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Failure to Reproduce: Assisted Reproductive Technology Policy in Canada

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Failure to Reproduce:

Assisted Reproductive Technology Policy in Canada

by

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Abstract

Comparative political science concerning assisted reproductive technologies (ARTs) has faced two problems: first, it has not adequately defined the field; second, it has focused almost exclusively on policy produced by national governments. This dissertation uses Canada as a case study to demonstrate how a new six-part typology for ART policy, coupled with a focus on multiple policymakers, can produce greater clarity. It uses historical institutionalism to trace Canadian policy, and finds that the 1993 Royal Commission on New Reproductive Technologies – a "critical juncture" – engaged in constitutionally unstable framing strategies that shaped policy for decades to come. The Commission framed certain practices and technologies by combining a pro-technology "medical-scientific" discourse with a "national" discourse to justify federal government intervention. These framing strategies were recreated in path-dependent ways leading up to the 2004 *Assisted Human Reproduction Act*.

However, framing the positive aspects of ART policy from a primarily "medical-scientific" perspective deprived the federal government of much of the constitutional ammunition that would permit a "national" response. This constitutionally risky strategy was confirmed in 2010 when a majority of Supreme Court justices struck down much of the *Assisted Human Reproduction Act* for violating provincial jurisdiction. In the face of this sub-optimal policy outcome, provincial governments, courts, and medical organizations have engaged in considerable policymaking concerning surrogacy, parentage, and assisted conception policy. While much of Canadian ART policy constitutes a "patchwork" of prohibitions, regulations, common law rulings, and clinical

guidelines, it is a mistake to call it "unregulated."

The Canadian case study provides several conclusions for comparative scholars. First, combining the six-part typology with a focus on multiple policymakers can better explain ART policy variation within and across regimes. Second, policy framing strategies must take into account existing institutional structures; how actors frame jurisdictional responsibilities can matter as much as how they frame policy content. Finally, scholars should pay more attention to how ideas become (or do not become) institutionalized. While policy framing can create ideational path dependence, the actual transfer from ideas to institutions often requires more than legislation.

Preface

Parts of Chapter 2 and Chapter 5 update and expand upon a research paper published by Dave Snow and Rainer Knopff for the School of Public Policy at the University of Calgary in 2012, entitled "Assisted Reproduction Policy in Federal States: What Canada Should Learn from Australia," 5 (12): 1-28. Dave Snow was the lead and corresponding author; both authors contributed to the conceptual framework. Parts of Chapter 5 and Chapter 7 update and rework information and analysis in a 2012 article by Dave Snow in the *Canadian Journal of Law and Society* entitled "The Judicialization of Assisted Reproductive Technology Policy in Canada: Decentralization, Medicalization, and Mandatory Regulation," 27 (2): 169-188.

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Contrary to the stereotype about men, I always ask for directions. Why trudge around aimlessly when someone else can help you reach your destination?

The same is true for my academic life. Throughout six-plus years of graduate school at the University of Calgary, I have habitually and shamelessly badgered peers, faculty, and staff to assist with my scholarly direction. Susan Franceschet, Tom Flanagan, Joshua Goldstein, Anthony Sayers and Lisa Young challenged me intellectually and improved my work considerably. Judi Powell, Ella Wensel and Bonnie Walter shouldered my administrative burden, eased me into my teaching career, and, as three genuinely lovely people, consistently brightened my day. Andrew Banfield, Mike Zekulin, Tim Anderson, Evan Wilson and Chelsea Ogilvie are among my closest friends.

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Dedication

For Nana Snow

Because we love the same things

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CHAPTER ONE: INTRODUCTION

In the last several decades, the world has undergone a revolution in assisted reproductive technology (ART). Rapid technological developments have created a host of procedures previously thought impossible, from *in vitro* fertilization to embryonic cloning to mitochondrial replacement. While these technologies provide new reproductive opportunities for many individuals, they have the potential to exploit women and commodify human life. Inevitably, these debates concern the proper role of government in preventing the negative consequences associated with new technologies, research, and activities. In recent years, several high-profile events have highlighted the perceived need for some degree of government regulation, yet there is little consensus concerning the level or kind of state intrusion required to prevent the harms associated with these emerging technologies. Accordingly, governments around the world have adopted myriad strategies when responding to these technologies, with varying degrees of success.

This study contributes to the emerging literature on these policies in two main ways: first, by providing a detailed case study of ART policy in Canada, and second, by developing and advancing the conceptual and theoretical approaches to the broader comparative study of this policy area. Together, these two components enhance our understanding of how policy framing is important in Canada's federal framework, provide a more precise way to measure ART policy for comparativists, and demonstrate comparatively the many ways in which federalism can limit the institutionalization of public policy in federations.

The Canadian Case Study

My title, *Failure to Reproduce*, indicates (in one of its meanings) that the Canadian experience has not been a success story. For fifteen years – beginning with the 1989 establishment of the *Royal Commission on New Reproductive Technologies* (also known as the Baird Commission, after its Chairperson Patricia Baird) – Canadian policymakers sought to achieve a comprehensive national framework to address ARTs. The Commission reported in 1993. In 2004, after three previous attempts, the federal government passed the *Assisted Human Reproduction Act* (*AHR Act*), which it lauded as one of the most comprehensive pieces of ART legislation in the world, and which most actors viewed as an important compromise (Jones and Salter 2007). The legislation included criminal prohibitions, a framework for forthcoming federal regulations, and a national agency to permit flexible responses to emerging technologies. While the process was long and arduous, the government maintained that its final legislation adopted a "comprehensive approach" that would "bring [Canada] into line" with other industrialized countries across the world (Canada 2004a).

A decade later, such optimism seems wildly inappropriate. After the *AHR Act* passed, Quebec challenged much of it in court, prompting the federal government to delay its regulatory framework. Transgressions of the law mounted, yet the criminal prohibitions were rarely enforced. Assisted Human Reproduction Canada (AHRC), the federal agency created to monitor the development of ARTs, was repeatedly subject to complaints about transparency and financial mismanagement, resulting in the sudden resignation of three board members in 2010 (see Baylis and Downie 2013). Patient advocates claimed the federal government was not doing nearly enough. And then, in late

2010, the most shocking development yet: by a 5-4 margin, the Supreme Court of Canada, agreeing with a unanimous Quebec Court of Appeal, struck down nearly every regulatory authority contained in the *AHR Act* for violating provincial jurisdiction over health care. Just six years after it had triumphantly signaled its new role as a world leader for the regulation of assisted reproductive technologies, the federal government's attempts to regulate the area had, according to one newspaper editorial, "collapsed in ruins" (Victoria Times-Colonist 2010).

The first component of my case study surveys the ruins and tries to explain how Canada arrived at a point that nearly every policymaker and stakeholder involved in the policy process would describe as suboptimal. Why, I ask, was Canada so unsuccessful in its major national attempt to institutionalize its ART policy? Most experts in the field called for some level of government regulation, and few if any of them thought provincial governments should play the main role. Clearly, constitutional constraints frustrated the expectations of actors in the policymaking process, but why were federal policymakers and constitutional experts so confident they would win a judicial challenge to the legislation on federalism grounds? And why were they so mistaken? Those are among the questions this study attempts to answer.

If the first component of the dissertation surveys the ruins, the second reconsiders whether the wreckage metaphor has been aptly applied. When the Supreme Court handed down its judgment in 2010, a great many observers lamented the "unregulated nightmare" they thought the decision would produce (Guichon, Giroux, and Mitchell 2008). This turns out to be an exaggerated reaction, one that understates not only the provincial role in ART policy (both before and after 2010) but also that of self-regulatory

medical organizations. In addition, courts can obviously also be major policymakers in this area (indeed, even in unitary states, where the subnational units of federalism do not exist, courts and professional medical organizations still play an enormous role in determining the content of ART policy). Analyzing the role of these additional actors – courts, provinces, and self-regulatory medical organizations – is the second important dimension of this study's account of the ongoing story of Canada's ART policy.

In sum, this dissertation will contribute the first large-scale qualitative study of ART policy in Canada to the comparative literature. It begins with the Baird Commission and ends at the present day, over three years after the Supreme Court of Canada's *Reference re Assisted Human Reproduction Act* (2010). Because the study looks beyond the federal government, it is also the first to describe in any comprehensive detail the extent to which provincial governments, professional medical organizations, and courts have influenced Canadian ART policy before and after the Supreme Court decision. While this detailed case study has value in itself, it also brings to light deficiencies in, and hence possible improvements to, the broader comparative literature on ART policy.

The Comparative Study of ART Policy: Unexplored Actors, Undefined Variables

Examining policy actors other than the federal government is one of the ways this study contributes to its second overarching purpose: advancing the still very young comparative literature on ART policy. While there has been a growing number of comparative studies in this field by political scientists over the last decade (Bleiklie, Goggin, and Rothmayr 2004; Engeli, Green-Pedersen and Larsen 2012a; Montpetit, Rothmayr, and Varone 2007a), existing frameworks and approaches have failed to

capture the full range of relevant phenomena and have often been overtaken by events. A leading example is the dominant focus of ART studies on policy produced by national governments, even in federal regimes (such as Canada's) where subunits have significant jurisdictional capacity. The neglect of federalism exhibited by Canadian scholars before 2010 has been just as evident in the broader comparative literature on ART policy.

In the Canadian case, it is true, there may have been some excuse for neglecting federalism prior to 2010, given that the federal government was the dominant player in ART policy up to that point. After the Supreme Court's 2010 decision, however – a classic example of events upsetting conceptual orientations – federalism can no longer be ignored. The comparative study of politics and policy cannot rely on case studies alone, but detailed case studies can serve to highlight what broader comparisons do not yet explain. The broader comparative literature on ART policy must ultimately account for what case studies bring to light, and in Canada's case that means accounting for federalism.

In fact, however, the ART literature's general neglect of federalism cannot really be excused by its failure to anticipate such events as the 2010 Canadian judgment. In other federal systems – and even in Canada prior to 2010 – subnational units have been more important in the ART policy field than one would guess from most of the existing literature. For example, Canadian provinces have always had uncontested authority over parentage policy, as even staunch proponents of sweeping federal ART policy have recognized. Parentage policy plays a critical role in the ART field (as Canada's federal policymakers also understood), because children conceived via assisted conception often raise novel questions and controversies about who counts as their legal parent(s).

Provinces have also always had considerable jurisdictional authority over issues related to surrogacy, which likewise plays an important role in the overall mix of ART policy. In other federal systems (e.g., the United States and Australia), subnational governments even have authority over criminal law, giving them substantial jurisdictional over the prohibitive aspects of ART policy, such as the commonplace prohibition of human cloning. Clearly, the literature on ART policy must more fully engage with the phenomenon of federalism than it has to date.

If the ART policy literature has focused too heavily on national governments to the relative exclusion of federal subunits, it has also focused too heavily on the executive and legislative capacities of *governments* as such, to the relative exclusion of the policy role of both courts and self-regulatory medical organizations. As for courts, the 2010 Supreme Court of Canada decision clearly demonstrates the risk of ignoring the role of judicial policymaking in the ART realm. This 2010 judgment was based on Canada's federal division of powers, but federalism jurisprudence is not the only basis for judicial contributions to ART policy. Given the modern rise of bills of rights, such as Canada's 1982 *Charter of Rights and Freedoms*, rights jurisprudence has enhanced the role of courts in policymaking, perhaps especially with respect to what the literature calls "morality issues," a category that definitely includes ARTs. In Canada, as elsewhere, there is good reason to pay more attention to courts as policymakers in the ART field than is common in the existing literature.

Self-regulatory medical organizations also need to be brought more thoroughly into the ART policy literature. In many countries, including Canada, professional medical organizations have been granted authority to issue licenses to allow physicians to practice

medicine, produce clinical guidelines and standards of practice, and conduct disciplinary hearings. They are often the primary policymakers for clinical practice and, particularly in the absence of government action, their internal rules constitute the only public policy concerning certain activities. Nevertheless, to an even greater degree than subnational units and courts, they have been effectively ignored in the literature, and our understanding of ART policy is poorer for it.

There are many reasons why the ART literature has thus far neglected the relevance of federalism, courts, and self-regulatory organizations. For one, it is still a young field. An additional factor that helps explain at least some of the areas of neglect is the lack of consensus on just how to define the field. Indeed, scholars have often not even agreed on the best name for their area of study. A variety of terms – assisted reproductive technology (ART), reproductive and genetic technologies (RGT), assisted human reproduction (AHR), "red" biotechnologies, and new reproductive technologies (NRTs) – have been used. True, "assisted reproductive technologies" (ART) (the usage adopted for this study) has recently emerged as the most common term, but that does not mean that clarity has been achieved on just what it captures. Does it include research not designed to produce human beings, such as embryonic stem-cell research? What about surrogacy, which is technically a private social arrangement rather than a "technology," although it is obviously heavily reliant on assisted reproductive technologies? Should "surrogacy" policy, which obviously affects the already mentioned "parentage policy," be included in ART policy? If not, then (in the Canadian context) the provincial role in surrogacy and parentage policy does not even come to light for ART scholarship, which may help

explain why provinces were neglected in pre-2010 accounts of Canadian ART policy. However, they obviously cannot be neglected post-2010.

Lack of definitional consensus poses other issues for ART scholars as well. Much of the comparative literature understandably wants to compare the "permissiveness" of different ART regimes (with "permissiveness" increasing as legal constraints on ARTs and associated social relations diminish), and I will do the same when comparing Canadian provinces. But permissiveness measures depend on what counts as ART policy. The United Kingdom, for example, is quite permissive with respect rules for prenatal screening and embryonic research, but it imposes considerable constraints on surrogacy and gamete donation by prohibiting compensation. Yet Engeli, Green-Pedersen, and Larsen (2012a) and Montpetit (2007b) see the UK as a permissive regime largely because these prohibitions are only one small part of the expansive field of overall ART policy. Does it really make sense to obscure such internal variation when assessing a regime's permissiveness with respect to ARTs? I argue that it does not, and that failing to distinguish between the subfields of ART policy can cloud both analysis and measurement. When rules for surrogacy, embryonic research, and in vitro fertilization are lumped into a single variable for the purposes of cross-national comparison and measurement, the resulting indicator says little about the overall policy mix within that jurisdiction. As a result, precise measurement, one of the paramount goals of modern comparative political science, is sorely lacking in the field of ART policy. For such an important developing field of public policy, one that pertains to the creation of life and the possibilities of curing disease, such consequences of definitional inconsistency are especially problematic.

Greater clarity will be achieved, I maintain, if we define assisted reproductive technology policy as consisting of six distinct subfields: 1) assisted conception, 2) surrogacy, 3) embryonic research, 4) reproductive human cloning, 5) screening, enhancement, and manipulation, and 6) parentage. This classification offers the advantages both of more comprehensive coverage of ART-relevant policies and of more precise classification within the field of coverage. While there is some overlap between the six subfields, it is nevertheless possible to offer precise definitions and delineate boundaries to enable scholars to more effectively assess policy variation across (and even within) jurisdictions.

Moreover, disaggregating ART policy into these six subfields turns out to dovetail in revealing ways with the broader array of relevant policymakers outlined above. Simply put, there appear to be different subfield emphases for different policymakers, at least in Canada. For example, professional organizations have tended to create internal rules primarily for assisted conception, while judicial influence has been especially pronounced with surrogacy and parentage policy, areas in which provincial governments also have a significant role. In other words, the failure of existing comparative accounts to properly assess the extent to which actors other than national governments engage in ART policymaking is compounded by their failure to properly define "ART policy" by breaking it into its constituent parts. Both in themselves and together, a better appreciation of relevant policymakers and more precise definitions (within more comprehensive coverage) promise greater analytical clarity. For Canada and comparatively, we have thus far been told only partial stories.

While I use the six-part typology and a focus on additional policymakers primarily to provide a more complete picture of ART policy in Canada, scholars could easily apply this framework to other jurisdictions, regardless of whether they are federations or unitary states. I am confident that this framework can serve as a model for comparativists, whether engaging in small-N qualitative case studies (as I do here), or large-N quantitative studies.

Structure of Dissertation and Overall Argument

This dissertation unfolds in several stages. Chapter 2 sets out the theoretical framework and approach used to conduct the Canadian case study. The chapter begins with a review of the still young comparative political science literature on assisted reproductive technology policy. Demonstrating the eclectic and incomplete nature of existing ART scholarship, I lay out in greater detail both the case for the new six-part typology mentioned above and the contributions that can be made by considering the role of subnational governments, professional medical organizations, and courts.

Chapter 2 also specifies the theoretical framework used to answer the first puzzle of the Canadian case study: how and why two decades of national policymaking collapsed in ruins in 2010. I combine the theoretical literatures of "historical institutionalism" and "policy framing" to resolve this puzzle. Briefly summarized, Canada's Baird Commission "framed" ARTs in a way that set its national policy agenda on a collision course with evolving constitutional jurisprudence. Acting as what historical institutionalism calls a "critical juncture," the Baird Commission's risky "framing" of ART policy persisted throughout the entire national policymaking process, even as its

risk should have become more apparent. The tragedy of Canadian ART policy, in short, can be traced to its first act.

