit. 13, §§801-818; Fla. Stat. Ann. §742.11 (1981); Ga. Code Ann., tit. 74, §101.1 (1973); Hawaii Rev. Stat. §§584-1 to 584-26; Ill. Ann. Stat., ch. 40, §§2501-2526 (Smith-Hurd); Kan. Stat. Ann. §23-128-130 (1981); La. Civ. Code Ann. art. 188 (West Supp. 1980); Md. Est. & Trusts Code Ann. §1-206(b) (1974); Mich. Comp. Laws Ann. §700.111 (West Supp. 1980); Minn. Stat. Ann. §257.56 (West Supp. 1980); Mont. Rev. Codes Ann. §40-6-106 (1979); Nev. Rev. Stat. §126.061 (1979); N.C. Gen. Stat. §49A-1 (1976); N.J. Stat. Ann. §§9:17-38 to 9:17-59 (1983); N.Y. Dom. Rel. Law §73 (McKinney 1977); Ohio R.C. §§3111.01-3111.19; Or. Rev. Stat. §§109.239, 109.243, 109.247, 677.355, 677.360, 677.365, 677.370 (1979); R.I. Gen. Laws §§15-8-1 to 15-8-27; Tenn. Code Ann. §53-446 (Michie Supp. 1981); Tex. Fam. Code Ann., tit. 12, §12.03 (Vernon 1974); Va. Code §64.1-7.1 (Supp. 1979); Wash. Rev. Code §26.26.050 (1981); Wis. Stat. Ann. §891.40 (1980); and Wyo. Stat. §14-2-103 (1978).

588 National Conference of Commissioners on Uniform State Laws, Uniform Parentage Act, Uniform Laws Annotated, Vol. 9A (hereinafter sometimes referred to as "UPA"). The states of Alabama, California, Colorado, Delaware, Hawaii, Illinois, Minnesota, Montana, Nevada, New Jersey, North Dakota, Ohio, Rhode Island, Washington, and Wyoming have enacted the UPA or a modification of it. See *supra*, note 587.

589 For the Yukon Territory legislation, see *supra*, note 586. The Uniform Law Conference of Canada first adopted the Uniform Child Status Act at the Conference's 1980 meeting: Uniform Law Conference of Canada, *Proceedings of the Sixty-Second Annual Meeting* (1980), at 28-29. A revised version was subsequently adopted in 1982: Uniform Law Conference of Canada, *Proceedings of the Sixty-Fourth Annual Meeting* (1982), Appendix F (Uniform Child Status Act). See, also, *ibid.*, at 31. Section 11 of the statute deals with artificial insemination and I.V.F. where the semen is either that of a donor or of a husband or cohabiting partner, and provides solely for the legal status of the parties involved.

590 45 C.F.R. §46 (1982). Federal regulations promulgated by the United States Department of Health and Human Services seek to protect human subjects by requiring, for example, that H.H.S. grants or contracts respecting I.V.F. must be reviewed by an Institutional Review Board (§46.205). The Board reviews and monitors the selection of participants, consents, research activities, and other matters. The regulations do not appear to deal with embryos that are not to be implanted.

By way of background, it bears mentioning that, because of the controversy surrounding the ethics of I.V.F., in 1975 the United States Department of Health, Education, and Welfare (now the Department of Health and Human Services) imposed a moratorium on federal funding of I.V.F. research until the ethical issues were examined further. In 1978, after hearings, the Ethics Advisory Board of the Department announced that it would support the ethics of allowing federal funding so long as certain conditions were met. For example, where no embryo transfer was contemplated, no embryos should be sustained *in vitro* more than 14 days after fertilization. Where embryo transfer was to take place, such transfer should be attempted only with gametes obtained from lawfully

Considerable legislative activity has also taken place in Australia. For example, statutes in Victoria deal, *inter alia*, with the status of a child conceived by artificial insemination and I.V.F. where donor semen is involved, and with artificial conception facilities, counselling, eligibility of participants and donors, and medical records. Legislation in New South Wales provides essentially for the status of artificially conceived children.

While the statutes considered in the following sections of this Report do not deal exhaustively with the many issues raised by the new artificial conception technologies, they do deal with some critically important questions, particularly the status of an A.I.D. child. We now turn to consider these legislative developments.

(b) CANADA

(i) Quebec

Quebec was the first jurisdiction in Canada to pass legislation dealing with artificial insemination. Article 586 of the Civil Code[591] provides:

> 586. When a child has been conceived through artificial insemination, either by the father or, with the consent of the spouses, by a third person, no action for disavowal or contestation of paternity is admissible.

Reference should also be made to article 588:

> 588. Any interested person including the father or the mother may, at any time and by any means, contest the filiation of a person whose possession of status is not consistent with his act of birth.
>
> However, no person may contest the filiation of a person because that person was conceived through artificial insemination.

Thus, in Quebec, an A.I.D. child is, in effect, irrebuttably presumed to be the natural, legitimate child of the consenting spouse.[592]

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married couples. See United States, Department of Health, Education, and Welfare, Ethics Advisory Board, *Report and Conclusions: HEW Support of Research Involving In Vitro Fertilization and Embryo Transfer* (1979), at 106-07, Conclusion (2), esp. (2)A.4 and (2)B.

591 *Supra*, note 585. The wording of the Quebec legislation is similar to that of art. 188 of the Louisiana Civil Code (*supra*, note 587), which provides, in part, that "... [t]he husband ... cannot disavow paternity of a child born as the result of artificial insemination of the mother to which he consented". All of the other relevant statutes set out a positive presumption of legitimacy, as contrasted with a statutory inability to disavow or contest paternity.

