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## Moral Evils v Health and Safety Evils: The Case of an Ovum “Obtained” from a “Donor” and Used by the “Donor” in Her Own Surrogate Pregnancy

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**MORAL EVILS V. HEALTH AND SAFETY  
EVILS: THE CASE OF AN OVUM  
“OBTAINED” FROM A “DONOR” AND  
USED BY THE “DONOR” IN HER OWN  
SURROGATE PREGNANCY**

**Pamela M. White\***

*This paper critically examines the amendment made in 2012 to section 10(2)(c) of the Assisted Human Reproduction Act, 2004 mandating the screening and testing of “obtained” ovum “donated” by a “donor” and*

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*used in her own surrogate pregnancy. The amendment at section 10(1) of the Act cites the federal government's obligation to reduce harm to human health and safety arising from use of sperm or ova for human reproduction, including the risk of disease transmission. This paper argues that the amendment mandating the screening and testing of surrogate ova when used by the surrogate in her own surrogate pregnancy creates a dangerous liminal regulatory space; one that transforms the surrogate into a third-party donor yet she incurs no health and safety risk to herself as she is the recipient of her own ova embryo. Genetic implications for the surrogate-born child makes a stronger case in support of mandatory testing, however the amendment imposes no similar screening and testing regime on the usual category of traditional surrogates: women who bear genetically-related children conceived through artificial insemination (IUI) rather than IVF. The paper questions the application of a health and safety evil that the amendment seeks to address. It suggests the real evil is a moral one whereby criminal code sanctions are being employed to discourage traditional surrogacy when practiced as a result of assisted reproduction techniques.*

## INTRODUCTION

One of the many criticisms levelled at Canada's *Assisted Human Reproduction Act*, 2004 has been its lack of regulatory certainty. By early 2018, only one set of regulations, the *Section 8 (Consent) Regulations*, had been

passed.<sup>1</sup> Ethicists,<sup>2</sup> lawyers<sup>3</sup> and clinicians<sup>4</sup> have repeatedly called on the federal government to take legislative action to update Canada's 1998 human sperm screening and testing regulation,<sup>5</sup> address the lack of health protections for patients using donated ova,<sup>6</sup> and bring clarity to the law regarding reimbursement of gamete donors and surrogates.<sup>7</sup>

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- <sup>1</sup> SOR/2007-137, s 8 [*Section 8 (Consent) Regulations*].
  - <sup>2</sup> Françoise Baylis, Jocelyne Downie & David Snow, "Fake it Till You Make it: Policy Making and Assisted Human Reproduction in Canada" (2015) 36:6 *J Obstetricians & Gynecologists Can* 510: 512; Jocelyne Downie & Françoise Baylis, "Transnational Trade in Human Eggs: Law, Policy, and (In)action in Canada" (2013) 41:1 *JL Med & Ethics* 224 at 239; Alana Cattapan, "Rhetoric and reality: Protecting Women in Canadian Public Policy on Assisted Human Reproduction" (2013) 25:2 *CJWL* 202.
  - <sup>3</sup> Erin Nelson, *Law, Policy and Reproductive Autonomy* (Oxford: Hart Publishing, 2013) at 326–34.
  - <sup>4</sup> Kelly Crowe "Test Imported Human Eggs, Doctors Urge", *CBC News* (29 April 2012), online: <[www.cbc.ca/news/health/test-imported-human-eggs-doctors-urge-1.1207174](http://www.cbc.ca/news/health/test-imported-human-eggs-doctors-urge-1.1207174)>.
  - <sup>5</sup> Stu Marvel, "Tony Danza is My Sperm Donor?: Queer Kinship and the Impact of Canadian Regulations around Sperm Donation" (2013) 25:2 *CJWL* 221 at 221.
  - <sup>6</sup> Vanessa Gruben, "Women as Patients, Not as Spare Parts: Examining the Relationship Between the Physician and Women Egg Providers" (2013) 25:2 *CJWL* 249 at 249–50.
  - <sup>7</sup> Alison Motluk "The Human Egg Trade: How Canada's Fertility Laws Are Failing Donors, Doctors, and Parents", *The Walrus* (April 2010), online: <[thewalrus.ca/category/issues/2010-04/](http://thewalrus.ca/category/issues/2010-04/)>; Alison Motluk, "First Prosecution under Assisted Human Reproduction Act Ends in Conviction" (2014) 186:2 *CMAJ* E75; *R v Picard and Canadian Fertility Consulting Ltd*, (2013) unreported, available online at: <[cdn.dal.ca/content/dam/dalhousie/pdf/sites/noveltechethics/AHRA\\_Facts.pdf](http://cdn.dal.ca/content/dam/dalhousie/pdf/sites/noveltechethics/AHRA_Facts.pdf)>.

The tide, however, appears to be turning. On September 30, 2016, Health Canada announced its intention to affirm and clarify several regulations listed in the *Assisted Human Reproductive Act 2004 (AHRA)*.<sup>8</sup> It plans to revise the *1996 Semen Regulations* and move them from the *Food and Drugs Act* to the *AHRA* (2012); develop regulations for the screening and testing of ova donors; establish gamete tracing protocols; clarify reimbursable expenses for parties involved in surrogacy arrangements and sperm and ova donation; and institute inspection procedures.<sup>9</sup>

Since the 2016 announcement, Health Canada has engaged in web-based consultations and invited stakeholders and interested parties to comment on its proposed pathways for regulatory change. Consultation has occurred alongside the Standards Council of Canada's re-development and re-release in late 2017 of a revised National Standard of Canada, *CAN/CSA-Z900.2.1.-17 Tissues For Assisted Reproduction*.<sup>10</sup> This updated

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<sup>8</sup> *Assisted Human Reproduction Act*, SC 2004, c 2 [*AHRA*].

<sup>9</sup> SOR/96-254 [*Processing and Distribution of Semen for Assisted Conception Regulations*]; Health Canada, News Release, "Government of Canada plans to introduce regulations to support the Assisted Human Reproduction Act" (30 September 2016), online: <[www.canada.ca/en/health-canada/news/2016/09/government-canada-plans-introduce-regulations-support-assisted-human-reproduction-act.html](http://www.canada.ca/en/health-canada/news/2016/09/government-canada-plans-introduce-regulations-support-assisted-human-reproduction-act.html)>; Canada Gazette, Government Notice, 150:40, "Assisted Human Reproduction Act" (1 October 2016), online: <[www.gazette.gc.ca/rp-pr/p1/2016/2016-10-01/html/notice-avis-eng.html#ne1](http://www.gazette.gc.ca/rp-pr/p1/2016/2016-10-01/html/notice-avis-eng.html#ne1)>.

<sup>10</sup> Standards Council of Canada, *CAN/CSA-Z900-17 Tissues for Assisted Reproduction*, Ottawa: SCC, 2017 at 8 [2017 *Can/CSA*].

Standard is a propriety set of guidelines, though it should be noted that its development, like that of its predecessors, was funded by Health Canada.<sup>11</sup> It has been expected that the 2017 *CAN/CSA* Standard would shape the screening, testing, labelling, packaging, and reimbursement regulations likely to be tabled in the 2018-19 Parliamentary Session.<sup>12</sup>

In early February 2018, Health Canada released a short overview report entitled: “*What We Heard*”.<sup>13</sup> It summarized the “57 sets of comments” received during the 2016–17 consultation period but did not reveal the direction that the government was likely to take in response to identified concerns.<sup>14</sup> Nor did it suggest how conflicting

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<sup>11</sup> *Ibid.* In January 2018, the cost for the standard was \$165.00 plus HST. This cost provides the purchaser with an independent licence to access the Standard. The purchaser is also entitled to obtain updates.

<sup>12</sup> *Ibid.* It should be noted that the 2017 *CAN/CSA* Standard also includes an itemization of the legitimate expenses for which gamete donors and surrogates should receive reimbursement; Health Canada, *Draft Directive: Health Canada, Directive: Technical Requirements for Therapeutic Donor Insemination*, Ottawa: Health Canada, 2018, online: [≤www.canada.ca/en/health-canada/programs/consultation-assisted-human-reproduction-regulations/technical-directive.html#c>](http://www.canada.ca/en/health-canada/programs/consultation-assisted-human-reproduction-regulations/technical-directive.html#c), will be incorporated by reference; See: Mark C McCleod, “Reimbursement of Expenditures and Possible Sub-delegation of the Assisted Human Reproduction Regulations” in *Surrogacy in Canada: Critical Perspectives in Law and Policy* (Toronto: Irwin Law, 2018) for an explanation of how incorporation by reference will be accomplished.

<sup>13</sup> Health Canada, *What We Heard Report: A Summary of Feedback from the Consultation: Toward a Strengthened Assisted Human Reproduction Act* (12 January 2018) [Health Canada, *What We Heard*].

<sup>14</sup> *Ibid.* at 1.

views might be addressed.<sup>15</sup> On September 27, 2018, Health Canada published in the Canada Gazette the long awaited draft Assisted Reproduction Act Regulations regarding Administration and Enforcement of the Act; Reimbursement of Expenditures under subsection 12(1) of the Act; Regulations Amending the Assisted Human Reproduction (Section 8 Consent) Regulations; Safety of Sperm and Ova Regulations and Draft Health Canada Directive: Technical Requirements for Conducting the Suitability Assessment of Sperm and Ova Donors.<sup>16</sup> Though not the explicit topic of this paper, the 2018 proposed Regulations and Draft Directive differ in important ways from the 2017 CAN/CSA Standard.<sup>17</sup> These differences along with non-acceptance of proposals for the reimbursement of gamete donors and surrogates for example submitted during the initial phase of the regulatory consultation can no doubt be expected to be

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<sup>15</sup> *Ibid.*

<sup>16</sup> Canada Gazette, Proposed Regulations, 152:43, “Safety of Sperm and Ova Regulations” at 3637–734; Canada Gazette, Proposed Regulations, 152:43, “Reimbursement Related to Assisted Human Reproduction Regulations” at 3735–40; Canada Gazette, Proposed Regulations, 152:43, “Regulations on the Administration and Enforcement of the Assisted Human Reproduction Act” at 3741–44; Canada Gazette, Proposed Regulations, 152:43, “Regulations Amending the Assisted Human Reproduction (Section 8 Consent) Regulations” at 3745–51, online: <[www.gazette.gc.ca/rp-pr/p1/2018/2018-10-27/html/index-eng.html](http://www.gazette.gc.ca/rp-pr/p1/2018/2018-10-27/html/index-eng.html)>; Health Canada, *Draft Directive: Technical Requirements for Conducting the Suitability Assessment of Sperm and Ova Donors*, Ottawa: Health Canada, 2018, online: <[www.canada.ca/en/health-canada/programs/consultation-assisted-human-reproduction-regulations/technical-directive.html#c](http://www.canada.ca/en/health-canada/programs/consultation-assisted-human-reproduction-regulations/technical-directive.html#c)>.

<sup>17</sup> Compare, for example, the 2017 CAN/CSA Standard for Reimbursement of Sperm and Ova donors and surrogates and the 2018 Proposed Regs.

raised during the second phase of consultations scheduled for late 2018 and early 2019.<sup>18</sup>

While such initiatives indicate that the federal government has finally decided to take-action to resolve some of the longstanding *AHRA* regulatory inadequacies, the approach falls short of the extensive legislative renewal advocated for by those seeking changes to the sections that ban commercial surrogacy and gamete donation and limit research.<sup>19</sup> Furthermore, little attention has been paid to the legal and policy implications of the amendments made to the *AHRA* in 2012.<sup>20</sup>

This paper critically examines section 10 of the 2012 *AHRA* amendment and Health Canada's proposed regulatory response. In particular, the paper focusses on the amendment made to section 10(2)(c) of the *AHRA* mandating the screening and testing of "obtained" ovum "donated" by a "donor" and used in her own surrogate

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<sup>18</sup> Health Canada, *Consultation on Proposed Assisted Human Reproduction Regulations*, Ottawa: Health Canada, 2018, online: <[www.canada.ca/en/health-canada/programs/consultation-assisted-human-reproduction-regulations.html](http://www.canada.ca/en/health-canada/programs/consultation-assisted-human-reproduction-regulations.html)>.

<sup>19</sup> Canadian Fertility & Andrology Society, "CFAS Position Statement: Compensation for Third Party Reproduction in Canada" (May 2017) and update provided May 2018, online: <[www.cfas.ca/public-affairs/position-statements/](http://www.cfas.ca/public-affairs/position-statements/)>; Alison Motluk, "Fertility Advocates Protest Criminal Sanctions in Assisted Reproduction Act" (2018) 190:2 CMAJ E58–E59.

<sup>20</sup> Alana Cattapan & Sara Cohen, "The Devil We Know: The Implications of Bill C-38 for Assisted Human Reproduction in Canada" (2013) 35:7 J Obstet Gynaecol Can 654 at 654–56.



pregnancy.<sup>21</sup> The stated rationale for the amendment at section 10 cites the federal government's obligation to reduce harm to human health and safety arising from use of sperm or ova for human reproduction, including the risk of disease transmission.<sup>22</sup> Indeed, one of the stated objectives of the 2016 Health Canada legislative renewal initiative acknowledges the need to "reduce the risk to human health and safety from using donor sperm and eggs (ova), including the risk of transmitting disease."<sup>23</sup> This paper argues that the amendment mandating the screening and testing of surrogate ova when used by the surrogate in her own surrogate pregnancy creates a dangerous liminal regulatory space; one that transforms the surrogate into a third-party donor yet she incurs no health and safety risk to herself as she is the recipient of her own ova embryo. Moreover, the amendment imposes a screening and testing regime that is not mandated for the usual category of traditional surrogates: women who bear genetically-related children conceived through artificial insemination (IUI) rather than IVF.

In advancing this argument, the paper identifies three issues raised by the 2012 *AHRA* amendment and 2018 proposed Regulations targeting traditional surrogacy when carried out as a result of IVF assisted reproduction

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<sup>21</sup> *Jobs, Growth and Long-term Prosperity Act*, SC 2012, c-19, s 714 [*Jobs, Growth and Long-term Prosperity Act*].

<sup>22</sup> *Ibid*, section 10(1) as amended by *Jobs, Growth and Long-term Prosperity Act*; *AHRA supra* note 8.