Using the frameworks and approaches developed in chapter 2, chapters 3-5 unfold the story of Canada's ART policy up to and including the 2010 Supreme Court decision. Chapter 3 focuses on the Baird Commission. At this "critical juncture" of policy development, the Commission adopted important framing strategies – strategies that would prove to be remarkably persistent – concerning both the *content* of ART policy and the *jurisdictional competence* over such policy. As to content, the Commission distinguished between ARTs that were medically beneficial and ought to be regulated (the medical-scientific frame) and other ARTs that were harmful and ought to be criminally prohibited (the moral frame). At the same time, the Commission's *jurisdictional* framing claimed that all of assisted reproductive technology policy, regardless of whether it was medically beneficial or morally harmful, should be administered by the federal government. While there may have been a division of labour between harmful and beneficial technologies, all the work was to be done by the same labourer: the federal government. Applying this "national" jurisdictional frame not only to the criminal prohibition of harmful ARTs but also to medically beneficial regulations was a constitutionally risky and probably unstable framing strategy. Although everyone concedes federal jurisdiction over criminal prohibitions, the provinces have considerable jurisdiction over health policy, including the regulation of medically beneficial technologies. The Baird Commission downplayed the potential risk and instability, however, arguing that all of the new ART policy realm (with the exception of parentage

policy) was just too important to leave to the provinces, and that it could be justified as national legislation in relation to "the Peace, Order, and Good Government" of Canada.

Chapter 4 moves beyond the Baird Commission to examine the federal policymaking process from 1993-2004, which led to the eventual creation of the *Assisted Human Reproduction Act* (*AHR Act*). Drawing from Hansard debates, policy documents, proposed legislation, committee hearings, and interviews with key policymakers involved in all levels of the process,[1] I demonstrate how the Baird Commission's framing strategies and recommendations were systematically adopted by the federal government, confirming that the Commission constitutes a "critical juncture" in the development of Canadian ART policy. One might have expected the federal government's approach to change during this intervening decade, as the technologies became normalized and public opinion liberalized. However, the policy design process – the goals, target groups, instruments, implementers, and policy rationales – remained the same. In the end, the federal government's historic legislation covered every subfield of ART policy with the exception of parentage. Its combination of prohibitions, regulatory authority for "controlled activities," and a national agency almost exactly mirrored the Commission's overarching recommendations.

As noted, this legislation resulted in a constitutionally unstable framework, particularly with respect to the medically-beneficial "controlled activities" and regulatory authority. Just as it had threatened, the Quebec government challenged the *AHR Act's* regulatory authority in court. Chapter 5 details the judicial process, explaining why a majority of justices in both the Quebec Court of Appeal and the Supreme Court of

[1] The interviews (completed in 2011 and 2012) included politicians, civil servants, and medical stakeholders.

Canada struck down the regulatory components of the legislation. These majorities explicitly referred to the Baird Commission and adopted its "division of labour" distinction between beneficial and harmful activities. However, in their constitutional analysis, the justices found that the medically-beneficial technologies fell under provincial jurisdiction. I also draw from Supreme Court federalism jurisprudence throughout the 1990s and 2000s to explain why this outcome was even more likely in 2010 than it was in 1993, as the Baird Commission's suggested major piece of constitutional ammunition – the Peace, Order, and Good Government (POGG) clause – was watered down. I then summarize the academic and journalistic commentary concerning this decision, which I characterize as "general outrage," punctuated by the belief that, absent federal action, Canadian ART policy constitutes an "unregulated nightmare."

Chapters 6 and 7 address this commentary and its assertion that the federal government is the only level of government capable of adequately regulating ARTs. First, I emphasize that the federal government, through various mechanisms, still effectively governs much of three subfields: reproductive human cloning; embryonic research; and screening, enhancement, and manipulation. It also maintains some regulations and prohibitions concerning surrogacy and assisted conception. However, other policymakers make the vast majority of policy pertaining to surrogacy, parentage, and assisted conception. In Chapter 6, I create a typology to enable measurement of surrogacy and parentage policy in terms of policy permissiveness, and apply it to the ten Canadian provinces. I find considerable policymaking in the two subfields, particularly parentage, and that policy is slowly leaning towards permissiveness. Moreover, in the absence of

clear provincial rules, the courts have also played an important role in these two subfields. Consistent with some of the literature on "morality policy" (Smith and Tatalovich 2003; Tatalovich and Daynes 2005), judicial decisions have tended to create permissive policy. This emphasis on provincial policymaking demonstrates that, in these two subfields at least, it is incorrect to refer to Canada as "unregulated," although it is certainly correct to refer to it as a "patchwork."

Chapter 7 focuses on assisted conception policy, the subfield most commonly associated with ART policy as a whole, and most subject to critical ire regarding a lack of national regulation in Canada. After defining this policy subfield as constituting three components – rules targeting medical professionals, rules targeting patients and donors, and rules for patient coverage – I examine who regulates these component areas and how they regulate them. In addition to the few federal regulations and prohibitions that do exist, I examine Quebec's comprehensive assisted conception policy, introduced in 2009. While Quebec is the only province to legislate in this subfield, its initiative demonstrates that provinces certainly have the capacity for effective regulation. What Quebec's legislation cannot explain is why the other nine provinces have failed to regulate. For such an explanation, I turn to the literature on professional medical organizations, and examine the role of provincial medical colleges in creating and sustaining assisted conception policy. While provincial colleges themselves have not engaged in ART policymaking, they have delegated their authority to national specialist organizations, who have over time created a number of assisted-conception-related guidelines. Moreover, there is growing evidence that medical practitioners are following the guidelines, as demonstrated by Canada's declining multiple birth rate. I suggest that the

existence of medical self-regulation provides an institutional explanation for why most provinces have not yet regulated in this subfield, insofar as the organizations are doing enough to prevent a true policy vacuum, obviating the incentive for provinces to become engaged in this morally contentious subfield. I also explore the possibility of judicial influence on this subfield, detailing the *Pratten* cases (2011, 2012) concerning donor anonymity. As with other subfields of ART policy, it is not surprising to see judicial policymaking over morally contentious policy, particularly in the absence of provincial legislation.

Chapter 8 draws together these various threads, reiterating the overall arguments and contributions from this dissertation. To briefly anticipate here, using a combination of policy framing, process tracing and identification of critical junctures to explain the development of ART policy in Canada, the dissertation finds that the development of ART policy was initially path dependent, reflecting the Baird Commission's framing of this emerging and unregulated policy field. However, a series of tensions embedded in this initial stage led to increasingly less predictable patterns of policy development in the mid-term. These tensions were of two orders: first, at the ideational level, there was an inability to adopt a universal "framing strategy" for the diverse elements captured under the ART policy umbrella; instead, some were deemed beneficial and others harmful. Second, at an institutional level, there was confusion as to which level of government should have responsibility for or capacity to deal with these various, distinct policy components. These two tensions were mutually reinforcing, as the Baird Commission's strict adherence to a national strategy meant that the competing ideational justifications

for government action in this diverse policy field were obscured by the desire for government to speak with one voice.

The collision of the initial path-dependent (but ambivalent) framing of the policy arena with the realities of federalism and the actions of independent actors and courts has led us to the current state of ART policy, which is best described as a patchwork of different rules and regulations from various policymakers. Within this patchwork, the permissiveness of Canadian ART policy ranges from subfield to subfield (and even between jurisdictions). On the whole, Canadian ART policy represents an "intermediate" policy compared with other countries, but it is not until we delve deeper that we develop a more complete understanding of which elements are more restrictive (such as human cloning and surrogacy) and which are, in several provinces, more permissive (assisted conception). Chapter 8 closes by drawing implications of this dissertation for both Canadian scholars and comparativists.

CHAPTER TWO:

ASSISTED REPRODUCTIVE TECHNOLOGIES AND COMPARATIVE POLITICAL SCIENCE

Although ethical and moral considerations about assisted reproductive technologies inevitably concern government intervention, political scientists and public policy analysts have been slow to address this new and dynamic field. In part due to limited regulatory activity, Blank and Hines observed in 2001 that political scientists were "largely absent" from debates concerning all biomedical policies, and that the literature was "rife with confusion… over what is meant by government intervention, what the policy process is and how the political system works" (2001: 107). Three years later, in the first attempt to provide a comparative framework for ART policy, Goggin et al. similarly concluded that there was "little political science research on the topic" (2004: 2).

The 2004 call to arms was part of an edited collection by Ivar Bleiklie, Malcolm L. Goggin, and Christine Rothmayr (now Christine Rothmayr Allison), entitled *Comparative Biomedical Policy: Governing Assisted Reproductive Technologies*. This volume, a critical step in the comparative development of ART policy, took the initial steps in terms of defining the subject area, adopting a particular political science approach, and developing a precise measure by which different states' policy mix could be categorized. In terms of *definition*, Bleiklie, Goggin and Rothmayr offered a tripartite typology for ART policy: basic techniques, such as IVF and artificial insemination; techniques related to basic techniques, such as surrogacy, sperm/egg donation, and cryopreservation; and research/experimental techniques, such as genetic engineering, embryo research, and reproductive human cloning. For an *approach*, Bleiklie et al. used a

comparative policy design framework (CPDF), which synthesized the literature on institutional analysis, advocacy coalition, and policy design (Linder and Peters 1991, 1992; Ostrom, Schroeder, and Wynne 1993; Sabatier 1999; Schneider and Ingram 1993, 1997). Under this framework, the dependent variable was policy design, defined as the "goals, instruments, and portrayal of target groups that make up policy content" (Goggin et al. 2004: 6). Their four independent variables included institutions, the characteristics of political actors, the broader context surrounding ARTs, and the policy-designing process itself (which included both the arena of power and the interaction of actors within that arena). This framework sought to explain how actors, institutions, and external environments combined to explain the policy process (2004: 5-13).

Finally, in terms of *measurement*, the authors developed a "permissive-intermediate-restrictive" scale, by which each regime's overall ART policy mix was placed under one of those three categories. The factors that determined permissiveness were practitioner autonomy (freedom for physicians and researchers to practice ARTs and conduct research) and access (the ability of would-be users to avail themselves of ARTs) (Goggin et al. 2004: 4). Using 11 country-specific case studies, including Canada, the authors found autonomy was closely related to access; Canada, the United States, Italy, and Belgium had high levels of both, and were classified as "permissive" regimes (230-231).[2] The collection concluded that fragmented political parties and interest groups, along with a medical community favouring permissive regulation, were among the factors that led to a permissive national framework (Rothmayr et al. 2004: 234).

[2] Although published in 2004, the chapter on Canada was written before the passage of the *Assisted Human Reproduction Act*. As noted below, Canada's ART policy was subsequently classified as "intermediate" due to its criminal prohibitions (Montpetit 2007a).

The authors did not find a great deal of support for an institutional basis for comparative convergence of ART policy, claiming "[c]lassification of countries according to constitutional features, type of democracy or political system has revealed no clear pattern with respect to policy output" (Rothmayr et al. 2004: 238). However, they did find that certain institutional factors, such as the federal division of powers and coalition stability, contributed to the avoidance or postponement of federal government intervention. In particular, they pointed to Canada and the United States as examples where federalism provided actors with additional veto points and, hence, additional opportunities for permissive policy (Rothmayr et al. 2004: 241-250). While the correlation between political institutions and ART policy output was weak across the board, there was some suggestion that institutions could explain particular outcomes on a case-by-case basis. Along with the other permissive countries, Canada was labeled as a jurisdiction that had created policy through "non-decision" (251).

Overall, the authors' policy design approach made assisted reproductive technologies a legitimate topic of inquiry within comparative political science. Recognizing that the field was "evolving with great speed," the authors stressed that political scientists ought to keep abreast of ongoing developments and continue the study of how ART policy develops across time and across space (Rothmayr et al. 2004: 253).

The subsequent decade saw a substantial growth in the comparative study of ART policy from political scientists, much of which applied and built on the Bleiklie, Goggin, and Rothmayr study (Adamson 2005; Bleiklie, Goggin and Rothmayr 2004; Engeli 2009; Engeli, Green-Pedersen and Larsen 2012; Fink 2008; Knowles and Kaebnick 2007; Wong and Quach 2009). In particular, many of the authors returned for an edited

collection in 2007 entitled *The Politics of Biotechnology in North America and Europe* (Montpetit, Rothmayr, and Varone 2007a). The scope of this project was broader, encompassing comparative analysis of both ART policy and non-human genetically modified organism (GMO) policy, such as agro-food, genetically modified crops, and animal cloning (see Bauer 2005; Rothmayr Allison 2009 for a discussion of the distinction between these two areas). Because the authors concluded that "policies vary not only considerably across countries, but also across sectors," ART policy was still analyzed as its own policy field, independent from GMO policy (Varone, Rothmayr, and Montpetit 2007: 28).

The ART component of this project was similar to the previous book, although the authors refined their earlier methodology. In terms of *definition*, they eschewed the tripartite distinction of the previous book, defining ARTs as "those techniques where egg and sperm are not united through, or an embryo is not created through, sexual intercourse but rather through medical intervention" (Varone, Rothmayr, and Montpetit 2007: 2). Perhaps because the scope of the overall project was more ambitious, this had the unfortunate effect of further aggregating components of this large field into one policy. The authors once again adopted the policy design *approach*, with a country's policy design acting as independent variable. However, the policy design variable was reconceptualized in a small but significant manner. In addition to policy goals, policy instruments, and target groups, the authors added two new attributes of policy design: "implementers," defined as "the public and/or private actors in charge of taking measures to implement the policy instruments"; and "policy rationales," defined as the "expressed justifications" for the other components of the overall policy design (2007: 6). As the

subsequent chapters of this dissertation show, this expanded focus on implementers and on rationales (which affect policy frames) can help explain a country's overall policy process. Their independent variables were adapted slightly, as they developed a set of hypotheses from three different approaches: the policy network approach, the country-pattern approach, and internationalization (2007: 9-27).

Finally, in terms of *measurement*, the authors maintained the permissive-intermediate-restrictive scale, with particular focus on embryonic research and access to ARTs (Varone, Rothmayr, and Montpetit 2007: 6-8). Using qualitative comparative analysis (QCA), they tested for whether differences in biotechnology policy (including both ART and GMOs) were explained by sector-specific factors, country-specific factors, or broad convergence due to international norms and rules (2007: 27). In the end, they found that none of the three explanations were particularly satisfying: permissive, intermediate, and restrictive policies were found with both ART and GMO policy, and there was considerable within-country variation across the two fields. There was also weak support for internationalization, as countries had experienced considerable policy divergence. In sum, the authors concluded that "explanations for biotechnology policies cannot rest on a single theoretical approach to policy-making and thereby invite us to endorse a complex understanding of causality" (Montpetit, Rothmayr, and Varone 2007b: 269). Few generalizable conclusions could be gleaned from the overall analysis; depending on the country of analysis, country-specific, sector-specific, and internationalization analysis all possessed some explanatory value, "lending support to the idea that policy explanations need to draw from several theoretical approaches" (280).

Canada's ART policy, following the passage of the *AHR Act*, was now classified as "intermediate" (Montpetit 2007).

The most recent cross-national comparative study of ART comes from Engeli, Green-Pedersen, and Larsen's 2012 *Morality Politics in Western Europe*. In this volume, the authors study five moral issues – abortion, euthanasia, same-sex marriage, assisted reproductive technologies, and embryo research – in five European countries and the United States. While the scope is wider than previous comparative ART studies, it nonetheless builds on the Montpetit, Rothmayr, and Varone (2007a) volume. In terms of *definition*, the authors usefully distinguish between assisted reproductive technologies and embryo research. Their description of ARTs contains assisted conception techniques such as cryopreservation of sperm, eggs, and embryos; preimplantation genetic diagnosis; and surrogacy (Engeli, Green-Pedersen, and Larsen 2012c: 28-29). For embryo research, the authors include embryonic stem-cell research, therapeutic embryonic cloning, and reproductive human cloning.

With respect to their *approach*, the authors examine party manifestos, parliamentary debates, and policy documents in an attempt to determine the extent to which debate over ART and embryo research was divided by partisan interest. In keeping with their overall methodology for studying morality policy, they delineate three different "frames" to describe policy rationales: *secular*, emphasizing values such as autonomy, self-determination, non-discrimination, and scientific progress; *religious*, pertaining to the sanctity of life and the authority of God; and *unsecular*, which share the religious opposition to ARTs, but do so "without invoking religious values" (Engeli, Green-

Pedersen, and Larsen 2012c: 31-32).[3] Finally, in terms of *measurement*, these authors once again employ the Bleiklie, Goggin, and Rothmayr (2004) "permissive-intermediate-restrictive" axis, using patient access and physician autonomy as the primary measures of permissiveness. The authors found considerable variation among nations with respect the restrictiveness of their ART policy, but also found broad support for their hypothesis that there are "two worlds of morality politics," whereby morality politics (including ART and embryo research policy) are more politically salient in countries that have a cleavage between religious and secularly-based parties in the party system (Engeli, Green-Pedersen, and Larsen 2012d: 185).