592 It is not provided that such consent must be in writing or witnessed. Moreover, it is unclear whether consent must be given prior to the insemination, although art. 586 may appear to imply that this is required.

(ii) Yukon Territory

In 1984, the Yukon Territory adopted,[593] almost verbatim, the part of the Uniform Child Status Act, proposed by the Uniform Law Conference of Canada, that dealt with human artificial conception.[594] Section 14 of the Yukon Territory *Children's Act* provides as follows:

> 14.-(1) In this section, 'artificial insemination' includes the fertilization by a man's semen of a woman's own ovum outside of her uterus and subsequent implantation of the fertilized ovum in her.
>
> (2) A man whose semen was used to artificially inseminate a woman is deemed in law to be the father of the resulting child if he was married to or cohabiting with the woman at the time she is inseminated even if his semen were mixed with the semen of another man.
>
> (3) A man who is married to a woman at the time she is artificially inseminated solely with the semen of another man shall be deemed in law to be the father of the resulting child if he consents in advance to the insemination.
>
> (4) A man who is not married to a woman with whom he is cohabiting at the time she is artificially inseminated solely with the semen of another man shall be deemed in law to be the father of the resulting child if he consents in advance to the insemination, unless it is proved that he refused to consent to assume the responsibilities of parenthood.
>
> (5) Notwithstanding a married or cohabiting man's failure to consent to the insemination or consent to assume the responsibilities of parenthood under subsection (3) or (4) he shall be deemed in law to be the father of the resulting child if he has demonstrated a settled intention to treat the child as his child unless it is proved that he did not know that the child resulted from artificial insemination.[595]
>
> (6) A man whose semen is used to artificially inseminate a woman to whom he is not married or with whom he is not cohabiting at the time of the insemination is not in law the father of the resulting child.

(c) UNITED STATES

(i) Artificial Insemination

a. General

In 1973, the National Conference of Commissioners on Uniform State Laws approved the Uniform Parentage Act.[596] This statute, enacted in whole or in part by fifteen states,[597] provides for the equal treatment and protection of children, regardless of the marital status of their parents.

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593 *Supra*, note 586.

594 *Supra*, note 589.

595 Where the closing flush of s. 14(5) applies, and given s. 14(6), it would appear that the child would have no legal father.

596 *Supra*, note 588.

597 See the states referred to in note 588, *supra*.

Section 5 of the Act, which deals with artificially conceived children, provides:

> 5.-(a) If, under the supervision of a licensed physician and with the consent of her husband, a wife is inseminated artificially with semen donated by a man not her husband, the husband is treated in law as if he were the natural father of a child thereby conceived. The husband's consent must be in writing and signed by him and his wife. The physician shall certify their signatures and the date of the insemination, and file the husband's consent with the [state department of health], where it shall be kept confidential and in a sealed file. However, the physician's failure to do so does not affect the father and child relationship. All papers and records pertaining to the insemination, whether part of the permanent record of a court or of a file held by the supervising physician or elsewhere, are subject to inspection only upon an order of the court for good cause shown.
>
> (b) The donor of semen provided to a licensed physician for use in artificial insemination of a married woman other than the donor's wife is treated in law as if he were not the natural father of a child thereby conceived.

It should be emphasized at the outset that the Uniform Parentage Act does not deal with access to artificial insemination services. Rather, section 5 deals with certain legal consequences of the procedure. The most significant feature of the section is that, where artificial insemination is carried out under the supervision of a licensed physician, there is established a legal parental relationship, with all its attendant rights and duties, between the recipient's consenting husband and the artificially conceived child, while expressly terminating those same rights and duties in the donor. Section 5 provides for confidentiality of records, while allowing access "for good cause shown" and by court order. Also of note is the fact that the provision applies to A.I.D. alone; insemination with the semen of the husband is apparently assumed not to raise a legitimacy question.[598]

The Commissioners' Comment to this section acknowledges that it is not comprehensive:[599]

> This Act does not deal with many complex and serious legal problems raised by the practice of artificial insemination. It was thought useful, however, to single out and cover in this Act at least one fact situation that occurs frequently. Further consideration of other legal aspects of artificial insemination has been urged on the National Conference of Commissioners on Uniform State Laws and is recommended to state legislators.

In addition to the states that have adopted the Uniform Parentage Act, several other states have enacted their own artificial insemination statutes. Although different in style, these statutes address several common issues.

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598 See Harris, "Artificial Insemination and Surrogate Motherhood — A Nursery Full of Unresolved Questions" (1981), 17 Willamette L. Rev. 913, at 917, and *In Re Adoption of Anonymous*, 74 Misc. 2d 99, 345 N.Y.S. 2d 430 (Surr. Ct. 1973).

599 Uniform Laws Annotated, Vol. 9A, *supra*, note 588, at 593.

b. Issues Addressed by Artificial Insemination Legislation

(1) Married v. Single Women

The vast majority of the artificial insemination statutes are directed to married women, either expressly or implicitly. Section 5(a) of the Uniform Parentage Act provides that, where a "wife", with the consent of her "husband", is inseminated artificially with donated semen, "the husband is treated in law as if he were the natural father of a child thereby conceived". It should be emphasized, however, that this section does not preclude the artificial insemination of single women; as indicated earlier, the Act does not deal with access at all, but only with the legal consequences for an A.I.D. child born to a "married woman".[600]

Significantly, California, Colorado, Washington, and Wyoming modified section 5(b) by dropping "married" from "married woman". However, these states continue to use "wife" in subsection (a) and to use the restrictive phrase "with the consent of her husband". The implication is that the scheme reflected in modified section 5 is designed to legitimize an A.I.D. child born to a married couple, but also to ensure that the donor will have no responsibility even where the insemination of a single woman has occurred.