<sup>23</sup> Health Canada, Public Consultation, "Strengthening the Assisted Human Reproduction Act" (26 January 2018), online: <[www.canada.ca/en/health-canada/programs/consultation-assisted-human-reproduction.html](http://www.canada.ca/en/health-canada/programs/consultation-assisted-human-reproduction.html)>.

technologies.<sup>24</sup> The first issue is that failure to screen and test a woman's obtained ovum used in her own surrogate pregnancy carries criminal penalties. The Supreme Court of Canada (SCC) decision in *Reference re Assisted Human Reproduction Act (Ref re AHRA)* permits the federal government to legislate in areas where a "health evil" is present.<sup>25</sup> The paper investigates the assumed "health evil" that requires the application of federal criminal law powers to mandate screening and testing of an "obtained" ovum "donated" by a woman and used in her own surrogate pregnancy.<sup>26</sup> It asks the following question: Can we be satisfied that the amendment meets the harm test for application of criminal law powers established by the SCC in *Ref re AHRA*?<sup>27</sup> It looks to the proposed 2018 regulations for guidance regarding the screening and testing regime to be mandated for this unique type of "donated" ova.

The second issue concerns the term "donor". Terminological confusion created by the *AHRA* is compounded by the use of a different definition of donor

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<sup>24</sup> Traditional surrogates are genetically related to the child if they agree to carry for intended parent(s). They supply their own ova used in their surrogate pregnancy. Most traditional surrogacy occurs as a result of assisted insemination. The amendment is directed at IVF treatments whereby the surrogate's ovum (ova) are obtained as a result of ovarian stimulation. The *ex utero* ovum would then be fertilized using sperm from the intended parent or by sperm obtained for the reproductive use of the intended parent(s).

<sup>25</sup> Ubaka Ogbogu, "The Assisted Human Reproduction Act Reference and the Thin Line Between Health and Crime" (2013) 22:1 Const Forum Const 93 at 93–97.

<sup>26</sup> *AHRA*, *supra* note 8, s 10(2)(c).

<sup>27</sup> *Reference re Assisted Human Reproduction Act*, 2010 SCC 61, [2010] 3 SCR 457 at paras 13–14 [*Ref Re AHRA*].

by the 2017 Canadian Standards Association Standard, provincial statutes, Canadian Fertility and Andrology Society treatment guidance documents, and 2018 proposed Safety of Sperm and Ova Regulations. The paper argues that confusion over the term “donor” contributes to a misunderstanding regarding the health and safety risks encountered by a woman using her own “obtained” ova in her own surrogate pregnancy. The paper critically explores the implications of this confusion for reproductive law and policy.

The third issue raised by the amendment centres on the legal transformation of a traditional surrogate who undergoes ovarian stimulation and IVF reproductive treatments. The paper argues that the transformation occurs in part due to confusion over the word “donor” alongside the multi-faceted fertility treatment roles taken on by a traditional surrogate which result in her being both an “egg donor” and a “surrogate”. The paper asserts that law and practice transform her into a legal liminal figure. Her status, as Turner who expounded on the concept of liminality explained, becomes being in “betwixt and between positions assigned and arranged by law, custom, convention and ceremony.”<sup>28</sup> It is this in-between status that presents confusion about health and safety risks, compromises her autonomy to make decisions about the use of her “obtained” ova and her treatment as a fertility

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<sup>28</sup> Victor Witter Turner, *The Ritual Process: Structure and Anti-Structure (Lewis and Henry Morgan Lectures)*, (New York: Aldine Transaction, 1969) at 95.

patient, and leads to her being viewed as a “spare part”<sup>29</sup> provider and as a “treatment option” for infertile patients and intended parent(s).<sup>30</sup>

To analyse these three substantive issues, the first section of this paper will review Canada’s assisted reproduction legal landscape. It examines the *AHRA* definition of “donor” and considers how the *AHRA* definition differs from the terminology used in provincial statutes, the 2017 CAN/CSA Standard, CFAS reproductive treatment guidelines, and the 2018 proposed *AHRA* regulations. The paper also chronicles the amendments made to the *AHRA* in 2012 that require screening and testing of human reproductive tissue used in fertility treatments and explore a number of implications of the amendment in regard to consent, reproductive autonomy, and health risks.

Having established the legislative parameters of the *AHRA* amendments, the second section of the paper analyses the health and safety harms that could be viewed as conditions sufficient to require the imposition of criminal law sanctions if untested and unscreened “obtained” traditional surrogate ova are used in the traditional surrogate’s pregnancy. I seek to establish

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<sup>29</sup> Vanessa Gruben, “Assisted Reproduction Without Assisting Over-Collection: Fair Information Practices and the Assisted Human Reproduction Agency of Canada” (2009) 17 *Health LJ* 225 at 229.

<sup>30</sup> Pamela M White, “‘Why We Don’t Know What We Don’t Know’ About Canada’s Surrogacy Practices and Outcomes” in *Surrogacy in Canada: Critical Perspectives in Law and Policy*, Vanessa Gruben, Alana Cattapan & Angela Cameron eds (Toronto: Irwin Law, 2018) 51 at 72–73 [White, “Why We Don’t Know”].

whether the health and safety harms would be to the traditional surrogate herself, the clinic, other fertility patients, surrogate-born child, or to society more broadly. The paper will examine if the identified health and safety harms meet the criminal law test set out by the SCC in *Ref re AHRA*. It is worth recalling that in *Ref re AHRA*, Justices LeBel and Deschamps took the view that not all public health risks should be addressed through criminal law in declaring that “. . . it must be found that there is an evil to be suppressed or prevented. . . .”<sup>31</sup>

The final section of the paper analyses several problems identified with the amendment, including whether a sufficient health and safety justification exists to impose criminal code penalties in cases where unscreened and untested “obtained” ova “donated” by a traditional surrogate are used in her own surrogate pregnancy. This section examines whether the proposed regulatory actions function as a thinly disguised attempt to discourage the practice of traditional surrogacy when undertaken using IVF. The paper posits that the legislated screening and testing requirements render traditional surrogates a special group of reproductive patients. It places them in a dangerous liminal legal reproductive space that potentially exposes them to risky practices.

To conclude, the paper highlights a number of regulatory problems that are created as a result of the inconsistent application of the term “donor”, legislative change to *AHRA* section 10 and the proposed 2018 Regulations on Safety of Sperm and Ova. These legislative instruments have reframed the boundaries of health and

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<sup>31</sup> *Ref re AHRA*, *supra* note 27 at para 243.

safety harms to create dangerous liminal legal regulatory spaces.<sup>32</sup> It concludes that the amendments at subsection 10(2)(c) further reveal the problems of Canada's misshapen and misplaced *AHRA*.

### **BRIEF HISTORY OF ASSISTED HUMAN REPRODUCTION ACT, 2004**

Canada's *AHRA* 2004 passed after nearly twenty years of extensive consultation, in-depth study and, at times, acrimonious debate.<sup>33</sup> It is considered by many legal and policy scholars to be seriously flawed.<sup>34</sup> The Act had freshly achieved Royal Assent when Quebec contested the use of federal criminal law powers to regulate the practice

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<sup>32</sup> Graeme Laurie, "Liminality and the Limits of Law in Health Research Legislation: What are We Missing in the Spaces in-Between?" (2017) 25:1 *Med L Rev* 47 at 48–49.

<sup>33</sup> Ottawa, Privy Council Office, *Proceed with Care - Final Report of the Royal Commission on New Reproductive Technologies* (1993) (Chair: Patricia Baird); House of Commons, *Assisted Human Reproduction: Building Families* (December 2001). The Baird report was voluminous. List of research studies and researchers can be found in the Appendix. This was a Parliamentary Committee Report. See also Monique Hébert, Nancy M Chenier, & Sonia Norris, *Legislative History of Bill C-13*, (10 October 2002), Library of Parliament.

<sup>34</sup> Pamela M White, "'A Less than Perfect Law': The Unfulfilled Promise of Canada's Assisted Human Reproduction Act" in Kristy Horsey, ed, *Human Fertilisation and Embryology: Regulation Revisited*, (London: Routledge, 2015) 170; François Baylis and Jocelyne Downie, "A Tale of Assisted Human Reproduction Canada: A Tragedy in Five Acts" (2013) 25:2 *CJWL* 183 [Baylis & Downie "A Tale of Assisted Human Reproduction"]; Alana Cattapan "Rhetoric and Reality: 'Protecting' Women in Canadian Public Policy on Assisted Human Reproduction" (2013) 25:2 *CJWL* 202.

of fertility medicine.<sup>35</sup> In 2010, the SCC agreed with Quebec's position in *Ref re AHRA* and rendered the sections of the Act legislating in areas under provincial constitutional jurisdiction *ultra vires*, most notably the practice of medicine and research.<sup>36</sup> The SCC decision left intact the sections protecting human health and safety, such as the testing and screening of human reproductive materials used for assisted reproduction.<sup>37</sup> The prohibition of activities deemed to be morally unacceptable (cloning, sex selection, discrimination, and commodification of human gamete donation and surrogacy) were upheld, as were the sections enabling enforcement of permitted activities, including the reimbursement of expenses incurred by gamete donors and surrogates.<sup>38</sup>

The purpose and effect of the SCC 2010 decision, *Ref re AHRA*, centres on the use of federal criminal law

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<sup>35</sup> Décret 1177-2004; Décret 73-2006; *Attorney General of Quebec v Attorney General of Canada*, 2008 QCCA 1167, [2008] RJQ 1551.

<sup>36</sup> *Ref Re AHRA*, *supra* note 27. Sections rendered *ultra vires*: ss 10, 11, 13–18 and 40(2) (3), (3.1), (4) and (5) and 44(2) and (3).

<sup>37</sup> *AHRA*, *supra* note 8. See the new section 10, *Assisted Human Reproductive Act*, 2004 as amended in 2012.

<sup>38</sup> *Assisted Human Reproductive Act*, 2004 *supra*, note 8, ss 5–9. Discussion of the decision found in: Barbara von Tigerstrom, “Federal Health Legislation and the Assisted Human Reproduction Act Reference” (2011) 74:33 Sask L Rev 41; Jonathan D Whyte “Federalism and Moral Regulation: A Comment on the Reference Re Assisted Human Reproduction Act” (2011) 74 Sask L Rev 45; Graeme G Mitchell “Not a General Regulatory Power: A Comment on Reference re Assisted Human Reproduction Act” (2011) 54 SCLR 633.; *AHRA*, *supra* note 8, s 12.

powers to uphold morality and deter a public health evil.<sup>39</sup> Relying on the argument advanced by Rand J. in the *Margarine* reference, *Ref re AHRA* reaffirms that the “evil” or threat must be real and legitimate.<sup>40</sup> The decision serves to remind Canadian legislators that in matters of health (an area of provincial constitutional responsibility), criminal law (when used to achieve a public purpose) is restricted to the suppression of a public health evil.<sup>41</sup> It underscores that mere identification of public purpose is not sufficient justification for invoking federal criminal law powers: as the SCC stated, the “evil must be real and the apprehension of harm must be reasonable.”<sup>42</sup> It is through this interpretive lens that subsequent *AHRA* legislative amendments and regulatory reform such as the one recently undertaken by Health Canada must be critically assessed and evaluated.

### **2012 LEGISLATIVE AMENDMENTS TO THE *AHRA***

In March 2012, the federal government used omnibus tax legislation, Bill C-38: *The Jobs, Growth and Long-term Prosperity Act*, to amend the *Assisted Human Reproductive*

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<sup>39</sup> *Ref Re AHRA*, *supra* note 27 at 189; J-F Gaudreault-DesBiens & N Karazavin, “Canada’s New Reproductive Technologies: A Moral Evil or Signs of Beneficial Medical Progress?” (2012) Public Law 147; Whyte, *supra* note 38.

<sup>40</sup> *Reference re Validity of Section 5 (a) Dairy Industry Act*, [1949] SCR 1, 1 DLR 433; *Ref Re AHRA*, *supra* note 27 at 251.

<sup>41</sup> Ogbogu, *supra* note 25 at 93.

<sup>42</sup> *Ref Re AHRA*, *supra* note 27 at 14.



*Act, 2004*.<sup>43</sup> The Assisted Human Reproduction Agency was eliminated, thereby saving the federal government some \$10 million, though it soon became apparent that any fiscal savings were likely to be considerably less, given that the Agency had never managed to spend even half of its annual budget.<sup>44</sup> Additionally, Health Canada was asked to assume a limited number of assisted reproduction regulatory, enforcement, and outreach responsibilities.<sup>45</sup>

The 2012 *Jobs, Growth and Long-term Prosperity Act* amendments also performed a legal administrative housekeeping function consistent with a regulatory pattern current at the time that resulted in the elimination of one regulation for every new one established.<sup>46</sup> The sections of the *AHRA* rendered ultra vires by the SCC decision in *Ref re AHRA* were repealed. At the same time, it consolidated a number of related regulatory responsibilities found in

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<sup>43</sup> *Jobs, Growth and Long-term Prosperity Act*, *supra* note 21.

<sup>44</sup> Tom Blackwell “Government Shuttters Agency that Oversees Canada’s Fertility and Assisted Reproduction Industry”, *National Post* (30 March 2012), online: <[nationalpost.com/news/government-shuttters-agency-that-oversees-canadas-fertility-and-assisted-reproduction-industry](http://nationalpost.com/news/government-shuttters-agency-that-oversees-canadas-fertility-and-assisted-reproduction-industry)>; Anne Kingston “Assisted Human Reproduction Canada: The Budget Cut Everyone Missed”, *Maclean’s Canada* (2 April 2012), online: <[macleans.ca/society/science/assisted-human-reproduction-canada-the-budget-cut-everyone-missed/](http://macleans.ca/society/science/assisted-human-reproduction-canada-the-budget-cut-everyone-missed/)>; Health Canada, *What We Heard*, *supra* note 13 at 3.1.

<sup>45</sup> See the critique of this administrative change presented in Baylis & Downie, “A Tale of Assisted Human Reproduction”, *supra* note 34.

<sup>46</sup> Laura Jones, “Cutting Red Tape in Canada: A Regulatory Reform Model for the United States?” (November 2015) *Mercatus Center at George Mason University*, online: <[www.mercatus.org/system/files/Jones-Reg-Reform-British-Columbia.pdf](http://www.mercatus.org/system/files/Jones-Reg-Reform-British-Columbia.pdf)>.

other statutes. For example, sections of the *AHRA* 2004 that regulated the use of human ova and sperm under the *Human Pathogens and Toxic Materials Act* along with the regulation that had mandated the testing and screening regime for human sperm under the federal *Food and Drugs Act* were repealed<sup>47</sup> thereby permitting human sperm and ova screening and testing, along with tracing and identification requirements, to be located wholly within the ambit of the *AHRA* at the amended section 10. The investigative abilities of Health Canada were strengthened and inspection provisions associated with the statute's regulations were revised.<sup>48</sup>

The 2012 *AHRA* amendments have been characterised by some scholars as a repeat performance of a failed legislative project, while others have been less generous in their criticism of Canada's renewed legislative foray into the law of assisted reproduction.<sup>49</sup> None of the critiques of the 2012 *AHRA* amendments, however, have examined the implications of imposing screening and testing regulations on an "obtained" ova "donated" by a traditional surrogate for use in her own surrogate

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<sup>47</sup> *Jobs, Growth and Long-term Prosperity Act*, *supra* note 21.