While these three studies have yet to lead to a "grand theory" of ART policy, they do raise several lessons for comparative scholars of ART, all of which suggest that there is a pressing need for clarification and identification of the object of study. First, the Montpetit, Rothmayr, and Varone (2007a) study demonstrates fairly conclusively that GMO and ART policies have arisen at different times in different countries, and that they ought to be analyzed as distinct policy areas. Simply put, ART policy itself contains a complex and multifaceted set of subfields, and given the myriad factors that explain ART development, the returns associated with studying it in tandem with GMO policy will be comparatively diminishing. While it is true from a technical standpoint that both GMOs and ARTs fall within "biotechnology," the distinction between human and non-human

[3] As the authors elaborate, "unsecular frames may refer to the preservation of society's 'fundamental values' or moral standards without specifying what those are. Other examples of unsecular frames could be family values, arguments about nature, slippery slope arguments or arguments critical of science, medicine or technology. In some instances it can be difficult to distinguish clearly between religious and unsecular frames, because there may be a gradual movement away from explicit religious references in morality arguments" (Engeli, Green-Pedersen, and Larsen 2012c: 32).

biotechnology renders these categories quite different. For that reason, this dissertation does not address GMO policy.

Second, and relatedly, the political science literature on ART policy lacks definitional coherence. Scholars do not always agree on the terms of analysis, and when they do, they often offer contradictory or insufficient definitions. Primarily because ART is an emerging field, it has been alternatively referred to as assisted reproductive technology (ART) policy, reproductive and genetic technology (RGT) policy, new reproductive technologies (NRTs), assisted human reproduction (AHR) policy, and "red" biotechnology.[4] Indeed, the term "technology" itself can be misleading because ART policy typically encompasses surrogacy, which itself is a private social and legal arrangement, not a technology. Nevertheless, because it has become the dominant term in the developing comparative political science literature (Adamson 2005; Bleiklie, Goggin and Rothmayr 2004; Engeli, Green-Pedersen and Larsen 2012; Montpetit 2004; Montpetit, Rothmayr and Varone 2005), this study retains "ART policy." However, below I suggest that for further clarity, ART policy ought to be divided into six constituent parts. In this vein, the Engeli, Green-Pedersen, and Larsen (2012) effort to disaggregate the assisted-conception components of ART policy from embryo research policy represents an important first step towards more precise definition and classification.

[4] Within the broader literature on biotechnology, Martin Bauer has usefully distinguished between green biotechnology (agro-food, genetically modified crops/food, and animal cloning) and red biotechnology (genetic testing, assisted conception, human cloning, embryo research) (Bauer 2005; see also Rothmayr Allison 2009: 414). When scholars use the terms ART, NRT, or RGT, they are referring to red biotechnologies; discussions of ART policy do not generally involve questions about crops and animals, focusing instead on human beings and human embryos.

Third, while the permissive-intermediate-restrictive scale has become the norm in terms of measurement, that measurement has been based almost entirely on the action of national governments. To get a better picture of a country's ART policy, the focus needs to be expanded to include the policymaking potential of other policymakers. In particular, three policy actors have been underplayed in the comparative literature: subnational jurisdictions, medical organizations, and courts. Even though the major comparative studies have analyzed federal jurisdictions, virtually no attention has been paid to subnational regulations, even in federations such as Canada and the United States where the majority of health care regulation occurs at the subnational level. Moreover, the fact that policymakers can include private actors has been understated if not ignored in the Canadian and comparative literature on the topic, which tends to focus on explicit state prohibitions and regulations. Christine Rothmayr Allison's (2009: 421) call for ART scholars to examine "self-regulatory mechanisms established by medical professionals" notwithstanding, the extent to which non-statutory guidelines actually bind medical professionals is only at the embryonic stage of exploration (see Engeli and Rothmayr Allison 2013). Finally, the role of courts has been entirely ignored, even though there is growing evidence of their involvement in affecting policy change, particularly in disputes involving federalism, surrogacy, parentage, and donor anonymity (see Snow 2012).

Thus, the comparative literature on assisted reproductive technologies has moved a considerable distance over the last decade, with three leading edited collections doing the heavy lifting. The three collections have made assisted reproductive technologies an important subset of health policy within political science, and they have set the framework by which political scientists pursue the study of ARTs. However, the field

requires further conceptual clarity with respect to both the content of the ART policy field and the actors engaged in policymaking. Below, I suggest a new framework by which to begin to address these issues.

Defining Assisted Reproductive Technology Policy: Six Subfields

The tripartite typology of ART policy offered by Bleiklie, Goggin, and Rothmayr (2004) – basic techniques, techniques related to basic techniques, and research/experimental techniques – was a useful beginning, but it does not sufficiently delineate the boundaries of these subfields. This was recognized by the work of Engeli, Green-Pedersen, and Larsen (2012), which distinguished between ART policy and embryo research. Although this was an important refinement, it still lumped policy concerning preimplantation diagnosis in with rules for in vitro fertilization. Nor does the refinement by Engeli, Green-Pedersen, and Larsen address such important issues such as compensation for sperm, eggs, and surrogacy. Ignoring the United Kingdom's constraints regarding these compensation issues, they characterize the UK ART regime as "permissive" (Engeli, Green-Pedersen, and Larsen 2012d: 194; see also Montpetit 2007b: 103), when it is clearly restrictive on some important matters. This study maintains that analytical clarity requires a more precise six-part typology:

1. *Assisted conception*, the subfield most commonly associated with ART policy, uses technology to enhance the prospects of reproductive success. It is most frequently used by those who have difficulty conceiving, those with heritable diseases, single women, and sexual minorities. Policies in this subfield address three things: first, rules for

medical professionals, including licensing, inspection, and clinical practice guidelines; second, rules for donors and patients, including screening requirements, donor identification, and database maintenance; and third, rules for patient coverage, typically for assisted conception treatments and fertility drugs. This subfield covers most of the day-to-day business of fertility treatment.

2. S*urrogacy* achieves assisted reproduction through a private social (and usually legal) arrangement in which a woman (the surrogate) gestates and bears a child to be raised by someone else (the intended parent(s)), whether the child bears a genetic relation to the surrogate or not. There are three distinctions with respect to surrogacy. First, surrogacy can be either traditional or gestational. In traditional surrogacy, the surrogate is impregnated with another man's sperm, becomes pregnant and gives birth. In gestational surrogacy, an embryo is created – often, but not always, from the intended parents' egg and sperm – and transferred into the surrogate, who becomes pregnant and gives birth. In traditional surrogacy, the surrogate has a genetic relationship to the child; in gestational surrogacy, she does not (Reilly 2007: 483; Shanley 2007: 103-104). Second, surrogacy typically, though not always, involves a written agreement between the surrogate and the intended parents to transfer custody and parental rights before the child is conceived. States can address such "surrogacy arrangements" by declaring them null and void (as in Quebec), permitting a pre-birth transfer scheme that acts as a justiciable binding contract (as in many American states), or producing a post-birth scheme that speeds up the transfer of parentage, but still allows the surrogate to change her mind (as in the UK; see Chapter 6; Millbank 2011: 177-186).

Finally, surrogates are either paid ("commercial") or unpaid.[5] In a paid surrogacy arrangement, the surrogate is given compensation for her gestational services above and beyond expenditures. In an unpaid surrogacy arrangement, there are no fees, no brokers, and the surrogate cannot be paid beyond direct expenditures (Reilly 2007: 483). Regimes that ban paid surrogacy but allow surrogates to be reimbursed for certain receipted expenditures (such as medical costs, legal fees, and counselling) are still referred to as unpaid or "altruistic" in the literature, because they have the same goal of preventing "surrogacy for hire." These three distinctions with respect to surrogacy are mutually exclusive: whether the surrogacy is traditional or gestational has no bearing on whether there will be a written arrangement or whether the surrogate is compensated; likewise, compensation can occur without a written arrangement.

3. *Embryonic research* concerns the creation, preservation, and manipulation of human embryos for scientific research and medical treatment. This includes research to develop fertility treatments, abortifacients or contraceptives, and regenerative medicine including, most controversially, embryonic stem cell research and "therapeutic cloning." The crucial distinction between embryonic research and related subfields is that embryonic research seeks to improve the lives of this generation rather than produce the next one. Thus, research that involves the manipulation of human reproductive material but has as its goal the eventual creation of a human being will fall into the subfield of reproductive human cloning or screening, enhancement, and manipulation, as described below.

[5] While the literature sometimes refers to unpaid surrogacy as "altruistic" surrogacy, this is a misleading term, as surrogates may enter into unpaid surrogacy arrangements for reasons other than pure altruism. Moreover, just because someone receives payment for an activity – such as a doctor, nurse, or priest – does not preclude those person's motivations from being altruistic (see Millbank 2011). In this dissertation, I use the neutral terms "paid" and "unpaid."

4. Reproductive human cloning, a related but conceptually distinct fourth subfield, involves the artificial creation of two or more genetically identical individuals through the manipulation of human reproductive material. While related to other subfields, reproductive human cloning is analyzed as a distinct subfield simply because so many countries have legislation directed solely at this practice. So-called "therapeutic cloning," also called "non-reproductive human cloning" and "cloning-for-biomedical-research," uses the same techniques as reproductive cloning (usually somatic cell nuclear transfer) to create a cloned embryo entirely for research purposes. Because therapeutically-cloned embryos will never be implanted into a human uterus, and thus do not have as their end goal the creation of a human being, therapeutic cloning falls into the subfield of "embryonic research" (see Caulfield and Bubela 2007, 51-52; Downie, Llewellyn, and Baylis 2005).

5. *Screening, enhancement, and manipulation* involves the application of technologies to determine the attributes of children before they are born, regardless of whether those children were conceived "naturally" or via assisted conception. Policy here concerns currently available screening technologies, such as prenatal screening and preimplantation genetic diagnosis (PGD) in addition to prospective technologies, such as genetic enhancement. In this category I include ectogenesis (the possibility of creating an artificial womb), the use of human reproductive material from cadavers and fetuses for the purposes of reproduction, and the creation of animal/human hybrids or chimeras.

6. *Parentage* – the most ignored policy subfield in the ART literature – concerns the procedures used to determine and transfer parental responsibility for children born through assisted conception and/or surrogacy. This subfield includes both the default presumptions concerning who becomes a legal parent, and the process (pre-birth or post-birth) for achieving legal parentage.

While there is some overlap between these six ART policy subfields – surrogacy obviously raises parentage issues and overlaps with assisted conception, while a total ban on embryonic research would make human cloning impracticable – there exists sufficient distinction to enable scholars to isolate and determine differences between polices, offering greater opportunity for meaningful cross-national comparison. This typology builds on the Engeli, Green-Pedersen, and Larsen (2012) division, but makes two distinctions: ART policy is subdivided into assisted conception, surrogacy, and parentage, while embryo research policy is divided in embryonic research, reproductive human cloning, and screening, enhancement, and manipulation. For comparative political scientists specifically, dividing ART policy into these six distinctive subfields enables scholars to isolate which political actors are responsible for implementing particular policy subfields, a point to which I now turn.

Not Just Federal: Examining Additional Policymaking Institutions

Above, I identify how existing comparative studies of ART do not sufficiently delineate the different subfields covered by the term. Yet this definitional difficulty is not the only problem with the comparative study of ART policy, which focuses primarily on public policy created by national governments, even when it is acknowledged that those national

governments do not play a prominent role in developing ART policy (see Studlar 2012). As a result, these studies pay minimal attention to the role of three important policymaking institutions: subnational governments (in federal states), professional medical organizations, and courts (exceptions include Levine 2010; Engeli and Rothmayr 2013). As the Canadian case study will demonstrate, each policymaker plays an important role in developing and maintaining different subfields of ART policy. As such, paying greater attention to the role of these different political actors can provide evidence as to whether different institutions are more or less likely to produce different *types* of regulations – a finding that would be consistent with institutional approaches to political science, which claims that different institutional venues produce different policy outputs (Immergut 1998; Peters 2005a). Below, I outline the way in which the three political actors have been under-examined in the literature on ART policy.

Federalism and Subnational Governments

The major comparative volumes (Bleiklie, Goggin, and Rothmayr 2004; Montpetit, Rothmayr, and Varone 2007a; Engeli, Green-Pedersen, and Larsen 2012) have all included federal countries, usually some combination of Canada, Switzerland, Germany, Belgium, and the United States. However, the comparative study of ART policy has not made federalism a major unit of analysis. Although two studies (Montpetit, Rothmayr, and Varone 2005; Rothmayr, Varone, and Montpetit 2003) have explicitly addressed federalism as an independent variable with respect to ART policy, few subsequent studies have addressed federalism in any meaningful way. These two studies made a key distinction between jurisdictional federations (such as Canada and Belgium) and

functional federations (such as Germany and Switzerland). To simplify, in jurisdictional federations, competencies are distributed between the national and subnational governments; each retain exclusive authority within these particular areas. In functional federations, by contrast, competencies are "attributed along the functions of policy formulation and policy implementation"; federal governments are normally responsible for formulating policy while subnational governments are responsible for implementing policy (Rothmayr, Varone, and Montpetit 2003: 113; see also Braun 2000). In both studies, the authors attributed the comparative permissiveness of the jurisdictional federations (Belgium and Canada) in part to the fact that federal governments framed ART policy in a medical-scientific[6] manner conducive to permissive policy. In this sense, the structure of the federation itself enabled functional federations to design policy independently of the physicians, which resulted in restrictive policies in those countries. ART "nondecisions" in jurisdictional federations such as Canada and Belgium, by contrast, were explained at least in part by the federal arrangements that allowed medical-scientific frames to dominate (Rothmayr, Varone, and Montpetit 2003: 121-124).

While these preliminary analyses of federalism made an important contribution, they are, most notably, out of date. Neither take account of the Canadian *Assisted Human Reproduction Act* (2004) nor the Belgian *Law on Medically Assisted Reproduction and the Disposition of Supernumerary Embryos and Gametes* (2007), as both laws were passed after the articles were submitted. Given that both laws introduced restrictions and regulations into what the authors had previously described as an unregulated "bioethical paradise" (Rothmayr, Varone, and Montpetit 2003: 124), the extent to which

[6] The authors do not use the term "medical-scientific," though their description of physician-friendly permissive policy is almost identical to the use of this term I adopt in Chapter 3, building on Scala (2002).

jurisdictional federalism produces permissive legislation needs to be revisited. Certainly, the authors make a case that jurisdictional institutional arrangements contributed to legislative *delays*, but beyond that, new research is required.

Perhaps most importantly, these studies of federalism and ART policy have focused exclusively on the extent to which federal arrangements have affected policy at the *national* level, ignoring the extent to which subnational governments have produced legislation independent of the federal government. As a result, countries such as Canada and the United States have perhaps erroneously been characterized as "permissive" regimes due primarily to the absence of federal regulations (Goggin and Orth 2004; Montpetit 2004), while Australia and other subnationally regulated regimes have been given little attention. Part of this has to do with the unit of analysis: major comparative studies have overwhelmingly focused on functional federations, where the national government is primarily responsible for policy creation and subnational governments are responsible for policy implementation. When comparative scholars applied this functional framework to jurisdictional federations such as Canada and Belgium, the assumption was that the absence of a national policy meant the absence of subnational policy. However, since 2004 – and indeed, for some countries such as Australia, prior to 2004 – subnational governments have created legislation in several subfields of ART policy in jurisdictional federations, most notably in the fields of assisted conception (often in terms of health care coverage for IVF), surrogacy, and parentage.

Moreover, while it is true that many subnational governments have yet to produce legislation, this does not mean that those jurisdictions are "unregulated" or represent a "bioethical paradise" for practitioners. For further clarification, there needs to be a shift

in focus to the policymaking role that has been undertaken by – and often explicitly granted to – medical organizations.

Medical Organizations and ART Policymaking

If comparative ART scholars have downplayed the policymaking role of subnational governments, they have almost uniformly ignored the policymaking capacity of and policy content produced by medical organizations. In spite of calls for greater examination of the extent to which medical self-regulation affects policy (Rothmayr Allison 2009: 421), there has been virtually no exploration of the way internal rules, norms, and best practices actively constrain the way in which physicians approach their practice with respect to ART.

There are various way in which self-regulating professions – known in the literature as self-regulatory organizations (SROs) – are granted policymaking power. In Canadian medical practice, each province delegates regulatory authority for medical practice to provincial colleges of physicians and surgeons (Epps 2007; Priest 1998: 240-242). Colleges issue licenses, maintain and monitor standards of practice, produce ethical and clinical guidelines, and conduct disciplinary hearings for professional misconduct. Although the colleges are not subject to continual government oversight, provincial governments do "retain an ultimate responsibility that can be exercised in the case of a loss of faith in the regulatory process" (Epps 2011; Priest 1998: 282; see also Montpetit 2004). In the self-regulatory literature, this is known as the "shadow of hierarchy," which refers to "threatened compulsory regulation that would come into force if no voluntary regulation was adopted" (Toller 2011: 502).