Outside the Uniform Parentage Act context, the Oregon legislation[601] arguably countenances, although implicitly, the insemination of single women.[602] While the language of most of the sections[603] refers to a married woman, section 677.365(1) provides that the request and consent of the woman is required prior to the insemination, as is the consent of her husband "if she is married".[604]

Whatever the implications for single women in respect of access to services, it is clear that the provisions relating to legitimacy under the artificial insemination statutes are limited to married couples. Primarily, the statutes deem the child to be legitimate where the recipient's husband has given his prior consent to the insemination. In this respect, the language of the legitimacy provisions is consistent, referring to "wife" and "married woman" throughout. Typical is the Florida legislation:[605]

> 742.11 Any child born within wedlock who has been conceived by the means of

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600 UPA, *supra*, note 588, §5(b).

601 Or. Rev. Stat., *supra*, note 587.

602 For the different viewpoints, see Harris, *supra*, note 598, at 934.

603 Or. Rev. Stat. §§109.239 and 109.243.

604 The Texas legislation, *supra*, note 587, raises the same issue by providing cryptically as follows (§12.03(b)): "If a woman is artificially inseminated, the resulting child is not the child of the donor unless he is the husband".

605 Fla. Stat. Ann. §742.11 (1981).

artificial insemination is irrebuttably presumed to be legitimate, provided that both husband and wife have consented in writing to the artificial insemination.

(2) Consent

Like all medical procedures, artificial insemination by a physician requires the informed consent of the patient. Under the relevant American statutes, the consent of the mother is often assumed. The consent of her husband, however, usually has to be in writing, often witnessed by his wife, certified by the inseminating physician, and frequently kept in a sealed file. Section 5(a) of the Uniform Parentage Act and the legislation of the states that have adopted this provision take this approach.

While the American Uniformity Commissioners stressed the need to enact legislation that provided for the equal treatment of all children, section 5(a) of the Uniform Parentage Act does not appear to have fully achieved this goal. The Act requires the consent of the recipient's husband before he will be treated in law as the natural father of the child. Presumably, this provision reflects the view that the wish to bring a child into the family is, or ought to be, a joint one; accordingly, a non-consenting husband should not have the responsibilities of parenthood foisted upon him by the independent act of his wife.

Moreover, there is an intimate nexus between the manner of consent and the status of the child. Section 5(a) of the Uniform Parentage Act requires that the husband's consent "must be in writing and signed by him and his wife". It would therefore appear that, where these preconditions have not been satisfied, the husband would not be treated as the natural father of the child, notwithstanding his actual consent to the use of artificial insemination.[606] And, since the donor would bear no responsibility, having regard to section 5(b), the child would in fact have no legal father.

American statutes not based on the Uniform Parentage Act have taken various approaches to consent, although they generally stipulate that the husband's consent is necessary. Some states[607] require written consents from both husband and wife and make provision for filing such consents with the court or state registrar. Other states[608] require both consents, but do not specify particular

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606 The argument that the failure to follow these formalities would preclude the husband from being treated as the child's natural father is arguably buttressed, at least by implication, by a further provision in UPA, *supra*, note 588, §5(a). This section requires that the attending physician "shall certify their [the husband and wife's] signatures and the date of the insemination, and file the husband's consent with" the state department of health. However, "the physician's failure to do so does not affect the father and child relationship". No such saving provision appears in respect of the husband's formal consent requirement or the wife's signature on the consent form.

607 See, for example: Conn. Gen. Stat. Ann. §45-69h; Kan. Stat. Ann. §23-130; Okla. Stat. Ann., tit. 10, §553; and Or. Rev. Stat. §677.365(2).

608 See, for example: Fla. Stat. Ann. §742.11; Ga. Code Ann., tit. 74, §74-101.1(a); N.Y. Dom. Rel. Law §73(1) and (2); N.C. Gen. Stat. §49A-1 (1976); Va. Code §64.1-7.1 (Supp. 1979); and Alaska Stat. §25.20.045.

filing requirements. On the other hand, several states[609] rebuttably presume the consent of the husband. And Tennessee, Louisiana, and Texas have adopted provisions similar to the Civil Code in Quebec.[610]

(3) The Donor

The American legislation generally reflects the traditional A.I.D. model where the donor is anonymous. For example, section 5(b) of the Uniform Parentage Act provides that the donor is treated as if he were not the child's natural father.[611] The remaining statutes terminate the donor's rights and responsibilities by implication, since they effectively deem the mother's husband to be the child's legal father.[612]

However, special mention should be made of legislation in Washington. The relevant provision significantly alters section 5(b) of the Uniform Parentage Act. It provides for an exception to the general rule — that a donor will not be treated in law as the natural father — where "the donor and the woman agree in writing that said donor shall be the father".[613] This modification may remove one obstacle to the recognition of a type of surrogate motherhood arrangement where the surrogate mother is not married or, if married, where her husband has not consented to the insemination (and, therefore, is not to be treated as the natural father).[614]

With respect to the selection of donors, only Oregon appears to have enacted express restrictions. The legislation provides that no semen may be donated by a person who has a transmissible disease or defect known to him or who knows or has reason to know he has a venereal disease.[615]

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609 See, for example: Ark. Stat. Ann. §61-141(c); Md. Est. & Trusts Code Ann. §1-206(b); and Mich. Comp. Laws Ann. §700.111(2).