<sup>48</sup> *Ibid.* See also s 45–68 of the *AHRA*, *supra* note 8.

<sup>49</sup> Alana Cattapan & Sara Cohen, "The Devil We Know: The Implications of Bill C-38 for Assisted Human Reproduction in Canada" (2013) 35:7 *JOGC* 654 at 654; Baylis & Downie "A Tale of Assisted Human Reproduction", *supra* note 34.

pregnancy<sup>50</sup>—a requirement added to the Act without public consultation or discussion by Parliament.<sup>51</sup>

In the absence of scholarly scrutiny, we need to examine the implications that legislative change involving traditional surrogates could have for reproductive law and policy. If the objective is to discourage the practice, then the requirement to screen and test obtained own ova used by a traditional surrogate delivers an unexpected punitive punch. On the other hand, if the purpose is to protect the traditional surrogate and her offspring from a health harm, the identified health risks need to be real and the protective measures proportionate. Finally, if the goal is to shelter Canadians from the harm of a moral evil, one needs to determine why traditional surrogacy, when performed through IVF as that is the only way to “obtain” ova from a woman, constitutes an evil that is absent when traditional

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<sup>50</sup> Glenn Rivard, “Federal and Provincial Jurisdictions with Respect to Health: Struggles and Symbiosis” in Trudo Lemmens, Andrew Flavelle Martin, & Cheryl Milne, eds, *Regulating Creation: The Law, Ethics and Policy of Assisted Reproduction* (Toronto: University of Toronto Press, 2017) 63 at 80–82. Rivard makes no reference to the requirement to screen and test of surrogate ova donors.

<sup>51</sup> “Bill C-38, An Act to implement certain provisions of the budget tabled in Parliament”, 3rd reading, *House of Commons Debates*, 146–42 (18 June 2012) at 1700 (Hon Andrew Scheer); “Bill C-38, An Act to implement certain provisions of the budget tabled in Parliament”, *House of Commons Debates*, oral questions, 146–41 (15 Jun 2012) at 1115. Bill C-38 passed without discussion as to the amendments being made to the *AHRA* apart from Mr Wayne Marston (Hamilton East-Stony Mountain, NDP) noting that the Assisted Human Reproduction Agency would be shut down and Ms Megan Leslie (Halifax, NDP) who asked about the fiscal savings to be achieved from the shutdown of the Assisted Human Reproduction Agency: *Official Report of Debates (Hansard)*, 41-1 (15 June 2012) at 9612.

surrogacy occurs as a result of artificial insemination, which is the more common way to undertake traditional surrogacy.<sup>52</sup>

### **EXAMINATION OF 2012 AHRA SECTION 10 AMENDMENTS**

The 2012 *AHRA* amendments at section 10 replace the original section 10 that was rendered ultra vires by the SCC in *Re re AHRA*.<sup>53</sup> The purpose of the impugned section 10 had been to support a federally managed licencing regime for human gametes used in assisted human reproduction.<sup>54</sup> With this type of federal activity ruled constitutionally invalid, the federal government repositioned its legislative responsibilities and subsequent use of *Criminal Code* powers to fall within a human health protection mandate. Indeed, at subsection 10(1) the health objective of testing and screening of human gametes used in assisted human reproduction is stated as being:

10(1) The purpose of this section is to reduce the risks to human health and

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<sup>52</sup> White, “Why We Don’t Know”, *supra* note 30 at 64. Canada keeps no statistics on the practice of traditional surrogacy. The Canadian Assisted Reproductive Registry (CARTR-Plus) counts only gestational surrogate cycles. This is one of the many Assisted Human Reproduction data gaps that exist in Canada. The 2018 Safety of Sperm and Ova Regulations make no attempt to mandate an IVF registry documenting the number and types of sperm and ova screened and tested. For a commentary on traditional surrogacy practices see: Jenni Millbank, “Rethinking ‘Commercial’ Surrogacy in Australia” (2015) 12:3 *J Bioethical Inq* 477.

<sup>53</sup> *Jobs, Growth and Long-term Prosperity Act*, *supra* note 21 at 717.

<sup>54</sup> *Re re AHRA*, *supra* note 27 at para 93.

safety arising from the use of sperm or ova for the purpose of assisted human reproduction, including the risk of the transmission of disease.

In the subsections that follow subsection 10(1), human sperm and ova obtained from specified types of donors at subsections 10(2)(a, b, c) and used by certain categories of female persons identified at subsections 10(2)(a, b, c) for the purposes of assisted reproduction may be exempted from testing and screening as indicated in subsection 10(3) and can be distributed and imported pursuant to subsection 10(4). At subsection 10(5) the term “common-law partner” is defined and at section 61, an amended set of penalties for failure to abide by the regulations to be promulgated pursuant to section 10 are specified.

It should be noted that the *AHRA* prohibits all uses of human gametes and embryos in assisted human reproduction unless the activity is expressly permitted by regulation.<sup>55</sup> The amendments made in 2012 preserve this position. As a result, assisted reproduction is characterised as a non-normative and unnatural activity. This characterization may have had salience in the 1980s when the practice was innovative, but it is much less defensible today. At section 10 the *AHRA* explicitly legalises a fertility patient’s use of their own untested and untested ova and the untested and tested sperm and ova of their

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<sup>55</sup> *Section 8 (Consent) Regulations*, *supra* note 1. The regulations are silent with respect to destruction of embryos no longer wanted for reproductive use, training, or research.

spouse, common-law partner, or sexual partner.<sup>56</sup> It makes the reproductive use of all other untested and untested human reproductive material illegal on the grounds of health and safety risk.<sup>57</sup>

**IDENTIFICATION OF THE TYPE OF DONATED SPERM AND OVUM TO BE TESTED AND SCREENED**

Section 10 amendments introduced by the *Jobs, Growth and Long-term Prosperity Act* state:<sup>58</sup>

- 10(2) Subject to subsection (3), no person shall distribute, make use of or import any of the following for the purpose of assisted human reproduction:
- (a) sperm that has been obtained from a donor and that is meant for the use of a female person other than a spouse, common-law partner or sexual partner of the donor;
  - (b) an ovum that has been obtained from a donor and that is meant for the use of a female person other than the donor or the spouse, common-law partner or sexual partner of the donor; or

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<sup>56</sup> *Jobs, Growth and Long-term Prosperity Act*, *supra* note 21, s 10(2); *AHRA*, *supra* note 8.

<sup>57</sup> *Ibid.*

<sup>58</sup> *Jobs, Growth and Long-term Prosperity Act*, *supra* note 21 at s 714–18.

- (c) an ovum that has been obtained from a donor and that is meant for the donor's use as a surrogate mother.

10(3) Subsection (2) does not apply if:

- (a) tests have been conducted in respect of the sperm or ovum in accordance with the regulations, and the sperm or ovum has been obtained, prepared, preserved, quarantined, identified, labelled and stored and its quality assessed in accordance with the regulations; and
- (b) the donor of the sperm or ovum has been screened and tested, and the donor's suitability has been assessed, in accordance with the regulations.

10(4) No person shall, except in accordance with the regulations, engage in any activity described in paragraph (3)(a) or (b) in respect of any of the following with the intention of distributing or making use of it for the purpose of assisted human reproduction:

- (a) sperm described in paragraph (2)(a);
- (b) an ovum described in paragraph (2)(b);
- or
- (c) an ovum described in paragraph (2)(c).

In subsection 10(5), "common-law partner", in relation to an individual, refers to a person who is cohabiting with the individual in a conjugal relationship at the relevant time, having so cohabited for a period of at

least one year.<sup>59</sup>

The penalties for failure to screen, test, label, distribute and import as specified in the regulations are set out in section 61.<sup>60</sup>

61 A person who contravenes any provision of this Act—other than any of sections 5 to 7 and 9—or of the regulations or an order made under subsection 44(1) is guilty of an offence and

- (a) is liable, on conviction on indictment, to a fine not exceeding \$250,000 or to imprisonment for a term not exceeding five years, or to both; or
- (b) is liable, on summary conviction, to a fine not exceeding \$100,000 or to imprisonment for a term not exceeding two years, or to both.<sup>61</sup>

### **WHO IS A “DONOR” AND WHY DOES THIS MATTER?**

The above noted subsections 10(2)(a, b, and c) begin by identifying gametes—sperm and ovum—obtained from three different types of “donors”. But before we examine

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<sup>59</sup> *Ibid* at 718.

<sup>60</sup> *Ibid* at 735.

<sup>61</sup> *Semen Processing Regulations*, *supra* note 9. No regulations pursuant to the amended s 10 have been made. Penalties for failure to test and screen human sperm are specified in SOR/96-254 [*Processing and Distribution of Semen for Assisted Conception*].



who the “donors” are and whether their gametes need to be tested and screened, we need to understand what the *AHRA* means by the term “donor”.

In law, the *AHRA* situates the act of donation—the giving, granting or conferring of human reproductive material—to the person from whose body the ovum or sperm was obtained. The *AHRA* considers *all persons* undertaking IVF treatment to be “donors”, even if the “donation” is made to oneself in the form of autologous use or when sperm or ovum are to be used by the donor’s spouse, common-law or sexual partner. The *AHRA* at section 3, defines a “donor” as:<sup>62</sup>

- (a) in relation to human reproductive material, the individual from whose body it was obtained, whether for consideration or not; and
- (b) in relation to an *in vitro* embryo, a donor as defined in the regulations.

The *AHRA Section 8 (Consent Regulations)* maintain the broad definition of the term “donor” and the “act of donation”. It specifies permitted uses, including own-use, third-party reproductive use, research use, and fertility treatment testing, which must be undertaken with the consent of the “donor” or “donors” in the case of an

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<sup>62</sup> *AHRA*, *supra* note 8, s 3.

embryo.<sup>63</sup> The goal being to ensure that all fertility patients are able to exercise autonomy in decision-making regarding reproductive use and donation of excess gametes and embryos for training, research and reproductive uses of others.<sup>64</sup> However, it should be noted that the *AHRA Section 8 (Consent Regulations)* clearly defines the “third-party” to be a reproductive party who is separate and apart from the “donor” of the ova, sperm, or embryo used in assisted reproduction.<sup>65</sup>

A major difficulty created by the *AHRA* definition of “donor” applied to the person as “donor” (noun) and the “act of giving” (verb) is that it encompasses both concepts in law: a “donor” who gives to oneself shares their title with a “donor” who gives human reproductive material to others. In so doing, it confounds and blurs common-use definitions of “donor” and “donation”. The Canadian Oxford Dictionary, for example, defines a “donor” as a person who gives (donates) blood, organs, or reproductive tissues to a third-party.”<sup>66</sup> Thus, the act of donation is defined as being other-motivated and other-directed. It is

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<sup>63</sup> *Section 8 (Consent) Regulations*, *supra* note 1. The *Section 8 Consent Regulations* state that a donor must provide consent for creation and use of an embryo: (i) for their own reproductive use; (ii) use following death; (iii) third-party use; and (iv) research (including IVF instruction). No changes have been introduced to the *Section 8 Consent Regulations* as a result of the s 10 amendments.

<sup>64</sup> Glenn Rivard & Judy Hunter, *The Law of Assisted Human Reproduction* (Markham: Lexis Nexis Butterworths, 2005) at 39–40.

<sup>65</sup> *Section 8 Consent Regulations*, *supra* note 1, ss 1(a)(i) and 1(a)(ii).

<sup>66</sup> Canadian Oxford Dictionary, 2nd ed, sub verbo “donor”: “2. a person who provides blood for a transfusion, semen for insemination, or an organ or tissue for transplant”. Origin from Latin donator, *donare*.

frequently characterised as the act of “gift” giving.<sup>67</sup> The *AHRA* however takes a much broader view of who is a donor and the act of giving, as it considers the donor and the act of donation to include the giving of a gamete or embryo to oneself as well as to others, including one’s spouse, common-law or sexual partner, in addition to the donation to anonymous or known third-parties for their reproductive use, or for research and training.

To further complicate the matter, the *AHRA*’s terminology differs from language adopted by provincial statutes, fertility association guidelines, 2017 CAN/CSA Standard,<sup>68</sup> and the 2018 proposed Safety of Sperm and Ova Regulations.<sup>69</sup> In these examples, “donor” refers to the person who donates human reproductive material or embryos for the reproductive use by a third-party.

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<sup>67</sup> See Richard Morris Titmuss, *The Gift Relationship: From Human Blood to Social Policy* (London: George Allen & Unwin, 1970).

<sup>68</sup> *Family Law Act, SBC 2011, c 25 [BC FLA]; All Families Are Equal Act (Parentage and Related Registrations Statute Law Amendment), SO 2016, c 23 [ON All Families Act]; 2017 Can/CSA supra note 10. Ontario sidesteps the use of the term “donor” by making the action of donation of reproductive material a negative action as it concerns parentage: “Provision of reproductive material, embryo not determinative” 5(1) reads: “A person who provides reproductive material or an embryo for use in assisted reproduction: (a) is not, by reason only of the provision, a parent of the child; and (b) shall not, by reason only of the provision, be recognized in law to be a parent of the child”; Jon Havelock et al, *Canadian Fertility and Andrology Society Guidelines for Third Party Reproduction*. Montreal: Canadian Fertility and Andrology Society, 2016 at 2, online: <cfas.ca/clinical-practice-guidelines/> [CFAS Guidelines].*

<sup>69</sup> *Canada Gazette*, Proposed Regulations, 152:43, “Safety of Sperm and Ova Regulations” [2018 Proposed Regulations], online: <www.gazette.gc.ca/rp-pr/p1/2018/2018-10-27/html/reg2-eng.html>.