Because this "ultimate responsibility" is rarely invoked, Canadian medical SROs are granted a great deal of policymaking authority, authority that has rarely been addressed in the literature. Granted, some studies have made hypotheses about the extent to which statutory self-regulation places constraints on physicians and researchers involved in ART policy. Montpetit, Rothmayr, and Varone (2007b: 11) hypothesize that such "policy communities" will produce comparatively permissive policy outputs because of self-interest. Other critics of self-regulation make similar arguments, stressing limited sanctions, rent-seeking, limited internal monitoring, and motivation for profits as factors that lead to under-regulation and weak accountability (Epps 2011: 92-94; Ogus 1995: 99; Posner 1974; Rowley, Tollinson, and Tullock 1988). Schneider and Ingram, in their influential study, go so far as to note that self-regulation can reinforce negative stereotypes, exclude certain groups at the expense of others, and as a result produce "degenerative politics" (1997: 105). Indeed, there can be little doubt that rules produced by medical self-regulatory organizations tend to be less restrictive than, for example, the blunt power of the criminal law. However, the extent to which such organizations actually have the capacity to introduce some restrictions, and the extent to which those restrictions are actually followed, requires greater attention in order to paint a more complete picture of the current framework.

Such examination of self-regulatory policymaking is not only useful in its own right; at times, it can help explain the outcome of ART policy within a given jurisdiction. As Rothmayr Allison notes, "in some cases, professional norms preceded governmental policies and had an impact on subsequent public policy-making" (2009: 421). The British and Australian experiences, whereby medical organizations voluntarily created bodies

that ended up impacting government legislation, are a case in point (Montpetit 2007b: 112; Snow and Knopff 2012). In their recent (unpublished) study of France, Germany, and the United Kingdom, Engeli and Rothmayr Allison demonstrate how "comprehensive and well-respected voluntary self-regulation strengthens the medical community's position as expert and its credibility as reliable partners in the regulatory process," thereby limiting or delaying state intervention (2013: 11). To complement this study, this dissertation engages the comparative literature on self-regulation generally (Garoupa 2011; Ogus 1995; Priest 1997) and medical self-regulation specifically (Levine 2010; Von Hagel 2013; Williams 2011) to examine whether, in the Canadian context, clinical and ethical guidelines have created a professional "ethic" in lieu of – or as a complement to – outright government legislation (Bardach and Kagan 1982; Gunningham and Rees 1997).

The Judiciary and ART Policymaking

In addition to including subnational governments (where applicable) and medical SROs to create a more complete analysis of a given state's ART policy, the judicial branch of government also deserves to be viewed as a policy actor in its own right. Especially given the widespread adoption of bills of rights throughout the liberal democratic world, there has been a growing scholarly preoccupation with the policymaking potential of courts (Hirschl 2004; Tate and Vallinder 1995). However, courts do not themselves initiate policy in the same way that other political actors do; as Canadian political scientist Alan Cairns (1971: 319) so sagely noted, "courts are not self-starting institutions." While appeal courts have gained increasing control over their docket, they do not determine the

cases that initially get launched in court; they do not have a bureaucracy (or the medical equivalent) charged with large-scale policy development and analysis; and they do not typically have the authority, other than to hear repeat litigation on a given issue, to assess the extent to which governments or private organizations implement their rulings. As Horowitz (1977: 38) notes, "[j]udges sit to hear disputes brought to them by parties; they do not initiate action" (Horowitz 1977: 38; see also Manfredi and Maioni 2002; Kennedy 2012: 17). As such their policymaking potential is primarily reactive.

Nevertheless, the impact of courts on public policy is unquestionable, particularly given the growing scholarly preoccupation with the "judicialization of politics" associated with the worldwide growth of judicial power (Ginsburg 2003). It is therefore curious that courts have been essentially left out of the discussion of ART policy by social scientists, particularly as judicial decisions have had a formative impact on rules concerning parentage and surrogacy in various jurisdictions (see Burpee 2009; Cameron, Gruben, and Kelly 2010; Snow 2012). Moreover, judicial decision-making should be especially relevant in the entire field of assisted reproductive technologies, not only because parentage orders are historically made by courts, but also because ART policy – and all its subfields – undoubtedly fall within the political science field of "morality policies." This subset of policies – such as abortion, euthanasia, same-sex marriage, and prostitution – are "legal sanctions of right and wrong" that validate contested "fundamental questions" of primary identity, especially race, gender, sexuality, and religion (Mooney 2001: 3-4; see also Engeli, Green-Pedersen, and Larsen 2012b: 23-26; Smith and Tatalovich 2003; Studlar 2001: 39).[7] And while there has been some debate

[7] See Studlar (2001: 46) and Engeli, Green-Pedersen, and Larsen (2012b: 23-26) for a discussion of what constitutes or does not constitute morality policy.

over the extent to which morality policy produces a distinct form of politics (Engeli, Green-Pedersen, and Larsen 2012a; Tatalovich and Daynes 2005),[8] there is little doubt that, particularly in jurisdictions with a constitutional bill of rights, interest groups concerned with morality politics tend to turn "claims into rights" and "legislation into litigation," increasing the likelihood that morality policy enters the courtroom (Lowi 2005: xii). Due in part to a growing rights consciousness and institutional incentives for political leaders to defer to courts on tricky moral issues, morality policy and judicial power have become mutually reinforcing.

For these reasons, scholars should not be surprised at the judicialization of ART policy. Certainly assisted reproduction falls under the umbrella of morality policy as defined in the scholarly literature (see Engeli, Green-Pedersen, and Larsen 2012a). Regulations regarding *in vitro* fertilization, embryonic stem cell research, and payment for sperm, eggs, and surrogacy constitute legal sanctions of right and wrong that validate a particular set of fundamental values. Although compensation can be involved, the central issues are not chiefly economic; rather, primary concerns involve parentage, identity, sexuality, reproduction, gender, and human life itself. Further, ART policy is almost always framed in the language of *rights*: the rights of the infertile, fetal rights, the rights of sexual minorities and, most frequently, the rights of children born through assisted reproduction. Thus, state action or inaction concerning assisted reproduction can be, and has been, challenged in court as a rights violation.

[8] In the preface to Tatalovich and Daynes (2005), Lowi (2005: xii) described the observed political behaviour associated with morality policy as "more ideological, more moral, more directly derived from fundamental values, more intense, less utilitarian, more polarized and less prone to compromise" than other types of policies. By contrast, the Engeli, Green-Pedersen, and Larsen comparative volume found "considerable national variation in the politics of morality issues" (2012: 23).

Canada in particular is no stranger to judicial resolution of morality policy. Judicialization of morally contentious legislation has been prominent in Canada since the introduction of the *Canadian Charter of Rights and Freedoms* in 1982. Because of Canada's unified court structure and federal jurisdiction over criminal law, the Supreme Court of Canada has ruled on many of Canada's most contentious morality policies, including euthanasia, pornography, abortion, same-sex marriage, and prostitution (*Rodriguez v. British Columbia* 1993; *R. v. Butler* 1992; *R. v. Morgentaler* 1988; *Reference re Same-Sex Marriage* 2004; *Canada v. Bedford* 2013). Indeed, most Canadian morality policies have received some input from the Supreme Court. Moreover, there is another reason to expect judicial involvement in ART policy in Canada: federalism. ARTs touch on health care, medical and professional licensing, criminal law, and family law. In federal regimes, where jurisdiction over these fields is often contested, the likelihood of judicial intervention increases. And while federalism decisions do not typically *create* policy in the way that bill of rights decisions can, they nevertheless can alter the status quo in ways that have a determinative impact on public policy. As Chapters 5-7 demonstrate, Canada has seen considerable judicialization of ART policy in rights cases (*Pratten v. British Columbia* 2011; *Rutherford v. Ontario* 2006), surrogacy cases (*M.D. et al. v. L. L. et al.* 2008; *W.J.Q.M. v. A.M.A.* 2011) and, most importantly, federalism cases (*Reference re Assisted Human Reproduction Act* 2010).

Canada as a Case Study: Method and Theoretical Approach

There is ample reason for comparativists to incorporate policies produced by subnational governments, medical organizations, and courts into analyses of assisted reproductive

technology policy. All three have been relevant in Canada, where ART policy has been shaped by three key events: First, the 1993 Royal Commission on New Reproductive Technologies, an enormous national study that recommended sweeping federal legislation, which I argue constituted a "critical juncture" for Canada's ART policy; second, the federal government's 2004 *Assisted Human Reproduction Act* (*AHR Act*), which implemented most of the Commission's recommendations; and third, a 2010 Supreme Court decision, which struck down most of the regulations in the *AHR Act* for violating provincial jurisdiction over health care (*Reference re Assisted Reproduction Act* 2010). After this decision, much of ART policy in Canada today is unregulated by governments, with most commentators critical of the status quo (Baylis 2011; Eggertson 2011). However, given limited attention to the role of provincial-government and medical-organization policy in the wake of this decision, Canada is an ideal place to begin the process of theory-building in order to gain a better understanding of the way different institutions can, alone or in combination, affect ART policy.

This study will provide the first comprehensive account of the history of assisted reproductive technology policy in Canada, from the Royal Commission to the present day. There have been other case studies of ART policy in Canada (Baird 2007; Baylis and Herder 2009a, 2009b; Jones and Salter 2007, 2010; Montpetit 2004, 2007a; Scala 2002, 2007, 2008; Scala, Montpetit, and Fortier 2005), but these analyses are insufficient for several reasons. First, and through no fault of the authors, they are nearly all outdated following the Supreme Court of Canada's 2010 decision. Because it struck down most of the federal regulatory structure, and the federal government subsequently shut down the national agency it had created, the dependent variable of most of these studies – Canada's

overall ART policy – has changed substantially. While certain studies have examined Canada's ART policy in light of the Court's decision, these accounts have consisted primarily of legal analyses (Lee 2012; Mitchell 2011; Newman 2011; Ogbogu 2011, 2013; Whyte 2011), short commentaries (Annas 2011; Baylis 2011, 2012; Deonandan and Rahman 2011), or reflections on how the changed law affects one small aspect of ART policy, such as the egg trade or surrogacy (Downie and Baylis 2013; Nelson 2013a).

Overall, there has been no systematic attempt to integrate how inputs and framing strategies produced the government's overall legislation, how that legislation interacted with developing Supreme Court jurisprudence and the constitutional structure of Canadian federalism, how the Court's decision has produced a new policy status quo, and how other political actors have responded to that status quo. This study incorporates all these components to provide the clearest picture yet of the law and politics of ART policy in Canada. Its goal is to tell the story of how Canada got to where it is in terms of ART policy. The approach most suited for this task is historical institutionalism.

Historical Institutionalism: Getting from A to Z

Fundamentally, much political science is concerned with answering one question: what drives politics? The post-war "behavioural revolution" in political science answered this question by focusing on observable individual behaviour to explain aggregate behaviour. New institutional scholars, beginning with March and Olsen (1984), criticized behaviouralists for ignoring the way political institutions constrain, proscribe, and prescribe certain forms of behaviour. By contrast to overly atomistic accounts, new institutionalists sought to re-emphasize the collectivist roots of political behaviour (Peters

2005a: 43). While there are many variants of new institutionalism, they all agree that "institutions *do* matter, and they matter more than anything else that could be used to explain political decisions" (Peters 2005a: 164). This study adopts Peter Hall's definition of institutions as the "formal rules, compliance procedures, and standard operating practices that structure the relationship between individuals in various units of the polity and economy" (Hall 1986: 19). While this is a broad definition, it is one that lends itself, in the words of Paul Pierson, to the analysis of "microphenomena," allowing us to view specific public policies as institutions in their own right (Pierson 2004: 78, 165).

New institutionalists also recognize that there is a dynamic relationship between individuals and institutions. As Robert Putnam argues in his studies of civic traditions in Italy, institutions shape politics, but they themselves were shaped by history and social context – that is, they have "inertia" and "robustness" (1993: 7-8). This renewed emphasis on the importance of time and history is particularly prominent in historical institutionalism, one branch of new institutional thought. Historical institutionalism's "deceptively simple" idea, according to B. Guy Peters, "is that policy choices made when an institution is being formed, or when a policy in initiated, will have a continuing and largely determinative influence over the policy into the future" (2005a: 71; see also King 1995; Pierson and Skocpol 2002). In this sense, historical institutionalism rejects the ontological view of the political world "as a sphere governed by causal relationships that take the form of lawlike regularities operative across space and time," suggesting instead that similar developments may have *different* impacts across cases, depending on the time at which they are initiated (Hall 2003: 373, 385). Or, as Pierson notes, historical institutionalists assume "earlier events matter much more than later ones, and hence

different sequences [of events] may produce different outcomes [across cases]" (Pierson 2000: 253; Peters 2005a: 71). Because the embeddedness of initial choices can often lead to unintended consequences over time, historical institutionalism rejects functionalist accounts by which "institutions take the form they do because powerful actors engaged in rational, strategic behavior are seeking to produce the outcomes observed" (Pierson 2004: 14). As subsequent chapters attest, such functionalism provides an inadequate account of Canadian ART policy; instead, constitutionally unstable framing strategies, taken on by well-meaning policymakers during the early stages of ART policy development, have created a status quo with which almost every stakeholder is dissatisfied.

As Capoccia and Keleman (2007) note, many historical institutional accounts posit a "dual model of institutional development" with two characteristics: "relatively long periods of path-dependent institutional stability and reproduction" and "brief phases of institutional flux—referred to as critical junctures—during which more dramatic change is possible" (341). Critical junctures – defined as "relatively short periods of time during which there is a substantially heightened probability that agents' choices will affect the outcome of interest" (348) – are more likely to occur when structural influences on political actors are "significantly relaxed for a relatively short period," resulting in an expanded "range of plausible choices" for which the outcome is "potentially much more momentous" (343). Critical junctures are thus more likely to occur (though not limited to occurring) in the context of a legislative vacuum. Because of the "relative structural determinism" during critical junctures, they demonstrate the "power of agency" that is prevalent in periods of institutional flux compared with subsequent periods of stability (Mahoney 2002: 7).

As an analytical framework, historical institutionalism is not without its problems; it has been criticized both for its inability to explain institutional formation and to predict future events (Peters 2005a: 71-86; Immergut 1998: 5-34). However, as a tool for explaining past political behaviour, it remains invaluable. It is especially useful for understanding the evolution of assisted reproductive technology in Canada for several reasons. First, the study of jurisprudence lends itself to historical institutional analysis, as judicial doctrine evolves in path-dependent ways (Clayton and Gillman 1999; Kahn and Kersch 2006). Chapter 5 describes the way in which the Supreme Court of Canada's evolving federalism jurisprudence came to affect Canada's ART policy, drawing from historical institutional themes in doing so.

Second, ART is a young policy field, which makes theories involving "critical junctures" and "path dependence" especially relevant. The medical technology used for assisted reproductive technologies only gained prominence in the late 1970s, and most states (including Canada) did not begin their legislative processes until the 1990s. As Miriam Smith notes, historical institutionalist analysis explains divergent policy outcomes by beginning with "the legacies of previous policies" (2008: 7). Because of the focus on "legacies," historical institutionalism privileges decisions made at the beginning of the policy process; thus, it is most useful when the beginning of the policy process – the initial critical juncture – can be readily identified. As my analysis will show, the legislative vacuum, the novelty of the technologies, and the wide scope of inquiry granted to the Baird Commission lend considerable weight to the argument that the Commission's final report constitutes a – more correctly, *the* – critical juncture in Canadian ART policy. The Commission represents a "relatively short" time period with

"significantly relaxed" structural constraints; the power and authority granted to the Commission gave its recommendations the capability to institute "momentous" change compared with other time periods in Canada and, indeed, similar time periods in other countries. Moreover, the Baird Commission fits with previous historical institutional work on critical junctures, wherein the "unit of analysis" is an "institutional setting in which actors' decisions are constrained during phases of equilibrium and are freer during phases of change" (Capoccia and Keleman 2007: 348, 343, 349).

While I argue historical institutionalism provides an excellent framework for studying Canadian ART policy, comparative studies of ART policy have thus far largely rejected institutional explanations. Christine Rothmayr Allison, a leading political scientist in the field, did claim ART scholars should adopt historical institutionalism "to analyze how and to what degree previously adopted regulation affects policies addressing new technological developments […and] to what extent existing policies mediate how technological innovation and progress are being addressed" (2009: 421). However, as noted above, Rothmayr et al. found there was "no clear pattern" in ART policy convergence "according to constitutional features, type of democracy or political system," although the federal division of powers did produce postponement of national action (2004: 238; see also Engeli 2009: 66). In her study of abortion and ART policy in Europe, Isabelle Engeli found "institutional arrangements at the national level do not tend to exert any clear systematic and direct impact on ART and abortion regulation in terms of policy content" (2009: 71). Finally, Simon Fink's qualitative study of embryonic research policy found "fragmented governance," which includes federalism, did not affect policy outputs, which depended more on "the structure of issue networks in the

field" (2008: 1647). By contrast, as subsequent chapters attest, the interaction of ideas and institutions are perhaps *the* explanation for the current state of Canada's ART policy.