610 Tenn. Code Ann. §53.446; La. Civ. Code Ann. art. 188; and Tex. Fam. Code Ann., tit. 12, §12.03. For legislation in Quebec, see text following note 591, *supra*.

611 See, also, Or. Rev. Stat. §109.239; Conn. Gen. Stat. Ann. §45-69j; and Tex. Fam. Code Ann., tit. 12, §12.03.

612 The language used may differ. The child may be "legitimate" (Fla. Stat. Ann. §742.11), "natural and legitimate" (Alaska Stat. §25.20.045), or may have the same status as a "naturally conceived" child (Kan. Stat. Ann. §23.129, and Conn. Gen. Stat. Ann. §45.69i).

613 Wash. Rev. Code Ann. §26.26.050(2).

614 However, the consequences are not entirely clear in the admittedly rare case where the surrogate mother's husband does expressly consent to her insemination and, as well, the donor and the surrogate mother "agree in writing that said donor shall be the father". Does the child have two fathers, the surrogate mother's husband and the donor? The statute does not render §5(a) inapplicable where such an agreement takes place.

With respect to whether certain paternity and artificial insemination statutes apply where there is a surrogate motherhood arrangement, see *Syrkowski v. Appleyard*, 122 Mich. App. 506, 333 N.W. 2d 90 (1983).

615 Or. Rev. Stat. §677.370 (1979).

(4) Medical Records

It is interesting to note that, under section 5(a) of the Uniform Parentage Act, the filed consents and the date of insemination are the only records of the insemination actually required. Although section 5(a) also provides that any other information that is held by the physician, the court, or other person or agency is subject to inspection "upon an order of the court for good cause shown", the section does not require anyone to keep information beyond the filed consents and the insemination date. The ability of a child or interested party to obtain such information as the child's genetic history would depend, therefore, on the record keeping of the particular inseminating physician (which, of course, might be governed by separate legislation or rules).

(5) The Performance of Artificial Insemination and Its Implications

Many of the statutes that legitimize A.I.D. children apply only where artificial insemination is performed by a licensed physician. As a result, where artificial insemination has been performed by a layperson, legitimization cannot be achieved. If, however, as in section 5(a) of the Uniform Parentage Act, the procedure may be performed "under the supervision of a licensed physician", A.I.D. children could be legitimized where the procedure was performed by the husband or a third person, so long as a physician had the requisite control.

Some states specifically provide for more than legitimization; they deal with the practice of artificial insemination itself. In some cases, only a licensed physician may perform A.I.D.[616] In other cases,[617] the performance of artificial insemination is prohibited unless it is undertaken by or under the supervision of a physician. Several states do not mention by whom the procedure must be carried out.

(ii) *In Vitro* Fertilization, Embryo Transfer, and Fetal Research

At present, over twenty American states have passed legislation governing fetal experimentation and research, several of which may potentially cover aspects of I.V.F. and embryo transfer.[618] However, it is important to bear in mind that the statutes are, in large part, the result of the abortion decision of the

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616 See, for example, Okla. Stat. Ann., tit. 10, §553.

617 See, for example: Ga. Code Ann., tit. 74, §101.1(b); Conn. Gen. Stat. Ann. §45-69g; and Or. Rev. Stat. §677.360. The Oregon section provides that "[o]nly physicians licensed under this chapter and persons under their supervision may select artificial insemination donors and perform artificial insemination".

618 See, for example: Me. Rev. Stat. Ann., tit. 22, §1593 (West 1980); Mass. Gen. Laws Ann., ch. 112, §12J (West Supp. 1983); Mich. Comp. Laws Ann. §§333.2685-333.2692 (West 1980); Mont. Rev. Codes Ann. §50-20-108(3) (1981); N.M. Stat. Ann. §24-9A (1981); N.D. Cent. Code §14-02.2 (Allen Smith 1981); R.I. Gen. Laws §11-54 (Supp. 1982); S.D. Comp. Laws Ann. §34-23A-17 (1977); and Utah Code Ann. §76-7-310 (Allen Smith 1978).

United States Supreme Court in *Roe v. Wade*.[619] In that case, the Court held that the state could not interfere with a woman's right to have an abortion within the first trimester of pregnancy. Consequently, it was contemplated that doctors and others would be faced with the question whether it was legally permissible to study or to experiment on an aborted fetus.

The statutes either prohibit or substantially restrict certain types of "experimentation"; many provisions also cover "research" or "study". With respect to these pursuits, we noted in chapter 3 the suggestion of one commentator in 1975 that, while I.V.F. was still experimental, it may be more apt to call the procedure therapeutic innovation rather than pure experimentation.[620] However, we also observed that the artificial reproduction technologies have gone through several significant stages of development since 1975. Accordingly, the historical context within which the various Acts were passed, and the language,[621] tenor, and purpose of those Acts, raise the argument that they were simply not directed toward the use of the artificial conception technologies directly on humans for the sole purpose of conceiving a child.

Only the New Mexico statute mentions I.V.F. expressly: it prohibits certain kinds of "clinical research activity" on fetuses. "Clinical research" is to be "construed liberally to embrace research concerning all physiological processes in man and includes research involving human in vitro fertilization".[622]

Yet, even here, it is arguable that the provision is not, in fact, designed to prohibit I.V.F. as such. The phrase "research involving human in vitro fertilization" seems a rather oblique means of precluding the direct application of I.V.F. to patients.