For example, in a British Columbia case involving traditional surrogacy, Fitzpatrick J. determined that the petitioner, K.G., “does not come within the definition of a ‘donor’ since his donation of sperm for the conception was for his “own reproductive use”.<sup>70</sup> This ruling is guided by the British Columbia *Family Law Act* definition of a “donor” as:

a person who, for the purposes of assisted reproduction other than for the person's own reproductive use, provides:

- (a) his or her own human reproductive material, from which a child is conceived; or
- (b) an embryo created through the use of his or her human reproductive material.<sup>71</sup>

The province of Ontario on the other hand sidesteps the use of the term “donor” by making the action of donation of reproductive material a negative permission as it concerns parentage. The *All Families Are Equal Act* at section 5.1 states: “A person who provides reproductive material or an embryo for use in assisted reproduction, (a) is not, by reason only of the provision, a parent of the child; and (b) shall not, by reason only of the provision, be recognized in law to be a parent of the child.”<sup>72</sup>

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<sup>70</sup> *Family Law Act (Re)*, 2016 BCSC 598, 80 RFL (7th) 443 at 17.

<sup>71</sup> BC *FLA*, *supra* note 68, s 20.

<sup>72</sup> ON, *All Families Act*, *supra* note 68, s 5.1.

If one looks at the Canadian Fertility and Andrology Society (CFAS) publication, *Guidelines for Third Party Reproduction*, yet another definition is used. This document adopts a definition similar to the one cited in the British Columbia *Family Law Act*. A gamete donor is a: “a person who donates oocytes or sperm to a known or anonymous recipient for the purpose of achieving a pregnancy for the recipient and their partner (if applicable).”<sup>73</sup>

Another guidance document, the 2017 CAN/CSA Standard, acknowledges that the *AHRA* provides a broader definition of “donor” noting that the Act defines “donor” as the “the individual from whose body it [human reproductive material] was obtained, whether for consideration or not.”<sup>74</sup> The 2018 proposed Safety of Sperm and Ova Regulation defines a “donor” as: “an individual who provides reproductive tissues for use in a recipient who is not his or her spouse, common law partner, or sexual partner, in accordance with established medical criteria and procedures.”<sup>75</sup>

Yet, upon closer inspection of the 2017 CAN/CSA Standard’s definition of donor, it becomes apparent that the notion of who is a donor is more nuanced than it appears on first reading. As the emphasis is on “providing” reproductive tissues for use in a recipient who is not his or her own spouse, common-law partner, or sexual partner, it addresses the case of sperm provided by the intended father

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<sup>73</sup> CFAS Guidelines, *supra* note 68 at 2.

<sup>74</sup> 2017 *Can/CSA*, *supra* note 10 at 17.

<sup>75</sup> *Ibid.*

and used to fertilise the ovum provided by the traditional surrogate. Sperm used in this manner would need to be screened and tested. Yet, it is not clear that the Standard's definition fully encompasses the situation of ova provided by a traditional surrogate as she would be receiving her own human reproductive material.

The 2018 proposed Safety of Sperm and Ova Regulations on the other hand adopts a more restrictive notion of donor compared with the one used throughout the 2012 *AHRA*. The Regulatory Impact Analysis Statement notes that the new prohibition introduced by the 2012 legislative amendment at section 10 had as its purpose the reduction of the risks to human health and safety arising from the used of third-party donor sperm and ova for the purposes of Assisted Human Reproduction. The definition of donor used in the proposed Safety of Sperm and Ova Regulations refers to third-party donor sperm and or ova named as "donor sperm or ova" which are defined as:

donor sperm or ova that has obtained from a donor [third-party] and is meant for use by a female person other than the spouse, common-law partner or sexual partner of the donor. Donor sperm or ova may be from an anonymous donor, a donor who acts as a surrogate mother, or may be from donor who is known to the recipient but who is not their spouse, common-law partner or sexual

partner.<sup>76</sup>

The 2018 proposed Safety of Sperm and Ova Regulations states that a “donor of ova” includes persons who act as a surrogate. As the type of “surrogate” is not defined, it could both treatment forms of traditional surrogacy: i) surrogacy achieves conception through IUI and ii) where an ova is obtained from the surrogate and fertilised ex utero before being transferred back to the traditional surrogate. The possible expansion in the proposed regulation of the surrogate screening and testing requirements to include all traditional surrogates retains a certain degree of logic regarding the notion of “third-party” reproduction. However, to do so would be at odds with the *AHRA* at subsection 10(2)(c).

To summarize, a face-value reading of the 2017 CAN/CSA Standard definition would lead one to conclude that a traditional surrogate who produced the “obtained ova” and who is also the recipient of it appears not to be captured within the scope of the definition.<sup>77</sup> The proposed 2018 Safety of Sperm and Ova Regulation states that a third-party donor includes a surrogate. However, the Regulation is not specific as to whether surrogate’s donated

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<sup>76</sup> 2018 Proposed Regulations, *supra* note 69. Also, the 2018 Proposed Regulations on the Administration and Enforcement of the Assisted Human Reproduction Act, *supra* note 16 adds a further wrinkle to the definition of “donor of embryo”. For the purposes of enforcement at s 54 of the Act in that the genetic relationship to the embryo carries more decisional weight in circumstances where the individual who did not provide genetic material (sperm or ovum) is no longer a spouse or common-law partner. See s 1(1), s 1(3) and s 3(3) of the proposed enforcement regulations.

<sup>77</sup> 2017 *Can/CSA*, *supra* note 10 at 17.

third-party ova is an “obtained” ex utero ova or whether it includes all forms of traditional surrogacy thereby opening the door to mandatory screening of larger sub-set of surrogates.<sup>78</sup> As gestational surrogates do not donate an ova they would not be caught by the mandatory screening and testing regime outlined by the 2018 proposed Regulations.

The definition of “donor” is crucial to examining and understanding the changes made to section 10 of the *AHRA*. It sets the dividing line separating autologous and own-use donation from third-party donated gametes. Use of untested and unscreened third-party sperm and ova bears a criminal penalty.<sup>79</sup> The requirement to test and screen a traditional surrogate’s ex utero ova as specified at subsection 10(2)(c) transforms her autologous use into a “third-party” activity. In so doing, the *AHRA* and accompanying regulations situate the traditional surrogate as a third-party donor who poses a health and safety threat.

This sleight of hand whereby the traditional surrogate is both third-party ova donor and surrogate who uses her own ovum distances her from the fertility patient who uses her own gametes or the person who receives the ova of her spouse, common-law or sexual partner. In these instances, no testing and screening is required as their use of such ova pose no health or safety use to the recipient. Interestingly, it is possible to observe the effects of this repositioning in the manner in which fertility treatments are recorded. Canadian and American fertility clinics, for

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<sup>78</sup> 2018 Proposed Regulations, *supra* note 69 at 2.

<sup>79</sup> *AHRA*, *supra* note 8, s 10(3).



example, report gestational surrogates<sup>80</sup> as receiving embryos containing either “own use” or “third-party” ova. In all cases where a gestational surrogate receives an embryo labelled “own use ova”, it is in fact the intended mother’s ova that is being used. This occurs because the clinics consider the intended mother to be the fertility patient, not the gestational surrogate.<sup>81</sup>

This paper argues that a similar reimagining occurs in the amendment at subsection 10(2)(c). By turning a traditional surrogate into a third-party donor, her ability to determine the use of her obtained ova will be constrained, especially if it means that she must agree to legally “donate” her ova to the intended parents. In this regard, the implications for consent and change in status of the mandatory screening and testing requirements as set out in *AHRA* section 10 and the obligations imposed by the *Section 8 (Consent) Regulations* given her newly acquired status as third-party donor are significant.

### **FROM WHICH TYPE OF DONOR IS SPERM AND OVA TO BE SCREENED AND TESTED?**

To better understand the implications of the proposed regulatory regime, one needs to examine which type of

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<sup>80</sup> Canadian and US assisted reproduction registries do not report fertility treatments given to traditional surrogates. See White, “Why We Don’t Know”, *supra* note 30 at 64.

<sup>81</sup> See Kiran M Perkins et al, “Trends and Outcomes of Gestational Surrogacy in the United States” (2016) 106:2 *Fertility & Sterility* 435. The analysis undertaken is conducted from the perspective of the intended parents as they are viewed by the fertility industry to be the patients with the result that very little information is obtained about the surrogate undergoing the embryo transfer or pregnancy.

donor and donation triggers mandatory screening and testing.

### **Sperm donors**

According to *AHRA* 2012 at subsection 10(2)(a), “obtained” sperm not used by the donor’s spouse, common-law or sexual-partner must be tested and screened pursuant to the criteria established by subsection 10(3). In principle, the approach represents no change to existing law.

In response to the use of untested sperm that resulted in unfortunate transmissions of HIV, all human sperm used by the person other than the donor’s spouse, common-law or sexual partner, or imported for third-party reproductive use must comply with the Health Canada screening and testing standard instituted in 1996.<sup>82</sup> The sperm testing regulations were further tightened in 2000 after a woman contracted chlamydia trachomatis from an infected donor.<sup>83</sup>

The text of the screening and testing amendment at subsections 10(3)(a) and (b) echo the procedures mandated

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<sup>82</sup> *Ter Neuzen v Korn* [1995] 3 SCR 674, 127 DLR (4th) 577; MR Araneta et al, “HIV Transmission through Donor Artificial Insemination” (1995) 273:11 JAMA 854 at 858; *Processing and Distribution of Semen for Assisted Conception Regulations*, *supra* note 9.

<sup>83</sup> Health Canada, *Directive: Technical Requirements for Therapeutic Donor Insemination*, Ottawa: Health Canada, 2000 [Health Canada *Directive*]; Alana Cattapan & Françoise Baylis “The Trouble with Paying for Sperm”, *Toronto Star* (9 April 2016), online: <[www.thestar.com/opinion/commentary/2016/04/09/the-trouble-with-paying-for-sperm.html](http://www.thestar.com/opinion/commentary/2016/04/09/the-trouble-with-paying-for-sperm.html)>.

in the *1996 Semen Regulation*, specified in the *2000 Technical Requirements Directive*, and explained in the *Guidance* document.<sup>84</sup> It is these technical conditions for the screening, testing, and labelling of human sperm that are under review as part of the Health Canada regulation exercise<sup>85</sup> and to which the 2018 proposed Safety of Sperm and Ova Regulations and Directive would apply.<sup>86</sup>

In the case of surrogates, the sperm of the intended father or donor sperm if used will need to be screened and tested for sexually communicable diseases. Given that gestational and traditional surrogates could know the sperm donor, the screening and testing regime to be applied could include that of the Designated Reproductive Donor schema specified by the 2017 CAN/CSA Standard and

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<sup>84</sup> *Processing and Distribution of Semen for Assisted Conception Regulations*, *supra* note 9; Health Canada *Directive*, *supra* note 83. See: Health Canada, *Guidance on the Processing and Distribution of Semen for Assisted Conception Regulations (Guide-0041)*, Ottawa: Health Canada, 2004.

<sup>85</sup> SOR/96-254 is controversial especially for male donors who have sex with males and for designated donors. See Marvel, *supra* note 5; See also Health Canada *What We Heard*, *supra* note 13 regarding comments received in the 2016–2017 consultation. The 2018 proposed Safety of Sperm and Ova Regulations and accompanying Directive contain restrictions on sperm donation by men who have sex with men and by women who have sex with men who have sex with men. See the following commentary: Rob Salerno “New Draft of Assisted Human Reproduction Act Continues Anti-Gay Discrimination”, *Daily Xtra*. (8 November 2018), <[www.dailyxtra.com/new-draft-of-assisted-human-reproduction-act-continues-anti-gay-discrimination-12799](http://www.dailyxtra.com/new-draft-of-assisted-human-reproduction-act-continues-anti-gay-discrimination-12799)>.

<sup>86</sup> 2018 Proposed Regulations, *supra* note 69. The accompanying Directives are found online: <[www.canada.ca/en/health-canada/programs/consultation-assisted-human-reproduction-regulations/technical-directive.html](http://www.canada.ca/en/health-canada/programs/consultation-assisted-human-reproduction-regulations/technical-directive.html)> [Proposed Directives].

outlined by the 2018 proposed Safety of Sperm and Ova Regulations. It should be noted that “designated sperm and ova donors” are not a donor type identified in the *AHRA* though this type of donation has been a contested feature of the assisted human reproduction landscape since the 1996 *Semen Regulations* were enacted.<sup>87</sup>

If we look at the 2017 CAN/CSA Standard specific criteria for donor suitability and the required elements for donor selection and the screening and testing regime to be applied to anonymous and designated reproductive donors are specified.<sup>88</sup> Compared to the 1996 *Semen Regulation* and related *Directive*, the restrictions imposed on “Designated Reproductive Donors” have been relaxed and the scope for designating a known donor has been widened. A Directed Reproductive Donor is defined in the 2017 CAN/CSA Standard as:

a person who is the source of reproductive cells or tissues [including semen, ova or embryos (to which the donor contributed the spermatozoa and ovum) to a specific recipient, and who knows and is known by the recipient before donation.

Notes:

- 1) This term does not include a sexually intimate partner. See Donor.
- 2) The terms “designated donor” and “known donor” are also used when

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<sup>87</sup> Marvel, *supra* note 5.

<sup>88</sup> 2017 *Can/CSA*, *supra* note 10.

referring to a “directed reproductive donor”.<sup>89</sup>

The 2018 proposed Safety of Sperm and Ova Regulations at section 32 to section 43 like the 2017 CAN/CSA Standard adopt a relaxation of the requirements for the screening and testing of the designated sperm and ova donor defined at section 32 as: (a) the “donor and the recipient know each other; and (b) the health professional requests the sperm or ova from a primary establishment in the context of a directed donation.”<sup>90</sup> No length of time for knowing a donor or the basis on which a donor is known has been specified which might have been a precautionary additional measure to have included given that social media is increasingly used by those seeking traditional surrogates and gamete donors.<sup>91</sup>

Also, the 2018 proposed Safety of Sperm and Ova Regulations unlike the 2017 CAN/CSA Standard do not contain a provision recommending counselling of surrogates who elect to receive directed human reproductive material (sperm and ova). Counselling or mandatory requirement to provide health and safety information about the possible risks associated with waiving the post-quarantine tests for infectious diseases

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<sup>89</sup> *Ibid.*

<sup>90</sup> 2018 Proposed Regulations, *supra* note 69, s 32.