Policy Framing and Historical Institutionalism

The third reason historical institutionalism is especially relevant for studying ART policy is that it takes *ideas* seriously. In particular, historical institutionalists assert that ideas prevalent early in policy development – and crucially, the way that political elites frame those ideas to the public – can have lasting effects on institutional arrangements (see Hall 1989). Dominant discourses during the initial phases of policy development can become embedded in particular institutions, thereby having a lasting effect on policy outcomes. In this sense, Daniel Béland argues that ideational "forces" should be analyzed as "an independent variable that must be understood within specific institutional arrangements" (2005: 2; Béland and Cox 2011: 9).

Historical institutionalism's focus on ideas should not lead to the erroneous claim that ideas are simply given. Instead, actors and interest groups actively construct ideas in order to influence policy. Crucial to this construction is the concept of "policy framing," defined by Daviter (2011: 2) as "the process of selecting and emphasizing aspects of an issue according to an overriding evaluative or analytical criterion." As Béland notes, frames and ideas are not identical. Rather, ideas exist independent of institutional setting, but require the "support of powerful actors that have an interest in promoting them." Frames, by contrast, "constitute a discourse that helps political actors sell policy choices to the public." In policy framing, political actors draw from "stable ideological repertoires" with the express purpose of "convincing the population to support the policy

alternatives they put forward" (2005: 10-11, 2-3). Policy framing thus involves the use of certain ideas to structure or manipulate the way in which social or political debate over a particular policy issue is contested by influencing the perception of available choices; frames are "normative concepts that elites use to legitimize these programs to the public" (Campbell 1998: 385). As Joel Best notes, those seeking to frame a given social issue "characterize problems in particular ways: They emphasise some aspects and not others; they promote specific orientations; and they focus on particular causes and advocate particular solutions" (1989: xxi). Or as Theodore J. Lowi puts it, we can often trace public policy outputs to "whose *definition of the situation* prevailed" in early stages of policy development (Lowi 1964: 682, emphasis in original).

The literature on policy framing is relatively new, although the definition and framing of policy issues was certainly part of earlier political science research concerning agenda setting (Cobb and Elder 1971; Rochefort and Cobb 1993). In contrast to agenda setting, modern research on policy framing, heavily indebted to the work of Baumgartner and Jones (1991, 2002), focuses more exclusively on what Daviter calls "the political representation of policy issues" (Daviter 2011: 2; see also Roberts 1998; Stone 1989; Petracca 1992, Peters 2005b). In the political arena, the goal of projecting a certain "frame" of an issue is often to produce a "simplified image of complex policy choices," one which privileges certain information, and thus certain interests, over others, and can even shape "the formation and organization of interests, at times restructuring political constituencies in the process" (Daviter 2011: 3-4, see also Baumgartner and Jones 1991; Pierson 1993).

The historical institutional approach lends itself to a policy framing analysis, providing a theoretical framework through which to analyze specific public policies within a given jurisdiction. Like historical institutionalism, policy framing privileges the causal importance of both ideas and institutional setting, especially during early stages of policy formation. On the one hand, as Baumgartner and Jones note, certain ways of framing ideas are more salient depending upon the institutional venue within which they are framed and articulated, as "policy images find a favorable reception in some institutional venues but not others" (1991: 1044). On the other hand, the way in which a policy is framed during the early stages of policy development can influence the subsequent formation of political interests and institutions; "the interaction between image and venue" – between idea and institution – "can lead to the rapid creation, destruction or alteration of policy subsystems" (1991: 1044). Framing is especially salient when political actors are "promoting alternatives at odds with the current institutional order" (Béland 2005: 15).

With the exception of Francesca Scala's study of Canada's Baird Commission (Scala 2002) and Steven Ketell and Paul Cairney's study of the United Kingdom's 2008 amendments to the *Human Fertilisation and Embryology Act* (Kettell and Cairney 2010), policy framing has not made its way into the mainstream (or even the fringes) of the comparative politics of ART. However, because both historical institutionalism and policy framing posit a dynamic, reciprocal relationship between ideas and institutions, they serve as an ideal framework through which to study Canadian ART policy. Indeed, policy framing's recognition of the interaction between ideas and institutions can shed light on an aspect of analysis for which historical institutionalists are often criticized:

institutional formation (Peters 2005a: 71-86; Immergut 1998: 5-34). Creation, destruction, or alteration of policy subsystems, whether or not it takes place within an existing institutional structure, can lead to the formation of entirely new political institutions. The ideas used to frame a policy during its early stages can serve as an explanation for the particular venues through which a policy was developed, as well as the level of government put in charge of implementing the policy. Policy framing thus demonstrates that ideas can interact with institutions by structuring different sets of preferences, influencing policymakers' perceptions, exerting greater causal force in certain types of institutions, and influencing the formation of entirely new institutions, themselves containing their own internal logic.

Conclusion

This chapter has offered a description of the state of the comparative politics literature on assisted reproductive technology (ART). While strides have certainly been made over the last decade, there is nevertheless a pressing need to offer a more precise definition of what is covered by ART policy while simultaneously providing a broader focus on the different political institutions that create ART policy. To rectify these issues, I propose a six-part typology by which to categorize different states' ART policy mix, encompassing six distinct subfields: assisted conception; surrogacy; embryonic research; reproductive human cloning; screening, enhancement, and manipulation; and parentage. By disaggregating ART policy in this way, scholars can get a better understanding of precisely which subfields of a state's ART policy are subject to regulation. This typology provides a concrete way to enhance and complement the dominant permissive-

intermediate-restrictive framework, but fine-tunes this framework by applying it independently to policies produced in each of the six ART subfields. Similarly, existing studies of ART policy focus primarily on public policy created by national governments, paying little attention to the role of subnational governments, professional medical organizations, and courts. However, there is considerable reason to believe that, particularly in federal jurisdictions with constitutional bills of rights, all three political institutions have the potential to influence and produce public policy in the field of ART.

These two contributions are complementary. Disaggregating subfields of ART policy enables scholars and practitioners to better identify which level of government is charged with responsibility over those particular subfields, while turning attention toward different policymakers gives a more complete understanding of a state's overall policy mix. Put another way, the typology offers a better way to understand the "division of labour" in which regulators ought to engage; the discussion of subnational governments, professional medical organizations, and courts adds other labourers to the mix. Together, these two contributions can enrich the ongoing debate within federal and unitary states about which, if any, level of government – national, subnational, or professional self-regulated – ought to have primary regulatory authority over the subfields of ART policy. Applied comparatively, they can offer greater opportunity for cross-national comparison and provide empirical evidence of the effectiveness of government regulations.

While this marks the beginning of a more expansive comparative research project, this dissertation moves from this theoretical base to a case study of Canada's experience with ART policy. The subsequent chapters (three, four, and five) examine three junctures (the first of which is "critical") that produced and struck down the majority of legislation

at the federal level: the 1993 Royal Commission, the 2004 *AHR Act*, and the 2010 Supreme Court of Canada Reference. While there is certainly a need to focus on other policymakers, there can be little doubt that these three junctures, and the periods in between, had the capability to produce the greatest effect on all aspects of ART policy in Canada. Using historical institutionalism and policy framing, I outline how the dominant ideas used to frame ART policy in the Baird Commission ended up affecting the subsequent legislation, and setting the stage for the Supreme Court of Canada's decision. These dominant frames, it will be shown, can explain much of how the federal government's ART policy failed to produce the outcome that its framers desired.

However, as the above framework suggests, it is not enough to simply study federal policymaking in this area. Chapters 6-7 examine the policymaking role, both potential and actual, that provinces, courts, and medical self-regulatory organizations can play both before and after the Supreme Court decision. In particular, they have continued to impact three subfields: surrogacy, parentage, and assisted conception. Chapter 6 provides a framework by which to measure variation in surrogacy and parentage policy, applying this framework to the Canadian provinces to determine policy permissiveness. Chapter 7 explores how these multiple policy "implementers" have affected assisted conception in various ways, both before and after the Supreme Court decision in 2010. As the subsequent chapters demonstrate, both before and after the decision, we can develop a richer understanding of Canada's ART policy through examining the roles of multiple actors.

CHAPTER THREE:

THE ROYAL COMMISSION ON NEW REPRODUCTIVE TECHNOLOGIES AND THE LEGACY OF PAST FRAMES

As the preceding analysis demonstrates, it is useful to conceive of assisted reproductive technology (ART) policy as six distinct subfields. However, legislatures do not always produce six separate pieces of legislation; instead, because of the myriad ways in which the subfields interact with one another, they are often covered by a single piece of legislation. Canada is a case in point. While the process of ART legislation in Canada was long in the making, a common thread was the federal government's view that ARTs should be legislated holistically, as part of a uniform approach. Much of this had to do with the early decisions by policymakers that led Canada down a centralized path – specifically, the recommendations of the 1993 Royal Commission on New Reproductive Technologies (known hereafter as the Baird Commission, for its Chairperson Patricia Baird).

Beginning with the Baird Commission as the first "critical juncture" in the development of Canadian ART policy, this chapter traces the development of Canadian ART policy using the complementary theoretical lenses of historical institutionalism and policy framing. Specifically, I use process tracing to provide a qualitative textual analysis of the formative ideas present from the Baird Commission to the 2004 *Assisted Human Reproduction Act* (*AHR Act*). I argue that the Commission, operating within the legislative vacuum that characterized Canadian ART policy, created two ideational frames that had a palpable influence on subsequent policymaking endeavors: first, that ARTs were primarily (though not exclusively) a *medical-scientific* issue, rather than a

moral one; and second, that ARTs required *national* attention in the form of comprehensive federal legislation. Because of the wide latitude granted to the Baird Commission and the lack of legislation at the time, I argue it constituted a "critical juncture" for ART policy development in Canada, and that these competing frames have continued to shape the trajectory of ART policy to this day.

By starting with the Baird Commission, I build on Francesca Scala's work (2002, 2007, 2008), in which she used policy framing to conclude that the Commission's recommendations were dominated by a "liberal, pro-technology stance" (2002: 214). Groups advancing "moral" criticisms of ARTs, such as radical feminists and religious conservatives, were marginalized in favour of a medical-scientific position. I largely concur with Scala's analysis, but make two qualifications. First, while Scala makes a strong case that the medical frame was the dominant discourse propagated by the Commission's recommendations for *regulations*, she downplays the Commission's recommendations regarding criminal *prohibitions*. While the regulations embodied the medical frame, the justifications for criminal prohibitions hinged largely on "moral" language used by critics of assisted reproductive technologies.

Relatedly, while Scala focuses on the medical-scientific vs. moral dichotomy, I argue there was a second, equally important framing dichotomy: provincial vs. federal jurisdiction. In federal jurisdictions, how an issue is framed not only affects the content of the policy, but also the level of government that will intervene (Daviter 2011: 27). Just as actors and interest groups can structure, manipulate, and emphasize the way a debate is framed in order to influence policymakers' perceptions about the *content* of a public policy, so too can they frame policy as a matter of federal or provincial jurisdiction. In

addition to framing its regulatory recommendations as a medical-scientific issue, the Commission was adamant that they constituted a single field in which uniform national intervention was required. Crucially, this national frame was used to justify federal intervention with respect to both regulations and prohibitions. As subsequent chapters show, however, the medical-but-national frame made the constitutional justification for federal involvement far more difficult, particularly with respect to the regulations.

The Royal Commission on New Reproductive Technologies

Following the 1978 birth of Louise Brown, the world's first "test tube" baby conceived using in vitro fertilization (IVF), there was widespread concern about the implications of assisted reproductive technologies. In Canada, after several small studies of the legal and medical implications of assisted reproductive technologies, a collection of feminist academics and women's health organizations – concerned that the issue had been overly medicalized and that women's issues had been under-emphasized[9] – lobbied the federal government to initiate a large-scale policy discussion on these technologies. The Canadian Coalition for a Royal Commission on New Reproductive Technologies, formed in 1987, was particularly concerned about the implications of ARTs for women (Scala 2002: 110; see also Montpetit 2004; Jones and Salter 2007). As a response, in 1989 Prime Minister Brian Mulroney announced the creation of the Baird Commission, which was given a mandate to "inquire into and report on current and potential medical and

[9] These included the *Ninth Report of the British Columbia Royal Commission on Families and Children's Law* and the Ontario *Report of Human Artificial Reproduction and Related Matters*, as well as an inquiry from the Medical Research Council of Canada. As Scala (2002) notes, these inquiries were smaller in scale and "did not challenge the medical-scientific discourse on reproductive technologies"; the focus on "rights issues" effectively amounted to the "legal appropriation and validation of medical definitions of reproductive technologies" (2002: 97).

scientific developments related to new reproductive technologies, considering in particular their social, ethical, health, research, legal and economic implications and the public interest" (Canada 1993: 2).

There are many reasons that Mulroney chose to appoint a Royal Commission rather than legislate immediately. Most obviously, as its name suggests, the Canadian Coalition for a Royal Commission on New Reproductive Technologies was convinced that a large-scale independent study was needed to gauge how best to legislate with respect to these technologies. Second, Royal Commissions frequently serve as a way to "secure information as a basis for legislative policy" (Doern 1967: 421). Particularly in a field as novel as assisted reproductive technologies, the creation of a commission certainly provided a great deal of information for policymakers. In terms of prime ministerial self-interest, Royal Commissions have also frequently enabled governments "to postpone action on a politically embarrassing question" (Doern 1967: 421; see also Fowke 1948). This was certainly the case with the Baird Commission. By referring the subject to a panel of nonpartisan experts and giving the Commission a sweeping mandate, Mulroney was able to postpone public policy on such a divisive issue and avoid confrontation with women's groups, religious groups, legal organizations, medical organizations, and disability organizations concerned or excited about the prospect of these new technologies.

It took four years before the Commission finally reported. After consultation with over 15,000 Canadians, the Commission published its final report, *Proceed with Care*, on November 15, 1993. The report comprised 1,275 pages, two volumes, and 293 recommendations. Using a framework that stressed an "ethic of care," the Commission

made three general, overarching recommendations: prohibiting certain activities and technologies using the criminal code; regulating permissible activities; and establishing a federal regulatory and licensing body that would provide "permanent mechanisms" to respond to ARTs (Canada 1993: 1049). The recommendations attempted to find a middle ground by providing a flexible response to emerging technologies, while using the criminal law to prevent the use of potentially harmful technologies. Stressing the principle of "non-commercialization of reproduction," the Commission recommended criminalizing the buying, selling, or exchange of eggs, sperm, zygotes, fetal tissue, embryos, as well as payment for surrogacy. The Commission also recommended criminal prohibitions for sex selection for non-medical purposes, germ-line genetic alteration, ectogenesis, cloning human embryos, creating animal-human hybrids, retrieving sperm or eggs from fetuses or cadavers for fertilization, and research involving the maturation of sperm and eggs outside the human body (Canada 1993: 915-917, 942, 1022; Harvison Young 2005: 131). It suggested that various other technologies, such as prenatal diagnosis and assisted insemination, be subject to oversight and licensing by a National Reproductive Technologies Commission (NRTC).

In terms of the six subfields of assisted reproductive technologies identified in chapter two, the Commission recommended that most be subject to a combination of regulation and prohibition (see Table 3.1). With respect to *assisted conception*, the Commission recommended that payment for sperm and ova be criminalized, but also that other aspects – sperm collection and storage, assisted insemination, assisted conception, and egg retrieval, to name a few – be subject to compulsory licensing by the national commission. It called for an "integrated, uniform approach" to create a donor

insemination, and to "standardize sperm collection, service provision, and record-keeping practices" (Canada 1993: 472). The Commission recognized that "much of the responsibility" for creating regulations would lie with provincial health authorities, but ultimately decided that the newly-created national regulatory authority should bear responsibility for creating the overall system (473-475).

For *surrogacy*, the Commission recommended criminal prohibitions for payment, and permitted – though frowned upon – unpaid surrogacy (Canada 1993: 689). It also recommended that provinces and territories amend their family law legislation to make all surrogacy arrangements (contracts) unenforceable (690).

For *embryonic research*, the Commission sought to ban research directed towards the sale of fetal tissues, and the use of human zygotes/embryos after fourteen days. It recommended that the proposed National Commission create compulsory regulations for research on zygotes, and that informed consent be a principle in such research (108, 636-645). It recommended a ban on *human cloning* and various components of *screening, enhancement, and manipulation*, including ectogenesis (creating an artificial womb) and creating animal-human hybrids; however, it also recommended regulations for screening and enhancement, claiming there should be a regulatory licensing regime for prenatal diagnosis (xxxiii).