While the statutes may, therefore, be limited in scope, many of them may preclude research and experimentation on, for example, "surplus" fertilized ova not implanted in the recipient. Most of the Acts prohibit experimentation on "live" or "living" embryos, fetuses, or concepti. Some statutes define "live" or "living" in a narrow way, so that I.V.F. would not be affected.[623] But others ban

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619 410 U.S. 113 (1973).

620 Dickens, "What is a medical experiment?" (1975), 113 Can. Med. Ass'n J. 635. See *supra*, ch. 3, text accompanying note 17.

621 Indeed, many of the statutes clearly would not affect I.V.F. Of the states in question, almost half cover research only where an abortion is anticipated or has been performed. Other states cover only research on a fetus that exhibits a heartbeat, spontaneous respiratory activity, spontaneous voluntary muscle movement, or pulsation of the umbilical cord. (In the latter case, however, one statute defines "living" as having "the presence of evidence of life, such as" some of the indicators just described. If this provision is to be read *ejusdem generis*, the statute would not apply to I.V.F. If, however, "evidence of life" is not so read, and if it includes, for example, an embryo, then the statute might well be relevant: see, for example, Minn. Stat. Ann. §145.421(3).)

622 N.M. Stat. Ann. §24-9A-1(D).

623 See *supra*, note 621.

experimentation in a more general manner,[624] often contrasting experimentation on "live" fetuses with experimentation on "dead" ones.[625] Where these terms are not defined, or not defined narrowly, research and experimentation on fertilized ova that are not implanted may well be affected by the statutes.

With respect to the possible application of the statutes to *in vivo* fertilization and embryo transfer, it should be noted that several states prohibit experimentation on aborted fetuses. In some cases, the definition of abortion may appear to be broad enough to include the nonsurgical "flushing" technique used in extracting a fertilized ovum from the body.[626] However, it bears re-emphasizing that the legislation is directed to experimentation and research on the human material; it may, therefore, say nothing of embryo transfer *per se*.

Some of the statutes also prohibit persons from selling a fetus,[627] while others prohibit persons from giving away[628] or permitting someone else to use a fetus. But, once again, the prohibited conduct is only in relation to experimentation and research.

Unlike the abovementioned statutes governing research and experimentation, new legislation in Pennsylvania deals not only with I.V.F. as experimentation, but also with I.V.F. as a means of circumventing infertility. The legislation is, however, rather narrowly framed, in that it merely requires the filing of public

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624 See, for example, the statute in Rhode Island, *supra*, note 618.

625 See, for example, the provisions in Massachusetts and North Dakota, *supra*, note 618.

626 In Oklahoma, for example, an abortion includes the administration of any substance intended to cause expulsion of a conceptus, zygote, morula, blastocyst, or embryo: Okla. Stat. Ann., tit. 63, §1-730(1), (2), and (7) (West Supp. 1982-83).

627 See, for example: Minn. Stat. Ann. §145.422(3) (West Supp. 1982), and Ohio Rev. Code Ann. §2919.14(A) (Baldwin 1982).

628 See, for example: Ky. Rev. Stat. Ann. §436.026 (Baldwin 1975); Mass. Gen. Laws Ann., ch. 112, §12J(a)IV (West Supp. 1982); and Mich. Comp. Laws Ann., §333.2690 (West 1980).

reports on I.V.F. with the Department of Health.[629] Thus, it essentially serves to monitor, rather than actively regulate, the procedure.[630]

In Illinois, legislation[631] provides that a physician who fertilizes a woman's egg *ex utero* becomes the custodian of the offspring for the purpose of an 1877 child abuse statute.[632] Given the context within which the latter Act was enacted, it is easy to see why a great many serious concerns have apparently been expressed by Illinois physicians, few of whom appear to use I.V.F.[633]

(d) AUSTRALIA

(i) Victoria

In 1984, the Victoria Legislature enacted two statutes dealing with artificial conception: the *Status of Children (Amendment) Act* 1984[634] and the *Infertility (Medical Procedures) Act* 1984.[635]

The first statute enacted a new Part II of the *Status of Children Act* 1974.[636] Part II deals with the status of children produced by artificial insemination where the semen used was not that of the woman's husband or was a mixture of her husband's semen and donor semen, and by I.V.F. where either the ovum or sperm

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629 Pa. Stat. Ann., tit. 18, §3213(e) (Purdon). The main part of the section provides for the filing of the following information:

> (1) Names of all persons conducting or assisting in the fertilization or experimentation process.
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> (2) Locations where the fertilization or experimentation is conducted.
>
> (3) Name and address of any person, facility, agency or organization sponsoring the fertilization or experimentation except that names of any persons who are donors or recipients of sperm or eggs shall not be disclosed.
>
> (4) Number of eggs fertilized.
>
> (5) Number of fertilized eggs destroyed or discarded.
>
> (6) Number of women implanted with a fertilized egg.

It bears mentioning that the names of donors and recipients are not required under the legislation.

630 Although, presumably, the former may be a prelude to the latter where state officials deem some form of intervention to be necessary or desirable.

631 Ill. Ann. Stat., ch. 38, §81-26(6) (Smith-Hurd Supp. 1984-85).

632 Ill. Ann. Stat., ch. 23, §2354 (Smith-Hurd).

633 For example, is it a crime to dispose of a defective embryo? The Illinois law also makes it a criminal offence for the physician to allow another person to endanger a child created by I.V.F. Just how far this provision is entitled to go is not at all clear. Must the physician constantly monitor a pregnant woman?