<sup>91</sup> See research using online surrogacy contacts: Zsuzsa Berend, “The Romance of Surrogacy” (2012) 27:4 Sociological Forum 913 at 913–14 [Berend, “Romance of Surrogacy”]; Zsuzsa Berend, “‘We Are All Carrying Someone Else’s Child!’: Relatedness and Relationships in Third-Party Reproduction” (2016) 118:1 American Anthropologist 24 [Berend, “Relatedness”].

would have been a prudent health and safety measure to have included.<sup>92</sup> It could have been justified on the basis that recent US research findings indicate that only 75% of gestational surrogates receive counselling.<sup>93</sup> The proportion of Canadian gestational and traditional surrogates who receive counselling is not known.

Even so, it may be difficult given the ambit of the *AHRA* to mandate fertility clinics to offer counselling to donors given that such an activity could be viewed as falling within the scope of the provision of health care treatment which is a provincial constitutional responsibility. Apart from Quebec, provincial governments have not sought to regulate fertility treatment.<sup>94</sup> In Ontario, the 2016 Ontario *All Families are Equal Act* requires that surrogates and intended parents have a legal arrangement in place but access to counselling is not explicitly required.<sup>95</sup> In this area of fertility treatment, Canada's approach has been to leave such matters to the unelected

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<sup>92</sup> 2017 *Can/CSA*, *supra* note 10, s 17.3.1.

<sup>93</sup> Erika L Fuchs & Abbey B Berenson, "Screening of Gestational Carriers in the United States" (2016) 106:6 *Fertility & Sterility* 1496.

<sup>94</sup> *An Act respecting clinical and research activities related to assisted procreation*, CQLR 2009, c A-5.01; *An Act to enact the Act to promote access to family medicine and specialized medicine services and to amend various legislative provisions relating to assisted procreation*, Assemble Nationale Du Quebec 2015, c 25. See amendments at s 10 regarding delivery of services and drawing up of ethical and safety guidelines by the Collège des médecins du Québec.

<sup>95</sup> In Ontario, for example, *All Families Are Equal Act*, *supra* note 68. An Act to amend the Children's Law Reform Act, the Vital Statistics Act and various other Acts respecting parentage and related registration, see ss 2(2) and 7 where legal advice is required. Counselling is not noted.

professional organisations such as the CFAS to recommend and implement.

### **Ova donors**

The 2012 amendments of the *AHRA* at section 10(2)(b) specify that all human ovum used for human reproduction not used by the “donor” or by the “donor’s spouse, common-law or sexual partner” must be screened and tested. The 2012 *AHRA* amendment mandating screening and testing of ova used in third-party reproduction corrects a long-standing legislative omission identified in 2005 by Rivard and Hunter who recommended that the government take steps to regulate health and safety measures for human ova used in third-party reproduction.<sup>96</sup> It is a regulatory modification that the federal agency, Assisted Human Reproduction Canada, could have brought into force prior to its suspension in 2012 had it used its mandate to protect the health and safety of Canadians. Unfortunately, it did not.<sup>97</sup> At the time of the 2012 legislative amendment to the *AHRA*, Canadian clinicians welcomed this long overdue legislative change requiring testing and screening of ova used by third-parties.<sup>98</sup>

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<sup>96</sup> Rivard & Hunter, *supra* note 64 at 39–40, 56.

<sup>97</sup> Baylis & Downie, “A Tale of Assisted Human Reproduction”, *supra* note 34.

<sup>98</sup> Crowe, *supra* note 4. It has taken over four years to commence consultation on regulatory framework to regulate sperm and ova screening and testing.

The practice of fertility medicine has evidenced an increasing use of third-party donated ova.<sup>99</sup> The change in practice has coincided with dramatic improvements in the techniques used to cryopreserve ova which is no longer considered to be an unproven or experimental technique. Research findings have failed to demonstrate superior pregnancy outcomes using fresh oocytes (ova) compared with pregnancy outcomes using vitrified egg-banked oocytes.<sup>100</sup> The Regulatory Impact Analysis Statement accompanying the 2018 proposed Safety of Sperm and Ova Regulations also documents changes in fertility clinic practices. It observes a reliance on imported donated ova while at the same time commenting that it is not aware of any transmission of disease caused by donor ova. Even so, there exists a need to establish Canadian ova screening and testing protocols.<sup>101</sup>

The 2017 CAN/CSA Standard provides operational guidance for the screening and testing of third-party ova donors, both anonymous and directed.<sup>102</sup> It establishes the

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<sup>99</sup> Pamela M White, “Hidden from View: Canadian Gestational Surrogacy Practices and Outcomes, 2001-2012” (2016) 24:47 *Reprod Health Matters* 205 [White, “Hidden from View”].

<sup>100</sup> Sara Crawford et al, “Cryopreserved Oocyte versus Fresh Oocyte Assisted Reproductive Technology Cycles” (2017) 107:1 *Fertility & Sterility* 110; Ana Cobo et al, “Use of Cryo-banked Oocytes in an Ovum Donation Program: A Prospective, Randomised, Controlled Clinical Trial” (2010) 65:12 *Annals of Obstetrical and Gynaecological Survey* 775.

<sup>101</sup> 2018 Proposed Regulations, *supra* note 69. See the preface to the Regulations: Regulatory Impact Analysis Statement at 3.

<sup>102</sup> 2017 *Can/CSA*, *supra* note 10, ss 13.2.2–13.3. Genetic history and testing is specified at s 13.7. See Proposed Directives, *supra* note 86, s 2.1.2 Genetic disease screening.



screening criteria for donation which includes the recording of the donor's family genetic history and medical testing for diseases, and establishes the criteria for donor suitability evaluations.<sup>103</sup> A similar set of requirements is found in the 2018 proposed Directives for Safety of Sperm and Ova regarding requirements for documenting family and medical history of the ova donor, a category that the 2018 proposed Safety of Sperm and Ova Regulations tells us includes surrogates.<sup>104</sup>

Subsection 10(2)(a) of the 2012 *AHRA* indicates that ova from a woman who uses her own reproductive material (ova) is exempt from mandated screening and testing. The 2012 amendment at subsection 10(2)(b) states that the use of a partner's ovum by a woman in same-sex married, common-law and sexual relationships carry a similar exemption from screening and testing.<sup>105</sup> This type of ova sharing (co-mothering) among lesbian partners is not unknown nor uncommon, though no Canadian data

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<sup>103</sup> The screening and testing parameters noted here also apply to sperm donors.

<sup>104</sup> 2018 proposed Safety of Sperm and Ova Regulations *supra* note 69 at ss 22–31 for Donor Suitability and at ss 32–43 for Designated Donors. The Proposed Directives, *supra* note 86, do not specify the requirements for Designated Donors. Health Canada, *supra* note 14, did note that some of the consultation submissions identified concerns with criteria for testing and screening developed by the 2017 *Can/CSA*. The Proposed Directives at s 2.1.2 set out the criteria required for the medical history and genetic background of the donor.

<sup>105</sup> *AHRA*, *supra* note 8.

exists as to its prevalence.<sup>106</sup> Yet, one needs to ask why Canadian legislators felt it necessary to specify that this type of reproductive tissue exchange was permitted by law and that the reason for its non-prohibition is one of health and safety. The *AHRA* at section 3 states that discrimination in assisted reproduction is prohibited. If heterosexual partners are permitted to exchange sperm and use their own ova, it is unclear why the same logic did not automatically apply to the exchange of ova between lesbian spouses, common-law, and sexual partners when the *AHRA* was amended in 2012.

Internationally, restrictions placed on lesbian exchange of ova have coincided with access to assisted reproduction being based on sexual orientation and marital status. There has also been an ethical discourse suggesting that the medical surgery needed to remove ova from one partner to give to another when both are fertile constitutes unnecessary medical treatment and, as such, could be considered maleficent.<sup>107</sup> Currently, the legality of the practice varies considerably across Europe depending on legal recognition of same-sex marriage, cohabitation and

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<sup>106</sup> Daniel Bodri et al, “Shared Motherhood IVF: High Delivery Rates in a Large Study of Treatments for Lesbian Couples Using Partner Donated Eggs” (2017) 36:2 *Reprod Biomed Online* 130; Ethics Committee of American Society for Reproductive Medicine, “Access to Fertility Treatment by Gays, Lesbians, and Unmarried Persons: A Committee Opinion” (2013) 100:6 *Fertility & Sterility* 1524.

<sup>107</sup> G De Wert et al, “ESHRE Task Force on Ethics and Law 23: Medically Assisted Reproduction in Singles, Lesbian and Gay Couples, and Transsexual People” (2014) 29:9 *Hum Reprod* 1859; WJ Dondorp, G De Wert & PMW Janssens, “Shared Lesbian Motherhood: A Challenge of Established Concepts and Frameworks” (2010) 25:4 *Hum Reprod* 812.

sexual partnerships. Countries like Belgium, Finland, Ireland, Netherlands, UK, Portugal and Spain permit it, while others such France or Germany prohibit or actively discourage it.<sup>108</sup> In the UK when the *Human Fertilisation and Embryology Act* was amended in 2008 to remove the need for a father and lesbian partners were recognised as legal parents the practice has become more common.<sup>109</sup> In the UK, the motivation driving this type of legislative change was more focussed on ensuring that all parties can exercise informed consent, rather than on the regulation of the health and safety of the practice.<sup>110</sup>

By not imposing prohibitions on the use by a fertility patient of the ova donated by her spouse, common-law or sexual partner, Canada's *AHRA* normalizes same-sex female relationships.<sup>111</sup> It accords the exchange of ova between female spouses, common-law, and sexual partners an equivalency status with autologous ova used by a woman in a heterosexual married, common-law, or sexual relationship. Specification that the sharing of ova between women engaged in a same-sex spousal, common-law or sexual relationship also serves to note that the federal government considers that the practice holds a no greater health risk to the lesbian recipient than would be experienced to exist for any other woman using her own ova or in the case of a heterosexual women from receiving

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<sup>108</sup> Bodri et al, *supra* note 106 at 130 (see: Table 1).

<sup>109</sup> See Sheelagh McGuinness & Amel Alghrani, "Gender and Parenthood: The Case for Realignment" (2008) 16:2 *Med Law Rev* 261 at 278–79.

<sup>110</sup> *Ibid.*

<sup>111</sup> *AHRA*, *supra* note 8, s 10(2)(b).

a transfer of sperm obtained from her male spouse, common-law, or sexual partner.

However, the reason for allowing equal treatment for the use of shared gametes among spouses, common-law, and sexual partners regardless of sexual orientation appears to be reliant on a health and safety rationale rather than legal marital equivalency and the right to equal treatment.<sup>112</sup> As was ruled by the SCC in *Andrews v. Law Society of British Columbia* (1989), “discrimination may be described as any distinction, conduct or action, whether intentional or not, but based on a person’s sexual orientation, that has the effect of either imposing burdens on an individual or group that are not imposed upon others, or withholding or limiting access to opportunity, benefits and advantages available to other members of society.”<sup>113</sup> The amendment could have referenced the principle of non-discrimination that underlies Canada’s *AHRA* which holds that “persons who seek to undergo assisted reproduction procedures must not be discriminated against, including on the basis on their sexual orientation or marital status.”<sup>114</sup> However, there is no mention of this principle in the rationale provided at section 10(1) of the 2012 *AHRA*.

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<sup>112</sup> *AHRA*, *supra* note 8, s 10(1); *Re Same-Sex Marriage*, 2004 SCC 79, [2004] 3 SCR 698; *Civil Marriage Act*, SC 2005, c 33; *Andrews v Law Society of British Columbia*, [1989] 1 SCR 143, 56 DLR (4th) 1; *Law v Canada (Minister of Employment and Immigration)*, [1999] 1 SCR 497, 170 DLR (4th) 1; *Egan v Canada*, [1995] 2 SCR 513, 124 DLR (4th) 609.

<sup>113</sup> *Andrews v Law Society of British Columbia*, *supra* note 112 at 174.

<sup>114</sup> *AHRA*, *supra* note 8, s 2(e).

It is unfortunate that the government did not use the 2012 legislative opportunity to indicate that co-motherhood assisted reproduction has been permitted since the inception of the *AHRA*, notwithstanding any stated ethical concerns advanced by those arguing that intra-couple egg sharing for nonmedical reasons could be considered to be ethically non-justifiable, risky, and not cost-effective.<sup>115</sup> Such argumentation is weak and profoundly dismissive of the reproductive autonomy of lesbians.<sup>116</sup> Moreover, little empirical research exists to support claims that the practice is any more risky compared to the harm endured by other patients undertaking ovarian stimulation related to third-party ova donation or for their own reproductive use.<sup>117</sup> This is an example of where the federal government has embedded a health and safety justification for permitting co-mothering and the exchange of ova between queer spouses and common-law and sexual partners rather than adopting an equality-based rationale as enabled by section 3 of the *AHRA*.

### **Traditional surrogates**

The amendment at subsection 10(2)(c) created another group of regulated autologous ova donors and users: traditional surrogates. So, to situate the discussion in the context of Canadian surrogacy law and policy, the legality of surrogacy will be briefly reviewed.

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<sup>115</sup> Bodri et al, *supra* note 106 at 131; S Marina et al, “Sharing Motherhood: Biological Lesbian Co-mothers, a New IVF Indication” (2010) 25:4 Hum Reprod 938.

<sup>116</sup> De Wert et al, *supra* note 107; Dondorp, De Wert & Janssens, *supra* note 107.

<sup>117</sup> Bodri et al, *supra* note 106.

**SURROGACY: “MORAL EVIL”**

The *AHRA* establishes that surrogacy is legal in Canada as long as the surrogate does not receive consideration (payment) though reimbursement of acceptable expenses is permitted.<sup>118</sup> Traditional surrogacy, where the surrogate is genetically related to the child she bears for intended parent(s), and gestational surrogacy, where the surrogate is not genetically related to her offspring, are permitted.<sup>119</sup>

The practice of a woman conceiving and carrying a child for an individual or couple who for medical or social reasons are unable to have their own children has been characterised as morally troubling as it disrupts the normative view of motherhood.<sup>120</sup> The practice of surrogacy and its potential for exploitation has been a controversial topic for Canadians.<sup>121</sup> Concerns about commercialisation of human reproduction, the practice of

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<sup>118</sup> *AHRA*, *supra* note 8, s 12. See also the 2018 Proposed Regulations, *supra* note 16.

<sup>119</sup> *AHRA*, *supra* note 8, s 6.

<sup>120</sup> Samantha Ashenden, “Reproblematising Relations of Agency and Coercion: Surrogacy” in S Madhock, A Phillips & K Wilson, eds, *Gender, Agency and Coercion* (London: Palgrave Macmillan, 2013) at 195–218; Elly Teman, *Birthing a Mother*, (California: University of California Press, 2010).