Finally, with respect to *parentage*, the Commission recommended provincial action, albeit with uniform standards. It claimed that "[m]atters so important to women and children, in terms not only of their health but of their legal status and how they are viewed, cannot differ from province to province" (xxvi). Yet it stopped short of recommending federal legislation, instead advocating legislation be adopted "in those

provinces where it does not already exist" to produce uniform legislation regarding the severance of parental ties to sperm donors, and legal parenthood for children born through assisted conception (468). The Commission doubtless recognized that, whatever the wisdom of having federal regulations, parental responsibility was unquestionably provincial jurisdiction, falling under the umbrella of family law.[10]

Table 3.1
Baird Commission Recommendations

	Federal Prohibitions	Federal Regulations	Provincial Regulations	Medical Regulations
Assisted Conception	Yes	Yes	No	No
Surrogacy	Yes	No	Yes	No
Embryonic Research	Yes	Yes	No	No
Human Cloning	Yes	No	No	No
Screening, Enhancement, Manipulation	Yes	Yes	No	Yes
Parentage	No	No	Yes	No

Clearly, the Commission envisioned that the federal government would be the key driver of ART policy. Between the criminal prohibitions and the proposed National Commission's regulations, each subfield of assisted reproductive technologies would be subject to federal involvement, with the exception of parentage (see Table 3.1). The only subfields where it recommended unilateral provincial legislation were surrogacy (nullifying surrogacy arrangements) and parentage (to clarify parental responsibility for

[10] As Boyd and Baldassi note, Canada's family law system represents a bit of a federal patchwork. The federal government defines marriage and divorce and administers certain benefits for couples. Most family law matters are provincial jurisdiction, including property, "custody, child support and spousal support outside of divorce" (2009: 112).

children born through assisted conception) – both with the goal of uniformity in mind. The Commission was also highly critical of the regulatory role of medical professionals, claiming that "levels of self-regulation and accountability vary enormously from one area of practice to another," and "many health care professionals are not well informed" about infertility and prenatal diagnosis (Canada 1993: 111, 1044). As a result, its recommendations for professional medical organizations were minimal, and mostly related to continued medical education, proposed standards for training, informed consent, and increased collaboration. The only recommendation that amounted to a regulatory role for medical professionals was that accreditation by the Canadian College of Medical Geneticists should be a precondition for the licensing of genetic centres (1043-1046). The rationale behind this national focus is discussed later in this chapter.

Opting for the Medical-Scientific Frame

While the Commission did not trust medical *professionals* to continue making ART policy, it nevertheless framed the technologies as primarily medical. In her detailed analysis of the Baird Commission, Francesca Scala (2002) identifies two incompatible positions regarding assisted reproductive technologies that were present during the Canadian debate. The first, which she refers to as the "medical-scientific" frame, "regards reproductive technologies as neutral and necessary, and transforms the patient into a client" (2002: 87). Those who subscribe to the medical-scientific frame were generally pro-technology; while they saw a role for the state in setting boundaries, they argued that the potential harms associated with assisted reproductive technologies can be "easily contained by suitable modes of regulation" (2002: 240). When ARTs are "medicalized,"

potential problems are "defined in medical terms, described using medical language understood through the adoption of a medical framework, or 'treated' with a medical intervention" (Conrad 2007: 6). The medical-scientific frame shares features (but is not identical) with what Engeli, Green-Pedersen, and Larsen refer to as the "secular" frame, insofar as it emphasizes individual reproductive autonomy, self-determination, non-discrimination, and scientific progress (2012c: 32). In large part, this frame was created and sustained during the Baird Commission by representatives from the medical and scientific community, who engaged in "boundary work," using their privileged societal position and expertise to "protect their autonomy and authority" by opposing both criminal sanctions and the creation of a regulatory body (Scala 2007: 220).

As Béland (2005: 11) notes, frames are "dialogical in nature: they anticipate what potential opponents could say to undermine the support for specific policy alternatives." The Baird Commission was no exception. In contrast to the medical-scientific frame was what I will refer to as the "moral" frame, the adherents of which applied a "broader critique of science and medicine" to assisted reproductive technologies (Scala 2002: 8). Proponents of the moral frame tend to call for outright prohibitions and moratoria on the use of technologies, and are generally pessimistic about the prospects of these technologies for society. They frequently make reference to the language of commodification, exploitation, commercialization, and social harms. While proponents of the medical frame tend to promote liberalized notions of reproduction and the family, opponents of ARTs typically include religious organizations, social conservatives, radical feminists, and people on the left concerned about a "new" eugenics (see Fukuyama 2002: 183). With respect to ARTs, moral framing can include what Engeli, Green-Pedersen,

and Larsen refer to as "religious" framing, which draws on explicitly religious doctrine, typically about the sanctity of human life and the need to avoid commodification, and "unsecular" framing, which "clearly oppose[s] secular arguments … without invoking religious values." Unsecular framing often include arguments regarding "family values, arguments about nature, slippery slope arguments or arguments critical of science, medicine or technology" (2012c: 32). While not all – or even most – groups opposing reproductive technologies during the Baird Commission were explicitly religious, there was considerable overlap between unsecular and secular arguments, confirming Engeli, Green-Pedersen, and Larsen's prediction that "[i]n some instances it can be difficult to distinguish clearly between religious and unsecular frames" (2012c: 32).

The medical-scientific and moral frames are indicative of a common split regarding two-sided "morality policies," which have become increasingly prominent in Western democracies since the latter half of the twentieth century (Engeli, Green-Pedersen, and Larsen 2012a; Smith and Tatalovich 2003; Studlar 2001). Morality policies – including abortion, same-sex marriage, prostitution, and euthanasia, among others – often involve "legal sanctions of right and wrong" over a "controversial issue of first principle" such as gender, sexuality, and religion (Mooney 2001: 3-4). The principles related to such policies are non-negotiable, typically presented by both sides as self-evident truths that cannot be resolved by mere argument (Black 1974, 23; see also Bowers 1984, xxiii). Because morality policy involves the regulation of "conduct deemed *good or bad in itself*" rather than by its consequences, compromise between opposing viewpoints is especially unlikely (Lowi 2005: xx, emphasis in original). Indeed, with respect to assisted reproductive technologies, Scala claims "the two positions – one in

favour of reproductive technologies and the other against it – were incommensurable" (2002: 210).

In many of these new "morality" conflicts – particularly prostitution and pornography – there exist "strange bedfellows," as some feminist organizations agree with religious organizations in opposing liberalization. This was the case with assisted reproductive technologies in Canada. During the Baird Commission, the Pentecostal Assemblies of Canada and the National Action Committee on the Status of Women both advocated restrictive ART legislation. While social conservatives and radical feminists are hardly traditional allies on issues such as abortion, gender roles, or religious doctrine, both are "highly suspicious of technology" which they perceive as having a "detrimental impact on the most vulnerable groups in society" (Scala 2002: 210). In the above terms, radical feminist arguments tended to be "unsecular," focusing on "slippery slope arguments or arguments critical of science, medicine or technology" rather than family values or the sanctity of life (Engeli, Green-Pedersen, and Larsen 2012c: 32). As a result, both groups advocated a restrictive approach to ARTs, although the feminist movement itself was heavily divided between radical feminists, who spoke in terms of "social justice" and favoured prohibition, and liberal feminists, who focused on "reproductive rights" and favoured regulation (Scala 2002: 100; Scala, Montpetit, and Fortier 2005).

Of these two perspectives, Scala concludes that the medical-scientific frame triumphed over the moral frame, as the structure and content of the Baird Commission's final report "consolidated the authority of medical-scientific experts and pushed to the margins the perspectives of expert and non-expert groups critical of reproductive technologies" (2002: iii). She identifies three interrelated reasons for this: the

organizational structure of the Commission, the privileged position Commissioners ascribed to the scientific community, and the Commission's "individual rights" discourse, stemming from Canada's then-recent legacy of abortion politics. Organizationally, the Commission was structured according to "classical bureaucratic norms of secrecy, centralized authority, and a hierarchical chain of command" (Scala 2008: 97). The buck stopped with Chairperson Baird, whose background in genetics left her open to the criticism that she was overly sympathetic to the medical-scientific frame (Scala 2002: 46). True, other Commissioners were more inclined towards the moral frame; Commissioners Louise Vandelac and Maureen McTeer, for example, openly supported a moratorium on certain technologies. However, they were frequently marginalized throughout the process. As a result, four Commissioners – McTeer, Vandelac, Maurice Hebert, and Bruce Hatfield – openly complained about Chairperson Baird's autocratic management style, which permitted her "scientific bias" to dominate proceedings (Scala 2008: 104). In an unprecedented move, the Prime Minister's Office fired the dissident Commissioners on December 6, 1991, replacing them with two Commissioners more sympathetic to the medical-scientific frame (Scala 2002: 163-165; see also Eichler 1998).

In addition to Baird's particular management style, Scala and others have claimed the Commission's overall organization was "driven by medical models of evaluation" and reflected a bias towards medical-scientific policymaking (Roberts 1999: 20). Public hearings were structured and timed to allow professional organizations a greater opportunity to influence the policy debate than other groups (Scala 2002: 7). The research team for prenatal diagnosis and genetic technologies was heavily tilted towards medical and scientific expertise, rather than social scientific and philosophical expertise (Scala

2008: 107). In vitro fertilization and embryonic research were "propelled by technological values and the positivist notion of 'scientific progress'" (Scala 2002: 79). Most importantly, the principle of "evidence-based research" guided the Commission's work, as Chairperson Baird and her staff frequently asked for quantitative data to substantiate claims counter to the medical-scientific frame (Scala 2008: 109). However, because arguments opposing assisted reproductive technologies are often based on difficult-to-quantify concerns such as "social harms," dehumanization, exploitation, and commodification – particularly when those arguments are future-oriented – evidence-based research tends to marginalize moral arguments in favour of medical-scientific ones.

At the same time, scientific lobbying was "accorded more power and authority relative to other forms of knowledge" (Scala 2007: 213; see also Baylis and Herder 2009b: 353). While professional organizations, including medical organizations, were certainly lobbying for certain policy outcomes that would favour their constituents, they were not regarded as interest groups *per se*, particularly compared with religious and feminist groups who sought to restrict access to assisted reproductive technologies:

> Presenters from professional associations, like the Canadian Medical Association and the Canadian Bar Association, were regarded [by Commissioners] as experts in their fields, imparting relevant and objective knowledge on the issue of reproductive technologies. Women's organizations, on the other hand, were regarded as advocacy groups representing particularized interests and value orientations. They were not regarded as 'experts' in women's health and social issues but rather

> proponents of a particular perspective on reproductive technologies (Scala 2002: 147).

As a result, the scientific community was able to relegate the concerns of other interest groups below their own. In reference to the Commission's work, Scala approvingly cites political scientists Anne Schneider and Helen Ingram (1997: 167), who assert that professional and scientific groups can "commandeer an issue with important social value implications and transform it into a matter of elite scientific and professional concern."

The Commissioners, particularly those who remained after four of their colleagues were fired, facilitated the dominance of the medical-scientific frame. For Rachel Ariss, although the Commission *claimed* to use Carol Gilligan's ethic of care as its dominant framework, in fact it relied heavily on bioethical principles such as beneficence in its recommendations. Radical feminist concerns, such as the "patriarchal culture of medicine and medical school, the long history of the exclusion of women from medicine, and medico-scientific stereotypic constructions of birth and femaleness," were systematically ignored in favour of the medical-scientific frame (Ariss 1996: 46). Some authors even went so far as to suggest that the biomedical industry was so powerful that government essentially surrendered to its demands (Eichler 1993).

"Anti-science" radical feminist arguments, particularly those that characterized medicine and health care as oppressive, male-dominated institutions, were largely unsuccessful before the Baird Commission (Scala 2002: 200). Instead, liberal feminist arguments were more successful, as the legacy of abortion rights contributed to an overall liberalized discourse that complemented the organizational dominance of the medical-scientific frame. Scala notes that infertility and disability were depicted as "diseases

amenable to medical treatments," which shifted the debate to funding and accessibility and "further validated the professional authority of the medical community" at the expense of those voices, groups, and individuals critical of ARTs (178).

To be fair, the Commissioners were certainly more nuanced than some of their detractors, including Scala, suggest; for example, they recognized that there was some legitimate concern over excessive medicalization, such as power imbalances between physicians and women, whose best interests do not always coincide (Canada 1993: 32-33; see also Baylis and Herder 2009b; Roberts 1999). And, as noted below, the Commission recommended several criminal prohibitions over the criticisms of medical professionals. On the whole, however, the Commission's organizational structure and recommendations certainly favoured the medical-scientific frame over the moral frame. Evidence-based medicine, rather than the "ethic of care," was the truly dominant paradigm: the Commission frequently asserted that policy disagreements could be overcome by a "step-by-step examination of evidence," a "systematic and rational approach," and a "careful examination and weighing of the evidence" (1993: 47, 71).

The Commission's recommendations make this particularly clear: it rejected a moratorium on assisted reproductive technologies because "[t]o deprive fully informed people of services that have been shown to make a difference in outcomes… would be inappropriate"; it claimed medicalization had "given some women options that otherwise might not have been available"; and it cited "substantial" potential benefits from fetal and embryonic research that created a duty to use such research to "avoid or prevent [human] suffering as much as possible" (Canada 1993: 14, 34, 1004). In areas over which there were (and still exist) significant ideological and philosophical dispute, the Commission

asserted unanimity; it claimed "[v]irtually all inquiries and advisory bodies" had agreed on the legitimacy of IVF and assisted insemination, the acceptability of certain forms of embryonic research, the permissibility of the use of donated gametes in ART, and the harmonization of parentage policy across the country (140). It is difficult to disagree with Ariss' assertion that the ethic of care was often used to "smother conflicts with niceness" (Ariss 1996: 4).

However, not every conflict was smothered. In spite of its reliance on the medical-scientific frame, the Commission did not take an entirely client-centred view of all assisted reproductive technologies. It declared several technologies and activities unacceptable, and its instrument of choice to police transgressions was the federal government's criminal law power.

Criminal Prohibitions in the Baird Commission

While the medical-scientific discourse undoubtedly framed the Commission's research and was made manifest in its regulatory recommendations, Scala and others have understated the extent to which moral arguments were used to justify the criminalization of certain technologies. The Commission noted that certain practices "conflict so sharply with the values espoused by Canadians… and are so potentially harmful to the interests of individuals and of society, that they must be prohibited by the federal government under threat of criminal sanction" (Canada 1993: 1022). These included any and all commercial for-profit activities related to human reproductive materials and surrogacy arrangements; human cloning; various types of embryonic research; genetic engineering; and unjustified medical interventions that threaten the autonomy of pregnant women

(108-109). Indeed, the Commission's proposed prohibitions were so extensive that they would encompass five of the six subfields of assisted reproduction described earlier in this chapter (see Table 3.1).

In contrast to the Commission's structure and its regulatory recommendations, the criminal recommendations did not stem from strict adherence to the medical-scientific frame. The entire twenty-fourth chapter of the report, "Commercial Interests and New Reproductive Technologies," frequently criticized commercial interests and the "profit motive." The Commission consistently made statements such as:

- "No profit should be made from the selling of any reproductive material… because of its ultimately dehumanizing effects" (447).
- "The impact of market forces in the area of human reproduction could, if not properly regulated, undermine important social values and ethical principles and harm people by leading to inappropriate, unethical, or unsafe use of technology" (699).
- "The presence of a profit motive means that commercially funded research is particularly in need of independent research ethics board approval" (713).
- "The Commission strongly opposes the development of a two-tier health care system" (716).
- "To allow commercial exchanges of this type would undermine respect for human life and dignity and lead to the commodification of women and children" (718).
- "Adoption of these recommendations would ensure that the commercial impetus is contained and regulated so that the vulnerable interests of individuals and society are protected" (725).

The language of dehumanization, human dignity, commodification, "two-tier" health care, and constraining the commercial impetus hardly represents an assertion of the medical-scientific frame, which, according to Scala, regards assisted reproductive technologies as "neutral, necessary, and client-centred" (2002: 9). Moreover, criminalizing compensation for surrogacy and reproductive material, prohibiting private health insurance, and banning various types of genetic and embryonic research do not privilege "technological values and the positivist notion of 'scientific progress'" (Scala 2002: 79). Medical professionals themselves strongly opposed the prohibitions, as Scala herself notes. The Canadian Medical Association at once point complained that proposed criminal prohibitions were "an unjustified intrusion of the government's criminal law power into the patient-physician relationship" and would "create a chill on much needed research on reproductive and genetic technologies"; likewise, the Canadian Fertility and Andrology Society (CFAS) and the Society of Obstetricians and Gynaecologists of Canada (SOGC) felt prohibitions would amount to "total control by the government" (Scala 2007: 223; see also Healy 1995).