634 *Status of Children (Amendment) Act* 1984, No. 10069.

635 *Infertility (Medical Procedures) Act* 1984, No. 10163.

636 *Status of Children Act* 1974, No. 8602, as am. by No. 9863.

is donated or where there is both donor sperm and donor ovum. Part II does not deal with A.I.H., but it does address the use of artificial insemination on an unmarried woman and a woman acting without the consent of her husband. For some reason, however, there are no comparable provisions respecting the use of I.V.F. on such women.

Essentially, Part II provides that where a married woman, with the consent of her husband, has undergone A.I.D. or I.V.F., the husband is irrebuttably presumed to be the father of the child and the ovum or semen donor is irrebuttably presumed not to be the mother or father.[637] In addition, where semen is used to inseminate artificially an unmarried woman or a woman who has not obtained the consent of her husband, "the man who produced the semen has no rights and incurs no liabilities" in respect of the resulting child unless, at any time, he becomes the woman's husband.[638]

A reference to a husband or wife includes a "person [who] is living with another person of the opposite sex as his or her spouse on a *bona fide* domestic basis although not married to the other person" and excludes, in the above case, "the spouse (if any) to whom the person is actually married".[639]

Under Part II, the husband's consent is presumed, but the presumption is rebuttable.[640] While Part II does not provide expressly for the consequences where the presumption of consent is rebutted, it would seem to follow that the non-consenting husband would not be the parent of the child. Since the donor is presumed irrebuttably not to be the father, the child would have no legal father in such a case.

Finally, the statute does not expressly state whether the consent must be written or when it must be given. Insofar as the form of consent is concerned, there seems to be no reason to assume from silence that it must be reduced to writing. With respect to the timing of consent, it is arguable that the language of the sections implies prior consent: they provide for the case where "a married woman, in accordance with the consent of her husband, *has undergone*"[641] the procedure in question.

Notwithstanding the title of the *Infertility (Medical Procedures) Act* 1984, the ambit of that statute extends beyond purely medical procedures to include such important matters as approval of facilities, counselling, eligibility criteria for recipients and donors, consents, payments to donors, donation by minors, hospital and other records, and disclosure of information. The Act covers I.V.F. with no donors, donor sperm, donor ova, and both donor sperm and donor ova. Artificial insemination is covered only by a few provisions. Finally, the Act deals

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637 *Status of Children (Amendment) Act* 1984, *supra*, note 634, s. 5, enacting new ss. 10C(2), 10D(2), and 10E(2).

638 *Ibid.*, s. 5, enacting new s. 10F(1).

639 *Ibid.*, s. 5, enacting new s. 10A(2).

640 *Ibid.*, s. 5, enacting new ss. 10C(4), 10D(4), and 10E(4).

641 *Ibid.*, s. 5, enacting new ss. 10C(2), 10D(2), and 10E(2) (emphasis added).

with experimentation, embryo freezing, embryo donation, false or misleading statements by gamete donors, the establishment of a Standing Review and Advisory Committee and an Administrative Appeals Tribunal, and surrogate motherhood.

It would appear that the Act prohibits all means of artificial conception other than artificial insemination and I.V.F. where the latter is carried out in accordance with the Act. Accordingly, it would seem to preclude, for example, the use of *in vivo* fertilization and lavage.[642]

In addition to regulating artificial conception in the manner just described, the Act establishes certain mandatory rules, breach of which may involve the imposition of a sanction. For example, the procedures permitted by the Act must be performed at a hospital approved by the appropriate Minister.[643] Such approval may be given subject to terms and conditions,[644] which may be varied.[645] The approval may be cancelled where the hospital or one of its designated officers[646] commits an offence under the Act or where the hospital fails to comply with a term or condition to which it is subject.[647] Where a person

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642 See *Infertility (Medical Procedures) Act* 1984, *supra*, note 635, s. 5(1), which provides that, "[s]ubject to sub-section (2), a person shall not carry out a fertilization procedure". Section 5(2) provides that "[s]ub-section (1) does not apply to a person who carries out a relevant procedure in accordance with this Act". The term "fertilization procedure" is defined in s. 3(1) to mean a "relevant procedure" or

> (b) any other procedure (other than the procedure of artificial insemination) for implanting in the body of a woman —
>
> (i) an ovum produced by that woman or by another woman, whether or not it is fertilized outside the body of the first-mentioned woman; or
>
> (ii) an embryo derived from an ovum produced by that woman or by another woman whether or not it is fertilized outside the body of the first-mentioned woman.

A "relevant procedure" is defined in s. 3(1) to mean "a procedure to which section 10, 11, 12 or 13 applies". Section 10 deals with I.V.F. using no donors; s. 11 deals with I.V.F. using donor semen; s. 12 deals with I.V.F. using donor ovum; and s. 13 deals with I.V.F. using donor sperm and ovum.

It would seem that clause (b) of the definition contemplates, *inter alia, in vivo* fertilization of an ovum of "another woman" — since such a procedure would be fertilization "outside the body of the first-mentioned woman" — and its subsequent transfer to the latter woman. Given that s. 5 prohibits all "fertilization procedures" except "relevant procedures" performed in accordance with the Act, the use of *in vivo* fertilization and lavage, not being a "relevant procedure", would appear to be precluded.

643 *Ibid.*, ss. 7, 10(2), 11(2), 12(2), and 13(2).

644 *Ibid.*, s. 7(3).

645 *Ibid.*, s. 7(4).

646 *Ibid.*, ss. 3(1) and 8, respecting a "designated officer".