<sup>121</sup> Nelson, *supra* note 3 at 326–8; Anne Phillips, *Our Bodies, Whose Property?*, (Princeton: Princeton University Press, 2013) at 65–96. Much disagreement exists concerning the moral evil of paid surrogacy. See also Karen Busby & Delaney Vun, “Revisiting ‘The Handmaid’s Tale’: Feminist Theory Meets Empirical Research on Surrogate Mothers” (2010) 26:1 *Can J Fam L* 13; Julie Shapiro, “For a Feminist Considering Surrogacy: Is Compensation Really the Key Question?” (2014) 89 *Wash L Rev* 1345.

traditional surrogacy, and the “moral panic” raised by the 1984 Baby M incident cast a long shadow over the deliberations of assisted reproduction undertaken by the 1983 Baird Commission, parliamentary committees, and parliamentarians.<sup>122</sup> The banning of commercial surrogacy by the *AHRA* conformed to the national narrative privileging the unpaid donation of blood, organs, and tissues, and reflected a desire on the part of regulators to avoid an American approach to the practice of fertility medicine.<sup>123</sup>

However, considerable social change has taken place in Canada since the Baird Commission held public consultations on the topic of assisted reproduction, including surrogacy. Twenty-first century Canada has witnessed the legalisation of same-sex marriage. IVF surrogacy costs for cis gay couples were covered by

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<sup>122</sup> *In the Matter of Baby M*, 217 NJ Super 313 (Ch Div 1987) rev'd 109 MJ 396 (1988); David Snow, “Criminalizing Commercial Surrogacy in Canada and Australia: The Political Construction of ‘National Consensus’” (2016) 51:1 *Austl J Poli Sci* 1 at 4; Baird Commission, *supra* note 33; House of Commons, *supra* note 33 at 12; Busby & Vun, *supra* note 121; Nelson, *supra* note 3. In *Baby M*, a paid traditional surrogate Mary Beth Whitehead bonded with the child she agreed to carry for Mr and Mrs Stern and contested the agreement to hand over the child to the Sterns. The nature of the commercial surrogacy transaction and ensuing court decisions created considerable tension among ethicists, feminists, and lawyers. A good overview is found at: Rayven Monique, “Baby M: Traditional Surrogacy Gone Wrong—What Really Happened with Mary Beth Whitehead”, online: <<http://information-on-surrogacy.com/baby-m>>.

<sup>123</sup> Snow, *supra* note 122 at 4.

Quebec's IVF funded program.<sup>124</sup> Since 2016, Ontario has paid IVF and IUI costs incurred by gestational and traditional surrogates.<sup>125</sup> Gradually provincial governments have been updating family law statutes to reflect parentage made possible by assisted conception, including traditional and gestational surrogacy.<sup>126</sup>

It is not surprising that there now exists growing evidence that for an increasing number of childless Canadian couples and individuals, surrogacy may be the only way to have biological children.<sup>127</sup> For example, a 2012 survey revealed that one-quarter of Canadian childless adult women and 40 percent of childless adult men would consider using a surrogate should they or their partner be unable to carry and give birth to their biological

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<sup>124</sup> *Civil Marriage Act*, *supra* note 112; “Quebec to Reimburse Gay Men for Surrogacy Costs, Celebrity Radio Host Joël Legendre and Husband First to Receive Coverage in Quebec”, *CBC News* (24 April 2014), online: <[www.cbc.ca/news/canada/montreal/quebec-to-reimburse-gay-men-for-surrogacy-costs-1.2620309](http://www.cbc.ca/news/canada/montreal/quebec-to-reimburse-gay-men-for-surrogacy-costs-1.2620309)>.

<sup>125</sup> In Ontario, surrogates are eligible for IVF and AI under the Ontario Fertility Treatment program. FOI Request A-2017-00-00166 made by Pamela White to Ontario Ministry of Health and Long-Term Care, 1 September 2017. Repeat request made one year later (September 3, 2018) affirmed the situation.

<sup>126</sup> BC *FLA*, *supra* note 68; *Family Law Act*, SA 2003, F-4.5; *All Families Are Equal Act (Parentage and Related Registrations Statute Law Amendment)*, SO 2016, c 23; Manitoba Law Reform Commission, “Assisted Reproduction: Legal Parentage and Birth Registration” (April 2014), Issue Paper, online: <[www.manitobalawreform.ca/pubs/pdf/additional/assisted\\_reproduction-legal\\_parentage\\_and\\_birth\\_registration.pdf](http://www.manitobalawreform.ca/pubs/pdf/additional/assisted_reproduction-legal_parentage_and_birth_registration.pdf)>.

<sup>127</sup> White, “Hidden from View”, *supra* note 99.



child.<sup>128</sup> It is not uncommon to read news articles detailing surrogacy experiences told from various perspectives.<sup>129</sup> Research with North American surrogates has shown that this demographic consists primarily of middle-class, college educated, heterosexual married women who have had non-problematic pregnancies and who undertake the practice for altruistic reasons regardless of the commercial/non-commercial regime in which they operate.<sup>130</sup>

Given this emerging acceptance of and growing practice of gestational and traditional surrogacy,<sup>131</sup> it is

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<sup>128</sup> Judith C Daniluk & Emily Koert, “Childless Canadian Men’s and Women’s Childbearing Intentions, Attitudes towards and Willingness to Use Assisted Human Reproduction” (2012) 27:8 Hum Reprod 2405.

<sup>129</sup> See e.g. Robert Cribb & Emma Jarratt “Made in Canada: A Surrogate’s Supporting Cast”, *Toronto Star* (28 September 2016), online: <[www.thestar.com/news/world/2016/08/28/made-in-canada-a-surrogates-supporting-cast.html](http://www.thestar.com/news/world/2016/08/28/made-in-canada-a-surrogates-supporting-cast.html)>; A Lau “My Co-worker Gave Birth to My Baby”, *Chatelaine Magazine* (18 April 2014), online: <[www.chatelaine.com/health/coworker-gave-birth-to-my-baby/](http://www.chatelaine.com/health/coworker-gave-birth-to-my-baby/)>; Karine Ewart, Claire Tansey & Tracy Moore “Candid Chat about Surrogacy” *Chatelaine Magazine* (18 March 2014), online: <[www.chatelaine.com/living/cityline/can-you-pay-a-surrogate-in-canada/](http://www.chatelaine.com/living/cityline/can-you-pay-a-surrogate-in-canada/)>.

<sup>130</sup> Busby & Vun, *supra* note 120; Heather Jacobson, *Labor of Love*, (New Brunswick, NJ: Rutgers University Press, 2016); Berend, “Romance of Surrogacy”, *supra* note 91; Berend, “Relatedness”, *supra* note 91; Marcin Smietana, “Affective De-Commodifying, Economic De-Kinning: Surrogates’ and Gay Fathers’ Narratives in U.S. Surrogacy” (2017) 22 Sociological Research Online 5.

<sup>131</sup> “As Demand for Surrogacy Soars, More Countries are Trying to Ban It”, *The Economist* (13 May 2017), online: <[www.economist.com/news/international/21721926-many-feminists-and-religious-leaders-regard-it-exploitation-demand-surrogacy](http://www.economist.com/news/international/21721926-many-feminists-and-religious-leaders-regard-it-exploitation-demand-surrogacy)>.

difficult to support the view that a “moral evil” rationale could be the justification for imposing a prohibition on the use of unscreened and untested obtained own-use ova used by an altruistic traditional surrogate in her own pregnancy. Thus, the reason must be as stated in the preamble to the amendment: it is to combat “health evil”. The question that needs to be answered is: to whom does the harm occur?

**IDENTIFYING THE HEALTH EVIL EMBODIED  
IN THE “OBTAINED” OVUM “DONATED” BY A  
WOMAN AND USED IN HER SURROGATE  
PREGNANCY**

The 2012 *AHRA*, as amended at section 10, applies criminal law sanctions to address the “health and safety evils” posed by a woman’s own “obtained” ovum being used in her surrogate pregnancy. The paper will attempt to determine what could be the health and safety risks posed by “obtained” traditional surrogate ova. It seeks to ascertain whether use of unscreened and untested obtained traditional surrogate ova warrants criminalisation.

**HEALTH AND SAFETY RISKS TO THE  
TRADITIONAL SURROGATE**

Does the use of one’s own untested and unscreened ova jeopardize the health and safety of traditional surrogate patient? As the traditional surrogate is the recipient of her own human reproductive material it seems illogical to suggest that a woman using her own ova in her own surrogate pregnancy faces a greater health risk than do other women who use their own ova or the ova of their spouse or common-law or sexual partner. For a traditional

surrogate, one could well argue that the greater health risk arises from the sperm used to fertilise her ova.

If the concern is that of transmission of a disease to the child conceived as a result of assisted reproduction, medical testing of the surrogate mother such as recommended by the CFAS in the 2016 Guidelines for Third-party Reproduction would detect the presence of HIV, Hepatitis C or other communicable disease.<sup>132</sup> It should be noted however that it is recommended medical practice for all IVF mothers, and not just traditional and gestational surrogates, to be tested.<sup>133</sup>

Yet, one could successfully argue that it is the act of “obtaining” the ova that poses a health risk, though in this case it occurs to the woman herself. Ovarian hyper-stimulation syndrome (OHSS) is a serious fertility treatment complication, one which could result in the death of the patient.<sup>134</sup> While OHSS is thought to affect approximately 1.8% of all IVF cycles,<sup>135</sup> it nonetheless represents one the most important negative health outcomes associated with modern IVF practice.<sup>136</sup> It should be noted that little to no study of Canadian fertility patients’

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<sup>132</sup> CFAS Guidelines, *supra* note 68 at 24.

<sup>133</sup> 2017 *Can/CSA*, *supra* note 10.

<sup>134</sup> MS Kupka et al, “Assisted Reproductive Technology in Europe, 2010: Results Generated from European Registers by ESHRE” (2014) 29:10 *Hum Reprod* 2099.

<sup>135</sup> Theoni B Tarlatzi et al, “What Is the Best Predictor of Severe Ovarian Hyper-Stimulation Syndrome in IVF? A Cohort Study” (2017) 34:10 *J Assist Reprod Gen* 1341 at 1344–45

<sup>136</sup> *Ibid.*

experience of OHSS has been conducted and the annual release of limited information from the IVF Directors' assisted human reproduction registry (CARTR Plus) provides minimal insight on the occurrence of this etiology in Canadian fertility clinics.<sup>137</sup> It needs to be noted, however, that Health Canada has limited ability to legislate in this area as fertility treatment is the practice of medicine which is a provincial constitutional responsibility.

Given the above analysis, the health and safety risk to traditional surrogates of using their own ova cannot be the reason for mandatory screening and testing of obtained ova and the imposition of criminal code sanctions applied in the event that the specified screening and testing fails to occur. The harm test established by the SCC in *Ref re AHRA* cannot be said to have been fulfilled with respect to the existence of a health and safety harm occurring to the recipient of the traditional surrogate's obtained ova. It is the surrogate herself who is exposed to the "obtained" ova and in this regard her risk is no more or less-greater than another other IVF recipient of her own ova or the ova or her spouse, common-law or sexual partner.

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<sup>137</sup> Between 2001 and 2012, CFAS published a more detailed report on OHSS. This ended with the transfer of the Canadian Assisted Reproductive Technology Registry (CARTR) to Better Outcomes Registry for Newborns (BORN). See CFAS website for annual media announcement on IVF success rates, online: <[www.cfas.ca](http://www.cfas.ca)>. Considerable research is being conducted elsewhere. See e.g. Ruth Howie & Vanessa Kay, "Controlled Ovarian Stimulation for In-Vitro Fertilization" (2018) 79:4 B JH M 194; Cindy Farquhar et al, "Management of Ovarian Stimulation for IVF: Narrative Review of Evidence Provided for World Health Organization Guidance" (2017) 35:1 *Reprod Biomed Online* 3.

### **HEALTH AND SAFETY RISKS TO CLINIC STAFF AND PATIENTS**

Most human sperm, ova, and embryos used and stored in IVF clinics are “autologous use” having been obtained from the fertility patient and their spouse, common-law, or sexual partner. These obtained sperm, ova and embryos are intended to be used in the fertility treatments of these individuals.<sup>138</sup> Autologous use gametes and embryos are not subject to mandatory screening and testing, though fertility patients, spouses, and partners must undergo a series of related medical tests, including ones capable of detecting the existence of sexually transmitted diseases.<sup>139</sup> The parties may also decide to undertake pre-natal genetic testing or subject their own human reproductive material to genetic screening and testing to prevent the transmission of genetic diseases to their offspring. Such decisions are made by the parents of the child conceived as a result of assisted reproduction.

As it concerns the risk of the transmission of communicable diseases, Canadian fertility clinics have been encouraged to follow human reproductive material

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<sup>138</sup> Data from the Canadian Assisted Human Reproduction Technology Registry CARTR-Plus show that 95% of IVF patients use their own gametes though over 50% of gestational surrogates receive embryos containing ova from a donor other than the intended mother. See White, “Hidden from View”, *supra* note 99.

<sup>139</sup> See for example literature on transmission of viral diseases: AM Abou-Setta, “Transmission Risk of Hepatitis C Virus via Semen During Assisted Reproduction: How Real Is It?” (2004) 19:12 Hum Reprod 2711; A Garolla et al, “Sperm Viral Infection and Male Infertility: Focus on HBV, HCV, HIV, HPV, HSV, HCMV, and AAV” (2013) 100:1 J Reprod Immunol 20.

and embryo labelling and to adopt handling and storage protocols designed to prevent cross-contamination and misidentification.<sup>140</sup> It appears that Canadian IVF clinics have voluntarily embraced the procedures and protocols developed by the Standards Council of Canada to prevent contamination and mislabelling, though to date no monitoring information informs Canadian consumers about compliance.<sup>141</sup> The 2017 CAN/CSA Standard recommends that fertility clinics ensure that Standard Operating Procedures are in place to address health and safety requirements regarding sperm, ova and embryo preparation and preservation, and packaging, storage, and the cleaning and maintenance of cryopreservation tank containers.<sup>142</sup> The 2018 proposed Safety of Sperm and Ova Regulations specify the standard operational procedures that are to be followed as well as requiring that the documentation and reporting of adverse reactions.<sup>143</sup>

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<sup>140</sup> 2017 *Can/CSA*, *supra* note 10. The 2018 Proposed Regulations, *supra* note 69 require that establishment identify (ss 44–45), label (ss 46–47), undertake quality management (ss 48–51), internal audit (s 52), establish standard operating procedures (ss 53–60), address error reporting (ss 61–68) and adverse reactions (ss 69–73), and support reports and record keeping (ss 74–77). It is not the place of this paper to examine the adequacy of the proposed procedures intended to manage the safety of sperm and ova used in human reproduction.