In sum, there is considerable evidence that Scala and others are correct in their determination that the Commission, on the whole, privileged the medical-scientific over the moral frame in terms of how it cast the policy debate over assisted reproductive technologies. The organizational structure of the Commission, the focus on evidence-based research, Chairperson Baird's top-down leadership style and personal history as a geneticist, the expert status attributed to medical and scientific professionals, and the individual rights discourse all contributed to this privileged position in the dominant frame. This medical-scientific predisposition was reflected in the general tenor of the

Commission's regulatory recommendations. However, when it came to certain activities and technologies that the Commission sought to deter, both the method (criminal prohibition) and the language were reflective of the moral frame and hostile to medical-scientific assumptions.

Why the incongruity? Why was a Commission that was systematic in its dismissal of moral arguments so quick to adopt those arguments when arguing for criminal prohibitions? Part of the reason is that the Royal Commission was not *uniformly* framed in favour of assisted reproductive technologies. The mere existence of criminal prohibitions provides evidence for this, as does its anti-commercialization bent. However, another reason lies in a second frame that the Commission consistently adopted throughout its report: that assisted reproductive technologies are an issue of inherent national, rather than provincial, concern.

Framing ART Policy in the National Interest

In comparative terms, Canada is a "jurisdictional federation," insofar as competencies to enact legislation are distributed between the federal and subnational governments (Montpetit, Rothmayr, and Varone 2005: 129; see also Braun 2000). Both the federal government and the provinces have primary responsibility for policy formulation and implementation in specific policy fields, enumerated through sections 91 and 92 of the *Constitution Act, 1867*. In many policy fields, jurisdiction is clear; few would dispute federal authority over military and national defense (section 91.7) or provincial authority over municipalities (section 92.8).

Yet the Constitution is less clear about relatively new policy fields, because existing constitutional provisions are often described in broad, general terms. Unsurprisingly, the Constitution does not assign jurisdiction over assisted reproductive technologies; in fact, it does not even assign clear jurisdiction over health care. Over the years Canadian courts tended to favour the provinces, as three provincial grants of jurisdiction have become tantamount to provincial health care jurisdiction: section 92(7), the "Establishment, Maintenance, and management of Hospitals, Asylums, Charities, and Eleemosynary Institutions"; section 92(13), "Property and Civil Rights in the Province," and section 92(16), "Generally all Matters of a merely local or private Nature in the Province." As a result, provinces are primarily responsible for health care by allocating spending and administering health insurance plans.[11] However, health care jurisdiction is complicated by two federal grants in the *Constitution Act, 1867*. First, section 91 gives the federal government a residual power to make laws for the "Peace, Order, and Good Government of Canada." Second, section 91(27) grants the federal government jurisdiction over criminal law. Federal policies that touch on both health care and the criminal law – such as prohibitions on tobacco advertising and marijuana – have been tested in (and largely upheld by) the Supreme Court of Canada in recent years (*R. v. Malmo-Levine, R. v. Caine* 2003; *RJR-MacDonald Inc. v. Canada (A.G.)* 1995).

Given the predominance of provincial governments in the creation of health care policy, the Baird Commission ought to have recognized considerable ambiguity over

[11] The federal government certainly has a role in Canadian health care policy. It has an entire ministry dedicated to health care (Health Canada), distributes billions of dollars to the provinces annually for health care purposes, and establishes standards for funding in the *Canada Health Act* (CHA). The federal government's main contribution to health care is financial, by offering block grants to the provinces through the Canadian Health Transfer (CHT) and threatening to withhold funds from the provinces for violating the principles in the CHA (Maioni 2008: 162-169).

whether ART regulation fell under federal or provincial jurisdiction. Criminal prohibitions would certainly constitute valid federal law under section 91.27, but the constitutionality of regulations related in principle to criminal prohibitions, such as physician permits, clinical licensing, and embryo transfer, was less clear. However, the Commission was unequivocal in its desire for a national framework and, with few exemptions, it called for the federal government to play the dominant role. The title of its first chapter – "A Comprehensive Response to Issues of National Importance" – sums up the Commissioners' views on the jurisdictional question.

Although Scala notes that the Commission dedicated space "to legitimising, constitutionally, the federal government's jurisdictional power to introduce legislation" (2002: 235), she does not devote much attention to the Commission's deliberate national framing strategy. I posit, however, that the Commission's decision to frame ARTs as a policy field that *only* the federal government could properly regulate is crucial to understanding the policy that developed from the Commission's recommendations. As Daviter notes, "[f]raming strategies that reorder jurisdictional responsibilities and translate into the empowerment of specific policy venues… limit the possibilities of frame contestation and can help to keep framing effects steady" (2011: 52). In initial stages of a policy's development in a federation, policy framing is relevant both with respect to policy *content* and policy *jurisdiction*. Decisions over jurisdictional capacity can be as important as decisions regarding the content of the policy itself.

In this vein, the Commission's efforts to frame ARTs as a field necessitating federal intervention were ubiquitous. It claimed ARTs were "unique in Canada's health care system" in that they "raise issues that require *national* attention" (Canada 1993: 16,

emphasis added). It stressed that a national strategy was "the only feasible response… [t]he field is developing too rapidly, the consequences of inaction are too great, and the potential for harm to individuals and to society is too serious to allow Canada's response to be delayed, fragmented, or tentative" (xxxv). It was hostile to anything other than a subordinate policy-making role for the provinces by claiming "[n]o other body [besides the federal government] is sufficiently broadly based or has the mandate" to implement ART policy (xxxvi). In recommending a national approach, the Commission also adopted a *holistic* approach that saw assisted reproductive technologies as constituting one inter-related policy field. It saw the compartmentalizing of assisted reproductive technologies as a further guarantee of poor public policy, rejecting the idea that ARTs could be effectively "subdivided into component parts and left to provincial legislatures, or delegated to self-governing professional bodies, for regulation on a province-by-province or even an institution-by-institution basis" (18). Instead, the proposed national regulatory agency should "assume comprehensive regulatory responsibility in this area" (122). Its functions would be immense, including "licensing and monitoring; guideline and standard setting; information collection, evaluation, and dissemination; record storage; consultation, coordination, and intergovernmental cooperation; and monitoring of future technologies and practice" (116). The Commission cited the desire of other groups for a national strategy, including the Ontario Medical Association, the Law Reform Commission of Canada, and the National Advisory Council on the Status of Women (13-18). Finally, it even claimed a national response was the preferred strategy of the general public, as it found "consistent and widespread demand for national leadership and action in relation to new reproductive technologies" (11).

The Commission did recommend a small role for provincial/territorial governments and professional medical organizations, but that role would be minor and subordinate to the federal government. It recommended that provincial family law, particularly parentage law, be amended "to reflect the reality of assisted conception," although it hoped the federal government would facilitate harmonization of such policy (1041). The Commission recognized that provincial consultation and cooperation was necessary, but generally limited such cooperation to public health educational campaigns concerning "infertility prevention, occupational health and safety, and adoption policy" (1041). With respect to medical organizations, the Commission made various recommendations for "education, training, and practices of health care professionals," as well as the creation of professional guidelines for treatment outside of a licensed clinic (1044-1046). However, there was a clear pattern throughout the recommendations that the federal government needed to have the dominant role: "[i]t is unrealistic to expect self-regulating professional bodies, or the provinces, individually or together, to provide the necessary level of regulation and control on issues that transcend not only provincial but national and intergenerational boundaries and have implications for all Canadians" (12). In sum, the technologies were "too important… to be left to be resolved by a fragmented and disjointed sector-by-sector or province-by-province approach" (17).

Throughout the entire report, the national frame was ubiquitous; at no point was it ever suggested Canada might be better off if even some of the subfields of assisted reproductive technologies were left to regulation by provinces or medical associations. Several factors explain this strong commitment to centralization. The first is the Commission's terms of reference, which, under Order-in-Council 1989-2150, were to

"inquire into and report on current and potential medical and scientific developments related to new reproductive technologies, considering in particular their social, ethical, health, research, legal and economic implications and the public interest, recommending what policies and safeguards should be applied." The terms of reference were framed broadly, so as to examine "in particular" the implications of ARTs for "women's reproductive health and well-being," "the status and rights of people using or contributing to reproductive services," and "the impact of these services on all concerned parties, particularly the children" (Canada 1993: 3). True, the federal government neither limited the Commission to exploring the federal role nor excluded it from making recommendations for provincial action. However, its broad scope lent itself to recommendations for federal action. Women's reproductive health, the rights of ART donors and patients, and the impact on children are hardly ever framed – and certainly were not framed by the Commission – as matters of provincial jurisdiction. The overall tone of the terms of reference, cast in terms of the importance of the developing technologies, was conducive to national recommendations.

Another factor, perhaps obvious but certainly worth noting, is that the *federal* government, not a provincial government, appointed the Commission. Federal Royal Commissions rarely recommend a robust provincial response to issues of perceived national importance. However, it is also true that not every federal Royal Commission makes as strong a case for national uniformity as the Baird Commission did. While the 2002 Royal Commission on the Future of Health Care in Canada (the Romanow Commission) certainly made recommendations for sustained federal intervention in the field of health care, it did not suggest that provincial governments abandon the field. A

major difference between the Baird Commission (which for the most part recommended *only* federal action in the field of Health Care) and the Romanow Commission (which recommended intergovernmental collaboration and national standards and funding, but emphasized a continued provincial role) is one of existing policy frameworks. In 1989 and even 1993, there was a policy vacuum in the six subfields of assisted reproductive technology policy; the Commission did not need to work around existing provincial structures, which meant an almost entirely national plan was much more feasible. Thus, the fact that the Commission was a "critical juncture" matters as much for policy jurisdiction as it did for content. Coupled with Chairperson Baird's strong belief in the importance of federal action and the fact that issues affecting women and children tend not to be thought of as merely provincial, it is not particularly surprising that the nationally-appointed Commission was inclined toward national action.

The Constitutional Justifications for National Action

While the Commission was committed to a national strategy, it did recognize, albeit without sufficient attention, that there were legitimate concerns over whether the federal government had the *constitutional* authority to create a national commission with permanent regulatory over certain areas of health care policy. The Baird Commission's recommendations were justified not just as a matter of desirable policy but also of constitutional law; it was convinced that the Canadian Constitution supported a centralized scheme. As mentioned above, Canadian courts have generally ascribed Canadian health care jurisdiction to the provinces. However, federal legislation that touches on provincial health care jurisdiction can be valid, provided it falls within a

legitimate federal power under the *Constitution Act, 1867*. The Commission cited both the criminal law power and the power to make laws for the "Peace, Order, and Good Government" (POGG) of Canada as legitimate federal powers for legislating ART policy.

The Commission relied on the POGG clause most heavily. As explained in greater detail in Chapter 5, by 1993 the Supreme Court of Canada had determined that POGG enables the federal government to enact legislation that might otherwise come within provincial jurisdiction in one of two instances. First, it can do so temporarily (and very extensively) in order to respond to emergency situations (see *Re Board of Commerce Act* 1922; *Fort Frances Pulp & Power Co. v. Manitoba Free Press* 1923; *Toronto Electric Commissioners v. Snider* 1925). However, while some of the Baird Commission's rhetoric reflected an "emergency" tone – such as its pronouncement that "[t]he field is developing too rapidly, the consequences of inaction are too great" – it did not intend for federal legislation to be a temporary response to an emergency. Indeed, its recommendation that "permanent mechanisms should be put in place" was antithetical to temporary action (Canada 1993: xxxv, 1049).

Absent an emergency, the federal government also has the authority to invoke POGG to justify permanent legislation in matters that *prima facie* implicate provincial jurisdiction if those matters have attained a sufficient "national dimension" or "national concern." The Commission referenced this branch of POGG early and often in its first chapter, claiming it gave the federal government a "clear basis for seeking national action" over assisted reproductive technologies (Canada 1993: 18-19). It approvingly cited, without reference to any cases, that the Supreme Court permitted invoking POGG when Parliament was legislating in areas of "genuine national concern" that possess "a

degree of singleness, distinctiveness, and indivisibility." It also claimed the Court had permitted the federal government to invoke POGG in the case of a "province's failure to regulate the intraprovincial aspects" of a matter through interprovincial cooperation, particularly if the legislative matter had "extraprovincial dimensions." While acknowledging that ARTs touched on "health issues," the Commission claimed the convergence of "other individual and societal issues" necessitated a national response. In its view, the new ART issues had attained such "profound importance" and exhibited such "inter-relatedness" that federal restriction of traditional provincial jurisdiction was justified (18-19).

From a constitutional law perspective, the Commission's evidence was not particularly convincing. True, "indivisibility," "distinctiveness," and "provincial inability" were all doctrinal tests that a majority of the Supreme Court had accepted as constitutional justification for federal action in the past (*Munro v. National Capital Commission* 1966; *R. v. Crown Zellerbach* 1988; *Reference re Anti-Inflation Act* 1976; see also Baier 2006: 128-142). However, the Commission made insufficient comparison between the content of some of those cases – such as the creation of a national capital region, fighting inflation, and combating environmental pollution – and assisted reproductive technologies. In particular, it did not draw a close enough connection between justifications based on *effectiveness*, listed above, and arguments based on *constitutionality*. The Commission instead relied on overly broad arguments, such as the fact that ARTs were "so important to women and children," were "unique in Canada's health care system" (what isn't?), raised "fundamental social, moral, legal, and ethical implications," reflected a "widely held public view… [that ARTs] *require* a national

response," and had "social implications" that could not be contained "within the boundaries of a single province**"** (Canada 1993: xxxvi, 16, 18, 21, emphasis in original). Jurisprudentially, the Commission's only reference to a "clear precedent" was that "radio and television broadcasting is regulated and monitored through a licensing agency for the Canadian public interest" (xxxvi).

The second constitutional lever that the Baird Commission referenced was the federal government's power to create criminal law. It justified the criminal law as an instrument for those activities which "conflict so sharply with the values espoused by Canadians and by this Commission" (1022). As such, its recommendations for outright prohibitions, such as those for payment for gametes, human cloning, and genetic engineering, relied on this power. Calling the Criminal Code "the most stringent form of control available" (108), however, the Commission limited the criminal law power's applicability to those technologies and activities that would be criminally proscribed with appropriate penalties. The Commission also briefly mentioned other areas of federal jurisdiction – including jurisdiction over environmental regulation, health care on Indian reserves, federal penitentiaries, and the federal spending power – that could theoretically justify federal intervention (79). However, it dedicated virtually no time to these supplementary arguments, and minimal time to criminal law justifications relative to POGG.

In sum, the Baird Commission constitutionally legitimized comprehensive federal intervention over assisted reproductive technologies by suggesting the federal government could use the criminal law power to justify the criminal prohibitions and the "national concern" branch of POGG to justify the regulations. Under such an

arrangement, the criminal prohibitions would almost certainly pass constitutional scrutiny, provided the legislation included a valid criminal purpose with a punishment (see *Reference re Validity of Section 5(a) of the Dairy Industry Act* 1949; Ogbogu 2013). The POGG arguments, however, rested on a shaky constitutional foundation, which the Commission certainly and dangerously underplayed in its final recommendations. Indeed, by 2010 the POGG clause had fallen into such disuse by the Supreme Court that the Commission's arguments would be turned on their head, as the federal government defended federal prohibitions *and* regulations using the criminal law power, dispensing with the Commission's POGG arguments entirely (see Chapter 5). As the next chapter attests, however, even in the midst of changing federalism jurisprudence, the Commission's dominant recommendations and framing strategies remained remarkably salient and consistent throughout the legislative process.

Conclusion: The Commission's Unintended Consequences

Like other Royal Commissions, the Baird Commission was *ad hoc*, public, and investigatory. It made recommendations but it did not legislate. The mere publication of a national report – even one as encompassing as this – does not immediately produce institutionalization. However, as I will detail in the subsequent chapter, the Baird Commission's recommendations had a formative, lasting effect beyond the scope of other Royal Commissions. The two most prominent recent Commissions, the 1996 *Royal Commission on Aboriginal Peoples* and the 2002 *Royal Commission on the Future of Health Care in Canada*, did not produce the sweeping changes envisioned by their Commissioners. By contrast, the Baird Commission's chief recommendations – federal

prohibitions, regulations, and a national commission – all came to fruition in the *Assisted Human Reproduction Act*, as detailed in Chapter 4.

Subsequent chapters will show that the Commission's framing substantially affected the trajectory of Canadian ART policy, and that the Baird Commission – an institutional setting where "actors' decisions" were "freer during phrases of change" – should itself be viewed as a "critical juncture," defined as a short time period "during which there is a substantially heightened probability that agents' choices will affect the outcome of interest" (Capoccia and Keleman 2007: 348-349). In a field as encompassing and controversial as assisted reproductive technologies, the wide latitude granted to the Commission meant the ideas it used to frame the emerging debate would become especially crucial. As noted by Scala (2002, 2007, 2008), the Commission's organizational structure, the scientific community's privileged position, and the individual rights discourse made the medical-scientific frame dominant for much of the Commission's recommendations. On balance, the evidence from the Baird Commission suggests that the medical-scientific frame was given precedence over the moral frame. However, my analysis in this chapter offers a few qualifications. The first relates to the recommendations for criminal prohibitions. In effect, the Commission created a "division of labour" between positive (medical-scientific) practices that should be regulated and negative (immoral) practices that should be proscribed. While the Commission's overall framework and its regulatory recommendations subscribed to the medical-scientific frame, its other recommendations – particularly those related to commercialization – were framed as "moral" issues requiring criminal prohibitions. Second, and relatedly, the Commission recommended that five of the six subfields of assisted reproductive

technology policy fall under federal rather than provincial jurisdiction, deliberately selecting a "national" frame.