647 *Ibid.*, s. 7(5) and (6).

commits an offence under the Act in an approved hospital, the hospital and its designated officer are also guilty of an offence.[648]

While, as indicated, artificial insemination is not covered by most of the provisions of the Act, as a result of section 7(7) a hospital may apply for approval as a place at which artificial insemination may be conducted. However, section 17(2) expressly provides that the normal rule, expressed in section 17(1) — that a "person, who is not a medical practitioner shall not carry out a procedure of artificial insemination" — does not apply "to a person who carried out a procedure of artificial insemination in an approved hospital". Moreover, although section 21 deals with medical records, it does envisage that artificial insemination may be carried out by a doctor outside an approved hospital.

We turn now to the prerequisites to the carrying out of I.V.F. under the statute. With respect to eligibility, I.V.F. may not be performed on an unmarried woman.[649] A married woman includes a woman who is "living with a man as his wife on a *bona fide* domestic basis although not married to him".[650] In all cases, both spouses or partners must consent in writing.[651]

Before undergoing I.V.F., the couple must be examined and treated by a doctor other than the I.V.F. physician. The doctor must be satisfied that the woman would not become pregnant except by artificial means and, where donor gametes are used, that if she were to become pregnant as a result of the use of her own ovum or her spouse's or partner's sperm, or both, "an undesirable hereditary disorder may be transmitted" to the resulting child.[652] In addition, the I.V.F. physician must be satisfied that the couple has undergone counselling by an approved counsellor[653] and that post-I.V.F. counselling will be available.[654]

A physician may not use a donated gamete unless the donor and his or her spouse (if any) have consented in writing to its use, have not withdrawn that consent, and have received counselling from an approved counsellor.[655] Where a donor or his or her spouse withdraws consent by notice in writing, the gametes must be destroyed unless the donor or spouse has consented to the use of the

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648 *Ibid.*, s. 28.

649 *Ibid.*, ss. 10(3)(a), 11(3)(a), 12(3)(a), and 13(3)(a).

650 *Ibid.*, s. 3(2)(a)(i).

651 *Ibid.*, ss. 10(3)(b), 11(3)(b), 12(3)(b), and 13(3)(b). Where there is gamete donation, the consents must not have been withdrawn: *ibid.*, ss. 11(3)(b), 12(3)(b), and 13(3)(b). For some reason, there is no mention of the withdrawal of consents where there is no gamete donation: see *ibid.*, s. 10(3)(b). In addition, the consent documents are retained by the hospital, with copies going to the recipient and her spouse or partner: *ibid.*, ss. 11(4), 12(4), and 13(4).

652 *Ibid.*, ss. 10(3)(d), 11(3)(d), 12(3)(d), and 13(3)(d).

653 The approval of counsellors is dealt with *ibid.*, s. 9.

654 *Ibid.*, ss. 10(3)(e), 11(3)(e), 12(3)(e), and 13(3)(f).

655 *Ibid.*, ss. 11(5), 12(5), and 13(5) and (6).

gametes in another I.V.F. procedure or the gametes have already been used.[656] No payment, except for travelling and medical expenses, may be made to a donor.[657] Finally, it is an offence for a gamete donor to give a false or misleading statement, unless he or she believed on reasonable grounds that the statement was true or not misleading.[658]

With respect to the source of the gametes, the Act provides that, where both ova and sperm donors are involved, I.V.F. should not be carried out unless, "where more than one embryo is used in the procedure, the gametes from which each embryo was derived were produced by the same two persons ...".[659] In addition, neither artificial insemination nor I.V.F. may be performed where the semen used was produced by more than one man.[660]

The Act also provides that gametes from an identified donor may be used, but only so long as the designated officer of an approved hospital certifies in writing that the same criteria for assessing suitability has been applied to this donor as would be applied to other, anonymous donors, and that the recipient, her husband or partner, and donor have received additional counselling respecting the use of the gametes of an identified donor. In no case may an unmarried person under the age of eighteen years be used as a gamete donor.[661]

Where an embryo, intended for implantation in an I.V.F. procedure, cannot be implanted because, for example, the recipient has died, the embryo may be donated by the gamete donors to another woman. Where the donors' consent for donation cannot be obtained, the Minister of Health must direct that the embryo be made available for use in an I.V.F. procedure.[662]

In section 6 of the Act, provision is made for experimentation and embryo freezing. After prohibiting cloning and any "procedure under which the gametes of a man or a woman are fertilised by the gametes of an animal",[663] section 6(3) prohibits all kinds of "experimental procedure"[664] except those approved by the Standing Review and Advisory Committee, established under section 29. In addition, section 6(5) prohibits the *in vitro* fertilization of ova for any purpose except implantation of the embryo in an I.V.F. procedure.

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656 *Ibid.*, s. 15.

657 *Ibid.*, ss. 11(6), 12(6), and 13(7).

658 *Ibid.*, s. 27.

659 *Ibid.*, s. 13(3)(e).

660 *Ibid.*, s. 26.

661 *Ibid.*, s. 25.

662 *Ibid.*, s. 14(1).

663 *Ibid.*, s. 6(1) and (2).

664 The term "experimental procedure" is defined in s. 6(4) to mean "a procedure that involves carrying out research on an embryo of a kind that would cause damage to the embryo, would make the embryo unfit for implantation or would reduce the prospects of a pregnancy resulting from the implantation of the embryo".