<sup>141</sup> Perhaps the best indicator is Accreditation Canada clinic evaluations conducted at the request of the IVF clinic, a practice encouraged by the Canadian Fertility and Andrology Society. See Accreditation Canada, *Assisted Reproduction Standards for Clinical Services*, online: <[store.accreditation.ca/collections/assisted-reproductive-technology-art](http://store.accreditation.ca/collections/assisted-reproductive-technology-art)>.

<sup>142</sup> 2017 *Can/CSA*, *supra* note 10, s 15. See also ss 15. 4, 15.6.

<sup>143</sup> 2018 Proposed Regulations, *supra* note 69, ss 67–69.

In light of the above information, it is difficult to sustain the argument that unscreened and untested ova obtained from a traditional surrogate represent a greater risk to IVF clinic staff and other patients than autologous ova and embryos stored, cryopreserved and handled by the clinic. Thus, the expectation that ova obtained from a traditional surrogate poses significant health risks to the routine operation of IVF clinics or to other patients cannot be the rationale for the imposition of mandatory testing and screening.

### **HEALTH AND SAFETY RISKS TO CHILDREN BORN TO TRADITIONAL SURROGATES**

The preamble to the *AHRA* includes a section setting out ethical principles guiding the practice of assisted reproduction in Canada. The importance of beneficence and non-maleficence in the practice of fertility techniques underscores subsection 2(a) of the *Act* which states that “the health and well-being of children born through the application of assisted human reproductive technologies must be given priority in all decisions respecting their use.”<sup>144</sup> The Regulatory Impact Analysis Statement accompanying the 2018 proposed Safety of Sperm and Ova Regulations notes that transmission of a communicable diseases and the risk of transmitting a serious genetic maladies to a child conceived using donor ova compels Health Canada to mitigate potential risks to human health and safety that could result from the use of donor ova.”<sup>145</sup>

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<sup>144</sup> *AHRA*, *supra* note 8, s 2(a).

<sup>145</sup> 2018 Proposed Regulations, *supra* note 69 at 3.

As already noted, traditional and gestational surrogates who receive treatment at Canadian fertility clinics are tested to establish their communicable disease status and to assess their ability to successfully conceive and bear children. The voluntary *Third-Party Reproduction Guidelines* developed by Canadian Fertility and Andrology Society apply regardless of the fertility treatment a surrogate may receive—ovarian stimulation, IVF embryo transfer, and artificial insemination.<sup>146</sup>

Regulating the screening and testing of a traditional surrogate for communicable health conditions and documentation of medical, genetic, and family history would provide additional health and safety assurances to commissioning parents that the surrogate-related child would not be prone to serious health or genetic conditions inherited from the traditional surrogate. The acquisition of obtained ova also enables preimplantation genetic diagnosis (PGD) and karyotyping, processes that permit detection of genetic defects and anomalies including trisomy and determination of risks for serious genetic disease.<sup>147</sup> These genetic screening tests are not mandated by the 2018 proposed Safety of Sperm and Ova Regulations or specified in the proposed Directive even though they would provide greater assurance of genetic

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<sup>146</sup> CFAS Guidelines, *supra* note 73 at 24.

<sup>147</sup> Trisomy 21 is commonly referred to as Down's Syndrome. It is but one of the more frequently occurring variants of trisomy (e.g. 18 and 13). Regarding screening options see Melissa Hill et al, "Has Non-Invasive Prenatal Testing Impacted Termination of Pregnancy and Birth Rates of Infants with Down Syndrome?" (2017) 37:13 *Prenat Diagnosis* 1281.



disease detection which is after all the *raison d'être* for the proposed mandatory testing and screening.

If testing and screening documentation obtained as result of screening and testing described by the 2018 proposed Safety of Sperm and Ova Regulations and set out in the proposed Directive was made available to surrogate-born children, they would have potentially crucial information about their genetic parentage and medical history. It should be noted that *AHRA* does not mandate that medical, personal and family history information be obtained from a gestational surrogate nor when traditional surrogacy is undertaken using assisted insemination, which is the more common practice compared with IVF.<sup>148</sup> Thus, there is a strong likelihood that an uneven collection of personal information is likely to occur as more personal health data and medical history information will be acquired in the isolated and rare instances where ova of a traditional surrogate are obtained.

Without a donor registry, there exists no formal means for a donor-conceived child or a traditional surrogate conceived child to learn about their biological parents. Without parental disclosure, no mechanism exists enabling them to know that they were a surrogate-born child or that sperm or ova have been provided by persons other than their social (intended) parents. Such information could be important, especially as our understanding of the implications of epi-genetic phenomena increases and in

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<sup>148</sup> As already noted, the 2018 Proposed Regulations, *supra* note 69, are not clear as to whether all traditional surrogates are to be screened and tested as third-party donors.

cases where inherited biological traits may have long-term medical and intergenerational health consequences.

Canada's federal donor registry, as envisaged by the *AHRA*, was ruled ultra vires by the Supreme Court decision in *Ref re AHRA*.<sup>149</sup> Provincial gamete and embryo donor registries do not exist. Submissions made to Health Canada as part of the consultation on regulatory change identified a need for them.<sup>150</sup> The 10 year record keeping requirement specified in the 2018 proposed Safety of Sperm and Ova Regulations will not fill this information gap.<sup>151</sup> Given that no Canadian donor registry exists, there is no organised and managed system that will enable the offspring of traditional surrogates to access the information obtained as a result of a screening and testing regime.<sup>152</sup> As the decision in *Pratten v. British Columbia* demonstrates, knowing one's genetic history is not a constitutional right.<sup>153</sup>

Information indicating that one has been conceived using donor sperm and/or ova is not recorded on birth

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<sup>149</sup> *Ref Re AHRA*, *supra* note 27 ruled *AHRA* s 19 ultra vires.

<sup>150</sup> Health Canada, *What We Heard*, *supra* note 13 at 3.

<sup>151</sup> See 2018 Proposed Regulations, *supra* note 69, s 77(1) "Records".

<sup>152</sup> This also applies to the off-spring of gestational surrogates. See 2017 *CAN/CSA*, *supra* note 10 at Table 2.

<sup>153</sup> *Pratten v British Columbia*, 2012 BCCA 480, 357 DLR (4th) 660; Vanessa Gruben & Daphne Gilbert, "Donor Unknown: Assessing the Section 15 Right of the Donor-Conceived Offspring" (2011) 27:2 Can J Fam L 247; Vanessa Gruben, "A Number but No Name: Is there a Constitutional Right to Know One's Sperm Donor in Canadian Law" in Trudo Lemmens, Andrew Flavell Martin, & Cheryl Milne, eds, *supra* note 50 at 145.

registration forms, though it could be if Canadian provinces were to follow the example set by the states of Massachusetts, Florida, Michigan, and Connecticut.<sup>154</sup> However, to do so would involve legislative change. The BC *Vital Statistics Act*, for example, prevents assisted human conception information from being recorded on birth registration.<sup>155</sup> In other provinces, vital statistics legislation is silent on the matter, though the activities of the Uniform Law Conference of Canada provide Canadian provinces the opportunity to consider the option.<sup>156</sup> In the absence of intended parents providing information about donors and surrogates, traditional surrogate-born children, like gestational surrogate-born children and other donor-conceived children, must look elsewhere to locate donor profile information and siblings, including, for example,

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<sup>154</sup> Bruce Cohen et al, “Accuracy of Assisted Reproductive Technology Information on Birth Certificates: Florida and Massachusetts, 2004–06” (2014) 28:3 *Paediat Perinat Epidemiol* 181 at 182.

<sup>155</sup> *Vital Statics Act*, RSBC 1996 c 479, s 14.1: “If a child is born in British Columbia as a result of assisted reproduction, nothing must appear on any certificate issued by the registrar general that would disclose that the child was born as a result of assisted reproduction.”

<sup>156</sup> British Columbia Law Institute, “Uniform Vital Statistics Act (Renewal) Project”, online: <[www.bcli.org/project/uniform-vital-statistics-act-project](http://www.bcli.org/project/uniform-vital-statistics-act-project)>. Uniform Law Conference of Canada is undertaking review of Canada’s Vital Statistics statutes, see the August 2017 meeting report: Uniform Law Conference of Canada, “Uniform Vital Statistics Act 1987 (Renewal) Report of the Working Group” (Kathleen Cunningham & Leslie Turner), online: <[ulcc.ca/images/stories/2017\\_pdf\\_en/2017ulcc0025.pdf](http://ulcc.ca/images/stories/2017_pdf_en/2017ulcc0025.pdf)>.

sperm and ova banks, the IVF clinic that performed the treatments, and the Donor Sibling Registry.<sup>157</sup>

Research shows that surrogates often bond with intended parents<sup>158</sup> and findings from UK studies demonstrate that gestational and traditional surrogates, intended parents, and surrogate-born children can maintain positive and supportive post-birth relationships.<sup>159</sup> In Canada, given the lack of a donor registry, the maintenance of relationships with intended parents between surrogates takes on heightened importance, as this may be the only way for the traditional surrogate-born child to learn about their genetic background. One advantage of the easing of the restrictions imposed on designated donation could be the facilitation of on-going contacts between sperm and ova and surrogates including traditional surrogates.

Yet if non-maleficence is the rationale invoked for application of criminal law powers to the screening and testing of only the traditional surrogates who undergo IVF

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<sup>157</sup> Vasanti Jadva et al, “Experiences of Offspring Searching for and Contacting Their Donor Siblings and Donor” (2010) 20 *Reprod Biomed Online* 523; The Donor Sibling Registry, “Homepage”, online: <[www.donorsiblingregistry.com](http://www.donorsiblingregistry.com)>; Emily Chung, Melanie Glanz & Vik Adhopia “Donor-Conceived People are Tracking Down their Biological Even if they Want to Hide”, *CBC News* (6 January 2018), online: <[www.cbc.ca/news/technology/sperm-donor-dna-testing-1.4500517](http://www.cbc.ca/news/technology/sperm-donor-dna-testing-1.4500517)>.

<sup>158</sup> Berend, “Romance of Surrogacy”, *supra* note 91; Berend, “Relatedness”, *supra* note 91.

<sup>159</sup> Susan Imrie & Vasanti Jadva, “The Long-Term Experiences of Surrogates: Relationships and Contact With Surrogacy Families in Genetic and Gestational Surrogacy Arrangements” (2014) 29:4 *Reprod BioMed Online* 424.

treatment, surely as an underlying *AHRA* ethical principle, it is owed to all offspring of traditional surrogates, regardless of the location of the ova at time of conception.<sup>160</sup> The amended *AHRA* at subsection 10(2)(c) represents, at best, a limited interpretation of compassion for the donor-conceived. As it concerns an application of criminal code powers, surely a more proportionate approach would have been to have left the screening and testing including the collection of surrogate medical and genetic information to the provincial medical bodies to regulate. This way the information could have been obtained from all persons undergoing surrogacy not just those persons who undergo the more medically invasive treatments associated with IVF. There remains the need for a Registry so that children can have access to the information for health, medical and social reasons. The 2018 proposed Safety of Sperm and Ova Regulations do not achieve this larger objective.

### **HEALTH AND SAFETY HARM OF AN “OBTAINED” TRADITIONAL SURROGATE’S OVUM**

On careful examination, it is difficult to determine how ova obtained from a traditional surrogate and used in her own pregnancy represents a health and safety harm to the recipient—the traditional surrogate—so significant as to justify the application of criminal code sanctions on those who would fail to screen and test it prior to its use. The argument for testing to prevent genetic disease to the

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<sup>160</sup> Vincent Couture et al, “Strengths and Pitfalls of Canadian Gamete and Donor Registries: Searching for Beneficent Solutions” (2014) 28:3 *Reprod Biomed Online* 369.

surrogate-born child is a stronger justification though due to its application to a very small number of traditional surrogate-born children the sanctions appear to be disproportionate to the overall benefit especially when medical testing for communicable diseases already occurs for surrogates.

**IMPLICATIONS FOR TRADITIONAL  
SURROGATES OF *AHRA* AMENDMENTS  
CONCERNING THE TESTING AND SCREENING  
OF OVA**

We now need to examine some of the legal implications of subsection 10(2)(c). By requiring screening and testing of an obtained ova donated by a woman and used in her surrogate pregnancy, the *AHRA* appears to transform a traditional surrogate's ova by means of law and regulation into a "third-party" body part notwithstanding her genetic affinity to it. Moreover, once the obtained ovum has been transferred back into her body, decisions made throughout the pregnancy and on the birth of the child as to whether she will fulfil the surrogacy arrangement will be hers to make.

It is also important to note that the act of obtaining an ovum from a traditional surrogate is rare. Neither the U.S. nor the Canadian assisted reproduction registries provide information on traditional surrogacy undertaken

using assisted insemination or IVF.<sup>161</sup> If we look at provincial programs, the Ontario Fertility Program for example, began funding IVF and assisted insemination for surrogate patients in 2016. Under this program, it is possible for a woman who has been or plans to be a surrogate (traditional or gestational) to receive ovarian stimulation for her own fertility uses. The program does not prevent her from using her own “obtained” ova in her own traditional surrogate pregnancy or in her own pregnancy. Regrettably, the Ontario program does not track surrogate treatments, and as such no information is available on the uptake of this program by surrogates or of the outcomes.<sup>162</sup>

It is worth noting that the Ontario program considers “gestational and traditional surrogates” to be patients even though the clinic which undertakes the treatment refers to the intended parents as the “fertility patients” and the data collected by them regarding the treatments involving the surrogate (traditional and gestational) is recorded from the perspective of the intended parent.<sup>163</sup> Review of the labelling system described in the 2018 proposed Safety of Sperm and Ova

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<sup>161</sup> For the U.S., see S Sunderam et al, “Assisted Reproductive Technology Surveillance - United States, 2015” (2018) 67:3 MMWR Surveillance Summaries 1; For Canada, see Better Outcomes & Registry Network Ontario, “CARTR-Plus”, online: <[www.bornontario.ca/en/partnership-projects/cartr-plus](http://www.bornontario.ca/en/partnership-projects/cartr-plus)>, annual reports are no longer disseminated. Also consult the website of the Canadian Fertilization and Andrology Society at <[www.cfas.ca](http://www.cfas.ca)>. See also White, “Why We Don’t Know”, *supra* note 30.