Finally, section 6 provides that a "person shall not carry out a procedure that involves freezing an embryo",[665] unless the embryo is "to be implanted in the womb of a woman at a later date".[666] However, research relating to the freezing of ova is expressly permitted.[667]

The statute also deals with record keeping. An approved hospital must maintain a register containing particulars of gamete donors and of the use of their gametes, the resulting child, consents, payments to donors, and any destruction of gametes,[668] in respect of both I.V.F. and artificial insemination.[669]

Non-identifying information respecting particulars of the donor must be given to the recipient, and the hospital must offer the donor non-identifying information concerning the recipient. In addition, a donor may request from the hospital that he or she be given non-identifying information respecting the artificially conceived child.[670]

Section 21 provides for record keeping where the artificial insemination procedure carried out by a physician is not performed in an approved hospital. In these cases, the physician must keep a written record of the particulars of the semen donor and any resulting child and send a copy to the Health Commission.

Section 22(1) of the Act requires the Health Commission to keep a central register. This register is to contain copies of the records sent to the Commission under section 19 or 21. With respect to disclosure, and leaving aside information that may flow to the donor and the recipient,[671] the regulations may prescribe classes of persons who may have access to specified portions of the Health Commission's register, subject, if necessary, to terms and conditions. In addition, the regulations may provide that the Minister or Secretary of the Health Commission may permit specified persons or classes of persons to have access to the register.[672] Finally, section 23 generally prohibits disclosure by persons who have access to certain medical records.

In Part V of the Act, the practice of surrogate motherhood is dealt with. The legislation is broadly conceived, covering women who, either before or after they become pregnant, agree with another person to act as surrogate mothers, whether or not for payment or reward. Section 30(2) and (3) then provides as follows:

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665 *Ibid.*, s. 6(6).

666 *Ibid.*, s. 6(7).

667 *Ibid.*, s. 6(8).

668 *Ibid.*, s. 19(2).

669 *Ibid.*, s. 19(5).

670 *Ibid.*, s. 20.

671 *Ibid.*

672 *Ibid.*, s. 22(2) and (3).

30.-(2) A person shall not—

(a) publish, or cause to be published, a statement or an advertisement, notice or other document that—

(i) is intended or likely to induce a person to agree to act as a surrogate mother;

(ii) seeks or purports to seek a woman who is willing to agree to act as a surrogate mother; or

(iii) states or implies that a woman is willing to agree to act as a surrogate mother;

(b) make, give or receive, or agree to make, give or receive, a payment or reward for or in consideration of the making of a contract, agreement or arrangement under which a woman agrees to act as a surrogate mother; or

(c) receive or agree to receive a payment or reward in consideration for acting, or agreeing to act, as a surrogate mother.

. . .

(3) A contract or agreement (whether made before or after the commencement of this section) under which a woman agrees with another person or other persons to act as a surrogate mother is void.

(ii) New South Wales

In 1984, New South Wales passed the *Artificial Conception Act, 1984*,[673] dealing essentially with the status and paternity of artificially conceived children. The main substance of the Act reads as follows:

5.-(1) A reference in this section to a fertilisation procedure is a reference to —

(a) the artificial insemination of a woman; or

(b) the procedure of implanting in the womb of a woman an ovum produced by the woman and fertilised outside her body,

where the semen used for the artificial insemination or the procedure —

(c) was produced by a man other than her husband; or

(d) was a mixture of semen, part of which was produced by a man other than her husband and part of which was produced by her husband.

(2) Where a married woman, in accordance with the consent of her husband, has undergone a fertilisation procedure as a result of which she has become pregnant, the husband shall be presumed, for all purposes, to have caused the pregnancy and to be the father of any child born as a result of the pregnancy.

(3) The presumption of law that arises by virtue of subsection (2) is irrebuttable.

(4) In any proceedings in which the operation of subsection (2) is relevant, a husband's consent to the carrying out of a fertilisation procedure in respect of his wife shall be presumed, but that presumption is rebuttable.

6.-(1) Where a woman becomes pregnant by means of —

(a) artificial insemination; or

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673 *Artificial Conception Act, 1984*, Act No. 3, 1984.

(b) the procedure of implanting in her womb an ovum (whether or not produced by her) fertilised outside her body,

any man (not being, in the case of a married woman, her husband) who produced semen used for the artificial insemination or the procedure shall, for all purposes, be presumed not to have caused the pregnancy and not to be the father of any child born as a result of the pregnancy.

(2) The presumption of law that arises by virtue of subsection (1) is irrebuttable.

The Act provides that a "married woman" includes "a woman who is living with a man as his wife on a bona fide domestic basis although not married to him".[674]

Insofar as the status of the child is concerned, section 5(1)(b) does not contemplate the use of donor ova. Accordingly, it would appear that, where, with her husband's consent, a "married woman" has had implanted in her an ovum produced by another woman and fertilized by donor semen, the husband would not be presumed to be the father of the child. As a result, where a donor ovum is used, the child would appear not to have a legal father, since, under section 6(1)(b) of the Act, the semen donor would have no status.

Reference should also be made to the companion statute, the *Children (Equality of Status) Amendment Act, 1984*,[675] which deals with conflicts between presumptions under the *Artificial Conception Act, 1984*, and the *Children (Equality of Status) Act, 1976*,[676] relating to the establishment of paternity and maternity.

674 *Ibid.*, s. 3(1). The terms "husband" and "wife" have correspondingly expanded definitions: *ibid.*, s. 3(2).

675 *Children (equality of Status) Amendment Act, 1984*, Act No. 6, 1984.

676 *Children (Equality of Status) Act, 1976*, Act No. 97, 1976.

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