<sup>162</sup> FOI Request A-2017-00-00166 made by Pamela M White to Ontario Ministry of Health and Long-Term Care, 1 September 2017.

<sup>163</sup> White, “Why We Don’t Know”, *supra* note 30 at 71–74.

Regulations for third-party donors raises questions about its ability to address the situation where the surrogate “donor” and the “recipient” are one in the same person and where the ova could be used in the person’s own pregnancy, in a surrogate pregnancy, or by another party such as the intended mother. The proposed data recording system appears to label the ova provided by a traditional surrogate and used in her own pregnancy as a third-party donor gamete. It codes the type of screening and testing that was undertaken and documentation regarding storage and handling. It is the “donor code” that links the donation to the donor.<sup>164</sup>

Muddled terminology about who is the fertility patient and when someone becomes a “third-party” reproductive actor (surrogate and donor) reveals the potential for problems in the area of consent to donate for use by the traditional surrogate in her own surrogate pregnancy, consent to donate for the use by the intended mother in her own pregnancy, or consent to use by the donor in her own non-surrogate pregnancy. Under such circumstances, law and regulation create liminal legal figures. As described above the “ova” and the donor, in this case the traditional surrogate, assume a betwixt and between legal reproductive status. Confusion regarding who has authority to use an ova can occur especially when roles become mutable and interchangeable. The case of a BC traditional surrogate, Ms. Chonn, is one recent example of such an occurrence.

Ms. Chonn acting as a traditional surrogate for intended parents had undergone ovarian stimulation and

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<sup>164</sup> 2018 Proposed Regulations, *supra* note 69, ss 44–47.



had agreed to have her obtained ova fertilised using the sperm of the intended father.<sup>165</sup> Embryos not used in Ms. Chonn's first surrogate pregnancy were cryopreserved and stored by the IVF clinic.<sup>166</sup> Sometime later, an embryo containing her ovum and the sperm of the intended father was transferred to the uterus of the intended mother. Ms. Chonn has indicated that she was not informed that the embryo containing her ovum had been transferred to the intended mother and that the use of the embryo occurred without her knowledge and written consent. Ms. Chonn as the ova donor is genetically related to the child subsequently born to intended mother. Her role as a traditional (genetic) surrogate is important to her and she has stated that she ". . . couldn't fathom someone else carrying her child."<sup>167</sup> The outcome of this situation has been especially stressful for her especially in light of the fact that she has lost contact with the parents and her genetic off-spring.<sup>168</sup>

This case exhibits a number of characteristics common to assisted reproduction. Reproductive roles can be variable and interchangeable. Creation of human life and the intermixing of family and relational bonds are complex and potentially contested. Rules regarding the

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<sup>165</sup> Eric Rankin "'Another Woman Gave Birth to My Child': Surrogate Sues Fertility Clinic", *CBC News* (30 November 2017), online: <[www.cbc.ca/news/canada/british-columbia/another-woman-gave-birth-to-my-child-surrogate-sues-fertility-clinic-1.4427248](http://www.cbc.ca/news/canada/british-columbia/another-woman-gave-birth-to-my-child-surrogate-sues-fertility-clinic-1.4427248)>.

<sup>166</sup> *Ibid.*

<sup>167</sup> *Ibid.*

<sup>168</sup> *Ibid.*

obtaining of consent are not always followed.<sup>169</sup> Unless an incident is reported by the media, the incident passes unnoticed. Whether the Chonn incident is an outlier or indicative of a larger problem, we do not know, as other instances have not garnered publicity. Interestingly, no information exists on compliance to the *Section 8 (Consent) Regulations*.<sup>170</sup> Whether such an incident would be recorded under the 2018 proposed Safety of Sperm and Ova Regulations as an adverse event is unclear.<sup>171</sup>

The amendment at subsection 10(2)(c) requiring the screening and testing of the “obtained” ova “donated” by a woman and used in her surrogate pregnancy means that the traditional surrogate assumes a dual reproductive identity: she is both an ova donor and surrogate. The shifting status of patient, donor, reproductive gamete and embryo recipient, and obtained ova create liminal reproductive legal categories. When a traditional surrogate is considered to be a “donor”, but not viewed by the clinic as a “patient”, there exists the possibility that possible mistakes and misunderstandings will take place like the one encountered by Ms. Chonn.

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<sup>169</sup> See UK, Department of Health, Human Fertilization & Embryology Authority, “State of the Fertility Sector: 2016–17” (December 2017) at 17, figure 5. The report reveals that even in a heavily regulated jurisdiction, failure to obtain consent is a persistent problem, one that has legal, parental, and regulatory consequences.

<sup>170</sup> No inspection reports or notices regarding compliance to the Section 8 (Consent) Regulations have been cited or published online by Health Canada.

<sup>171</sup> 2018 Proposed Regulations, *supra* note 69, s 69.1: “An establishment and a health professional that have reasonable grounds to believe that an adverse reaction has occurred.” The protocol appears to refer to safety precautions rather than incorrect use or transfer.

## CONCLUSION

The SCC in *Ref re AHRA* stated that “. . . criminal law power does not give Parliament the unconditional right to action to protect morality, safety and public health. . . . It is not enough to identify a public purpose . . . the evil must be real and the apprehension of harm must be reasonable.”<sup>172</sup>

This paper has argued that when the harm test established by the SCC in *Ref re AHRA*<sup>173</sup> is applied to the situation of a traditional surrogate using her own “obtained” ovum in her surrogate pregnancy, one encounters difficulty in isolating specific health and safety risks capable of meriting criminal code sanctions being applied to persons who would use an unscreened and untested obtained ovum donated by a woman and used in her own surrogate pregnancy. The paper could not identify health and safety risks posed by unscreened and untested traditional surrogate’s obtained ovum either to the traditional surrogate ova recipient (the person from whom the ova were obtained), IVF clinic and staff, or to stored human reproductive materials and embryos obtained from other patients. A stronger argument can be found in the benefits to children born of a traditional surrogacy, particularly if screening and testing could be applied to pinpoint the presence or absence of inheritable genetic diseases.

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<sup>172</sup> *Ref Re AHRA*, *supra* note 27 at 13–14.

<sup>173</sup> *Ibid* at para 243.

Yet, as beneficent as genetic testing and the collection of surrogate health and medical history information may be, the 2012 amendment at subsection 10(2)(c) will apply to an extremely small subset of traditional surrogate-born children. The number of children born to traditional surrogates is unknown as no Canadian public health agency or birth registry separately identifies these births.<sup>174</sup> The proportion of traditional surrogate children conceived as a result of IVF techniques is also unknown though IUI is the more common treatment used by this group of surrogates.<sup>175</sup> Decision making in the absence of population health evidence combined with no commensurate requirement to maintain a donor registry renders a failure to use unscreened and untested obtained ova used by traditional surrogate in her surrogate pregnancy an unsubstantiated harm to the surrogate and imposes a misplaced and misshapen law regarding the protection of children born as a result of this type of surrogacy. One is left wondering why failure to collect genetic and health information from such a small group of surrogates constitutes a pressing health and safety evil meriting criminal law sanctions especially when the majority of traditional surrogates will not be subject to the mandatory testing and screening specified in the 2018 proposed Safety of Sperm and Ova Regulations and accompanying Directives.

It is important to recall the remit of the *AHRA* as stated by the government when it announced its intentions to bring this section of the *AHRA* into force: “The Act

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<sup>174</sup> White, “Why We Don’t Know”, *supra* note 30 at 64.

<sup>175</sup> Millbank, *supra* note 52.

protects individuals in Canada by setting out prohibited activities related to assisted human reproduction that may pose significant human health and safety risks or that have been deemed to be ethically unacceptable or incompatible with Canadian values.”<sup>176</sup> The practice of commercial surrogacy is a prohibited activity as it has been deemed to be morally unacceptable and incompatible with Canadian values. An unscreened and untested ovum obtained from a woman and used in her surrogate pregnancy now falls into the category of prohibited activities on the basis of its risk to health and safety. Yet, as this paper has argued the extent of the health and safety test as laid out by the Supreme Court in *Ref re AHRA* cannot be fully sustained.<sup>177</sup> Moreover as Justices Le Bel and Deschamps opined not all public health risks should be addressed through criminal law.”<sup>178</sup> It is worth considering whether the medical testing of surrogates, including those who use their own ova in their surrogate pregnancy, more appropriately falls within the scope of provincial health responsibilities. Certainly, if the more pressing justification warranting mandatory medical and genetic screening and testing is that of concern of transmission of genetic disease it follows that the government should have taken measures to ensure that all surrogates are screened and tested and that a pan-Canadian third-party donor registry established.

It is tempting to argue that the imposition of mandatory screening and testing of ova obtained from a

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<sup>176</sup> *Processing and Distribution of Semen for Assisted Conception Regulations*, *supra* note 9.

<sup>177</sup> *Ref Re AHRA*, *supra* note 27 at para 243.

<sup>178</sup> *Ibid* at 243.

donor and used in her surrogate pregnancy was a misplaced attempt to suppress the “moral evil” of traditional surrogacy though in this case through the guise of a “health and safety evil”. If this is the case, then subsection 10(2)(c) functions as a backdoor means of marginalizing and discouraging the practice of traditional surrogacy enabled by assisted reproductive methods as the imposition of mandatory screening and testing procedures may serve to discourage the practice. For example, not all clinics have the expertise or ability to follow the procedures required to test and screen ova as was the case when the federal semen regulations were adopted in 1996.<sup>179</sup> The Designated Donor option as described in the 2017 CAN/CSA Standard and 2018 proposed Safety of Sperm and Ova Regulations will assist to decrease the ova screening and testing burden in cases where the traditional surrogate is known to intended parents. Even so, not all traditional surrogates will qualify as Designated Donors though the requirements of the type of qualifying relationship needed have not been fully described.<sup>180</sup>

More troubling, however, is the potential for confusion created by the blurring of roles as the traditional surrogate is the recipient of her own ova. Precise clinic practice guidelines need to be in place so that traditional surrogates retain the ability to exercise control over “obtained” ova. Application of the *AHRA Section 8 (Consent) Regulations* needs to be significantly robust to ensure that the act of “obtaining” the patient’s ova will not

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<sup>179</sup> Daria O’Reilly et al, “Feasibility of an Altruistic Sperm Donation Program in Canada: Results from a Population-Based Model” (2017) 14:8 *Reprod Health* 1 at 1.

<sup>180</sup> 2018 Proposed Regulations, *supra* note at 69, s 32.

interfere with the ability of the “donor” to determine its reproductive use, be this in her own pregnancy, a surrogate pregnancy, or by a third-party. The surrogate’s ova can also be donated for research or training.

Another source of confusion originates from the failure to regard surrogates as “fertility patients”. The traditional surrogate who will be the recipient of an embryo comprised of her ovum and sperm donated by the intended father or some other third-party has not been regarded as a “fertility patient” as this term is reserved by fertility clinics for the intended parents as it is this party who experiences infertility.<sup>181</sup> As the Chonn incident reveals the liminal legal status the traditional surrogate assumes by agreeing to undergo ovarian stimulation to obtain ova blurs the lines of fertility patient, third-party donor, and reproductive ova user. This mutable status has the potential to create confusion for the clinic tasked with delivering fertility treatments and to foster misunderstanding among all of the parties involved.

The amended 2012 *AHRA* at subsection 10(2)(c) seeks to discourage and criminalize the use of unscreened and tested ova obtained from a traditional surrogate and used in her own surrogate pregnancy. This measure harkens back to the Baird Commission’s 1993 report, which stated that “surrogacy of any sort is exploitative and unacceptable.”<sup>182</sup> The Baird Commission which recommended the prohibition of surrogacy sought “to prevent psychological harm to the surrogate who may bond

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<sup>181</sup> For a discussion of who is a “fertility patient” see White, “Why We Don’t Know”, *supra* note 30 at 71–74.

<sup>182</sup> Baird Commission, *supra* note 33 at 1115.

with her unborn child and to save women from the ‘evil’ of surrogacy.”<sup>183</sup> A subsequent Parliamentary Committee report, *Building Families*, written as part of a review undertaken of the proposed 2004 Assisted Human Reproduction legislation expressed the view that “non-commercial (altruistic) surrogacy arrangements can also be socially harmful for the resulting child and place the health of women at risk.”<sup>184</sup> Even though the Commissioners agreed with the proposed prohibition of surrogacy for commercial gain, they stated nonetheless that “surrogacy for non-commercial reasons should be discouraged but not criminalized.”<sup>185</sup>

This paper has advanced the argument that the rationale for mandating criminal code powers requiring screening and testing of a traditional surrogate’s ova is based on a tenuous health and safety rationale. The potential for transmission of genetic disease is a stronger justification though the *AHRA* at subsection 10(2) c) does not require screening and testing for all traditional surrogates with the result that its application to a small set of cases suggests a disproportionate use of criminal code powers. The real “evil” in this arrangement is not one of health and safety but that of the use of criminal law powers to constrain the practice of traditional surrogacy, a legally permissible activity when conducted in a non-commercial manner.<sup>186</sup> An analogy to this situation can be found in a recent American anti-abortion legislation, Texas HB2,

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<sup>183</sup> *Ibid.*

<sup>184</sup> House of Commons, *supra* note 33 at 12.

<sup>185</sup> *Ibid* at 12.

<sup>186</sup> *AHRA*, *supra* note 8, s 5.



which was proposed as a patient health and safety protection measure, but which would have seriously transformed the ability of women to access abortion services had it been approved.<sup>187</sup>

Canada's assisted human reproduction legislation is deeply flawed. Piecemeal amendments and regulatory tinkering serve to further confuse Canada's fertility law. The federal government's application of a health and safety justification to support criminal code penalties for failure to screen and test ovum obtained from a woman and used in her own surrogate pregnancy is tenuous. More dangerous, however, are the underlying implications for consent and reproductive autonomy of a traditional surrogate undergoing IVF treatments and the dangerous legal liminal spaces it creates. The on-going lack of a pan-Canadian donor registry weakens further the health and safety justification for a legally mandated medical and genetic history data collection from this subset of traditional surrogates. Failure to tackle these matters is the true "evil" that needs to be addressed.

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<sup>187</sup> *Whole Woman's Health et al v Hellerstedt, Commissioner, Texas, Department of State Health Services et al*, 579 US (2016), No 15-274, argued 2 March 2016, decided 27 June 2016.