Just as the policy framing literature would predict, the Commission selected, emphasized, and manipulated particular aspects of the policy issue to influence and limit the perception of available choices to future policymakers (see Daviter 2011: 2, 52). It consciously chose to represent assisted reproductive technologies as a policy field that was primarily medically beneficial, but nevertheless required a uniform national response. However, those in the policy framing perspective also stress that political scientists must pay close attention to the way in which "framing effects interact with the organization of politics" (Daviter 2011: 3). It is my contention that that Commissioners' framing did not adequately take into account the organization of Canadian politics, specifically the constitutional incommensurability of its dual medical/national frame. The Commissioners did not realize that framing the positive aspects of ART policy from a primarily "medical-scientific" perspective deprived the federal government of much of the constitutional ammunition that would permit a "national" response. Coupled with the Supreme Court of Canada's evolving jurisprudence on the division of powers, this made the Baird Commission's recommendations constitutionally risky.

The Commission's framing strategy, particularly its faith in federal policymaking authority, had an undeniable influence on the way future policymakers viewed assisted reproductive technologies. It also put the federal government on a collision course with the provinces in the Supreme Court of Canada. The following two chapters examine the way in which the two vehicles – the federal Parliament and the Supreme Court of Canada – came crashing together in 2010, nearly two decades after the Commission reported.

CHAPTER FOUR:

FROM COMMISSION TO CONCEPTION – THE ASSISTED HUMAN REPRODUCTION ACT

In Chapter 3, I showed how ideas mattered early in the federal policymaking process for ART policy. The organizational structure of the Royal Commission, dependent on the leadership and ideological predispositions of its Chairperson, meant that certain frames were emphasized while others were systemically underplayed or even omitted. ARTs were successfully framed as a primarily medical-scientific issue requiring national intervention, which led to the formation of Canadian ART policy. The Baird Commission's goal was to have ART policymaking take place in particular institutional venues, namely the federal government.

This chapter moves beyond the Baird Commission to the major public policy that it produced: the 2004 *Assisted Human Reproduction Act* (*AHR Act*). While many studies recognize that the Baird Commission's influence on the *AHR Act* (Jones and Salter 2010; Montpetit 2007a), few have examined the legislative debates and committee hearings that followed the Commission's recommendations. This chapter thus includes a qualitative analysis of legislative proposals, legislative debates, and expert analysis at Committee hearings, as well as journalistic and academic commentary pertaining to this legislation. In it, I use the same dual lenses of policy framing and historical institutionalism that were adopted in the previous chapter, and find that the dominant frames were systematically reproduced throughout the process. My analysis demonstrates that, with minor exceptions, the Baird Commission's recommendations regarding content *and* jurisdiction were reproduced in the *Assisted Human Reproduction Act*. Specifically, the medical-

scientific frame was used for regulated activities, while the moral frame was prominent in justifying proposed criminal prohibitions. While there was some ambivalence on this front, however, the national frame dominated the entire proceeding, and was rarely questioned by policymakers. In effect, the dominant ideas in one temporary institution (the Baird Commission) created a new policy framework (*AHR Act*), albeit one whose institutionalization would be long in the making and never fully completed.

After the Royal Commission: A Long Gestation

The Baird Commission did not immediately, or even necessarily, lead to the creation of legislation. There was no guarantee that policymakers would adopt its recommendations, particularly given the fact that the Commissioners themselves held no political power; a Royal Commission is "dismantled once it has carried out its investigatory function on a specific policy topic" (Doern 1967: 418). Indeed, 1993, the year the Commission reported, brought with it a change in the Canadian power structure. By the time the Commission reported in November, Jean Chretien's Liberal Party had swept to power with a majority government, while the previously governing Progressive Conservatives were decimated, returning just two seats in the 1993 federal election. Regardless of the fact that the Commission itself was not a partisan exercise, there was no inherent reason for the new government to feel obliged to listen to its recommendations.

However, the Commission's recommendations – particularly the desire to produce a national framework on ARTs – were something the incoming Liberal government was attracted to, albeit not with any great immediacy. In the wake of deficit-slashing measures in the 1990s, the creation of a framework to deal with reproductive

technologies was not at the top of the legislative agenda. Nevertheless, ARTs never fell of the agenda entirely. Beginning in 1994, the year after the Commission reported, there were a series of federal initiatives that would continue for a decade until the *AHR Act* was passed in 2004. Table 4.1 lists these initiatives, beginning with the Commission itself.

Table 4.1
Federal Responses to ART

	Date Created*	**Initiated By**	**Content**	**Outcome**
Baird Commission	October 1989	Federal Government	Recommended: Prohibitions Regulations Agency	Reported November 15, 1993
Voluntary Moratorium	July 1995	Federal Government	Moratorium	Announced
Bill C-47	June 1996	Federal Government	Prohibitions	Died on Order Paper (Election) April 27, 1997
Setting Boundaries	June 1996	Minister of Health	Recommended: Regulations	Sent to public
Bill C-247	October 1997	Bloc MP	Prohibitions	Died on Order Paper (Prorogation) First Reading September 18, 1999
Bill C-336	April 2001	Bloc MP	Prohibitions	Died on Order Paper (Prorogation) First Reading September 16, 2002
Draft Legislation	May 2001	Minister of Health	Prohibitions Regulations	Referred to Standing Committee on Health
Brown Committee	December 2001	All-Party Committee	Prohibitions Regulations Agency	Presented to Government
Bill C-56	May 2002	Federal Government	Prohibitions Regulations Agency	Died on Order Paper (Prorogation) Referral to Committee September 16, 2002
Bill C-13	October 2002	Federal Government	Prohibitions Regulations Agency	Died on Order Paper (Election) Second Reading in Senate November 12, 2003
Bill C-6	February 2004	Federal Government	Prohibitions Regulations Agency	Royal Assent March 29, 2004

* For legislation, this is the date of first reading.

The post-Commission items in Table 4.1 fall into three stages of parliamentary development: the failed Bill C-47 (including its aftermath); the Standing Committee on Health's report on draft legislation in 2001 (the Brown Committee); and the three subsequent legislative attempts that ultimately culminated in the *AHR Act*.

Bill C-47: Criminalizing Issues of Grave Concern

In 1994, Health Canada initiated a consultation of the Commission's recommendations with 50 stakeholders (Baylis and Herder 2009a: 113). Then, in 1995, the Minister of Health announced a voluntary moratorium on nine of the practices for which the Baird Commission had recommended criminal prohibitions. The activities included in the moratorium covered five of the six areas of ART policy:

- Assisted conception (purchasing or selling eggs, sperm and embryos; egg donation in exchange for IVF)
- Surrogacy (commercial surrogacy arrangements)
- Embryonic research (non-reproductive human cloning)
- Human cloning (reproductive human cloning)
- Screening Enhancement, and Manipulation (germ-line engineering; non-medical sex selection; retrieval of reproductive material from cadavers and fetuses; ectogenesis; creating animal-hybrids) (Norris 2012: 2).

The moratorium was primarily targeted at medical practitioners and scientific researchers. However, there was soon evidence that certain clinicians and physicians were not abiding by the moratorium (Jones and Salter 2010: 428; Health Canada 1996:

25).[12] After the creation of an *ad hoc* committee charged with defining the status of human embryos, the federal government made its first attempt at creating ART legislation in 1996. Bill C-47, *the Human Reproductive and Genetic Technologies Act*, would have given teeth to the moratorium by imposing criminal sanctions. In addition to criminalizing the above activities, it would have criminalized the use of sperm/ova without consent, transfer of embryos between human and other species, research on embryos after 14 days, the creation of embryos solely for research, and offers to pay for any prohibited practices (Health Canada 1996; Norris 2012: 2). While it did not contain regulations, the bill was created with the expectation that a second bill would introduce a regulatory framework consistent with the Baird Commission's recommendations (Norris 2012: 2).

By focusing on the most unacceptable practices, the Bill did not at all fit with the "medical-scientific" frame described in Chapter 3; indeed, it began with the preamble that the Parliament of Canada was "gravely concerned" about threats to human dignity, health, and safety. This made the Bill far more consistent with the moral frame. One commentator claimed the tone of the legislation was "quite simply hostile to reproductive technology," as it made no mention of individual rights and "essentially ignored the *Charter*" (Harvison Young 2005: 128). It was not well received by medical and professional organizations; Jones and Salter refer to C-47 as "almost a slap on the wrist" for physicians not abiding by the terms of the moratorium (2010: 427). In sum, it was a far cry from the medical-scientific frame that dominated the Commission's proceedings.

[12] According to Health Canada's 1996 report, many physicians were openly ignoring the moratorium: "Two sex selection clinics operate in Canada; payment to sperm donors continues to occur in most facilities; seven advertisements have appeared to date in student newspapers seeking women to sell their eggs; and one physician has reported that he has been approached by women to have sperm removed from the corpses of their dead husbands so that they may attempt pregnancy" (Health Canada 1996: 25).

The Bill made it to the second reading, was referred to the Standing Committee on Health, and brought back to the House of Commons, where it died on the order paper on April 16, 1997.

At the same time, the federal government announced the "third phase" of its plan to deal with ART policy, following the voluntary moratorium and Bill C-47. In 1996, Health Canada released a discussion paper, entitled *New Reproductive Technologies: Setting Boundaries, Enhancing Health*. This paper was the first to put forward the federal government's proposed regulatory framework, and it was far more consistent with the medical-scientific frame than the moral frame, although it did endorse the criminal prohibitions in Bill C-47. Like Bill C-47, it also conformed to the national frame, as the federal government would implement all the proposals. It did include one new gesture to the provinces: it was the first federal proposal to include a provision for the creation of "equivalency agreements," whereby federal regulations could be suspended if a province or territory enacted a regulation that was "substantially the same as, but not necessarily identical to, the federal legislation in substance and enforcement" (Health Canada 1996: 33). Nevertheless, by mandating that such agreements would be the same as existing federal regulations, provinces would be clearly subservient to the federal government.

In terms of institutionalization, the document proposed that the federal regulatory structure "could" include an agency separate from Health Canada, which would report to the Minister of Health, but was not as definitive about the agency as the Baird Commission (Health Canada 1996: 8, 27). Regardless of whether it would take place within a separate agency or simply within Health Canada, federal ART regulatory work would include issuing licenses, monitoring compliance through enforcement, creating

and maintaining information registries, and developing national standards for the use of reproductive materials. These standards would be subject to Ministerial approval (28-32; see Table 4.2). The Department's goal was to pass Bill C-47 and then introduce these regulatory aspects as an amendment to that legislation, in order to produce a "single piece of legislation containing both prohibitions and regulatory controls" (27). However, after an election was called in 1997, Bill C-47 died on the order paper.[13]

The Brown Committee: Continuing Centralization

Following the 1997 election, the pace of legislative development was slow. Health Canada continued its consultations with stakeholders, including provincial and territorial governments, and issued a feedback report in 2000 (Health Canada 2013; Norris 2012). Provincial governments themselves showed no strong position on federal legislation, although the Province of Quebec would in subsequent years oppose the legislation quite strongly. Rather than tabling the draft legislation as a Bill in the House of Commons, federal Minister of Health Alan Rock asked that the House of Commons Standing Committee on Health first examine the document, entitled *Proposals for Legislation Governing Assisted Human Reproduction*, and provide recommendations. This draft legislation was given to the Committee – often referred to in the Canadian ART literature as the "Brown Committee" after its chairperson, Liberal MP Bonnie Brown – in May 2001, and the Committee released a report with its own recommendations in December 2001, entitled *Assisted Human Reproduction: Building Families*.

[13] During the same session of Parliament, Bloc Québécois MP Pauline Picard also introduced private member's legislation in the form of Bill C-247. The legislation sought to prohibit human cloning through the Criminal Code. Picard sponsored a similar bill in 2001 (Bill C-336, see Table 4.1). Like most private members' legislation, both bills died on the order paper before they made it to second reading.

The Committee, which maintained the national frame, made 33 recommendations based on the draft legislation. The biggest difference between the draft legislation and previous legislation was the distinction between "prohibited activities," which were banned by the legislation itself, and "controlled activities," which could only be carried out with a license in accordance with regulations. Under this framework, both prohibitions and controlled activities would be brought in at the same time by Parliament. The Committee made only minor adjustments to the recommended criminal prohibitions, approving of bans for the following technologies and activities: reproductive and non-reproductive human cloning, germ-line engineering, ectogenesis, creating embryos solely for research, the removal of gametes from embryos in order to create another embryo, animal-human reproductive experimentation, non-medical sex selection, paid surrogacy, the purchase of gametes and embryos, and the use of reproductive materials without consent. Like those in the moratorium, these bans encompassed five of the six areas of ART policy, with the exception of parentage.

While it did not suggest the legislation articulate regulations directly, the Brown Committee did recommend that regulations subsequently be developed in a number of areas, such as counseling, eligibility requirements for donors, and the maximum number of eggs that could be harvested (Canada 2001b: 17). It made a host of recommendations relating to the legislation's proposed Personal Health Information Registry, which would collect information about donors and donor offspring. Along these lines, it recommended that the federal Minister of Justice collaborate with the provinces and territories in order to create uniform parentage legislation, as the Baird Commission had recommended (22). Additional recommendations made by the Committee include a three-year parliamentary

review clause (the draft legislation had set it at five years), and the replacement of a legislative preamble with a statutory declaration, which would have greater legal force.

The draft legislation had left open the possibility for an arms-length body to deal with monitoring, licensing, and regulations. As Health Minister Allan Rock told the committee, "we need your advice on how this body could be structured – whether it should be part of Health Canada or an external organization" (Canada 2001a). The Brown Committee, like the Baird Commission, found "most witnesses felt that an arm's length agency would be more appropriate" (Canada 2001b: 25). Yet the agency would not be nearly as autonomous as the Commission had envisioned. Under the Committee's recommendations, regulatory authority would rest with the Minister and the Department of Health, who "would be responsible for establishing general policies and standards" as well as enforcement and inspection. The Committee defended its approach by claiming that "requiring the agency to report to the Minister is more in keeping with the principle of ministerial accountability," and would also facilitate intergovernmental cooperation (25). The Committee did include a provision that all ART regulations coming from the Minister would be subject to approval or modification by the House of Commons within 30 sitting days (19). The national agency, which would be given a statutory base and have a Board of Governors, would be tasked with maintaining a personal health information registry, keeping abreast of national and international trends, issuing licenses, ensuring compliance, and public reporting. The overall direction of the agency, as well as ART regulations, would rest with the Minister of Health (25-28; see Table 4.2).

Bills C-56, C-13, and C-6: The AHR Act Comes to Fruition

Following the Committee's recommendations, Bill C-56, *An Act Respecting Assisted Human Reproduction*, was introduced in May 2002. The Act was far more comprehensive than Bill C-47, containing both provisions for prohibitions, regulations, and a semiautonomous national agency. Bill C-56 was referred to committee, but died on the order paper when Parliament was prorogued in September. Bill C-13, an exact replication of Bill C-56, was introduced on October 9, 2002. Although the Bill passed all three readings in the House of Commons, Parliament was once again prorogued before it passed third reading in the Senate. Like the two bills before it, Bill C-13 died on the order paper, this time on November 12, 2003.

In February 2004, Bill C-13 was reintroduced as Bill C-6, *An Act Respecting Human Reproduction and Related Research*. The House deemed it adopted at all stages and passed it quickly. It just as quickly made its way through the Senate. The legislation received Royal Assent on March 29, 2004, and most sections of the Act came into force on April 22, 2004. Almost 15 years after the Baird Commission was established, Canada finally had legislation with respect to new reproductive technologies: the *Assisted Human Reproduction Act* (*AHR Act*).

The *AHR Act* prohibited several activities, including the creation of animal-human hybrids, human cloning, embryonic sex selection, and commercial surrogacy. Those who violate the terms of these activities are subject to criminal sanctions of up to a $500,000 fine or ten years in prison. The Act also created a federal regulatory structure for controlled activities, which were prohibited unless carried out in accordance with future regulations and a license. Subsequent regulations defining the parameters of such

activities were to be created by Health Canada. The Act also created Assisted Human Reproduction Canada (AHRC), a federal agency charged with monitoring compliance and enforcement with the *AHR Act,* creating and administering a licensing framework for the controlled activities, and maintaining a health data registry (Canada 2004b).

In terms of the six subfields of ART policy, the *AHR Act* did the following:

- *Assisted conception:* The Act prohibited compensation for gametes, although it permitted reimbursement for certain receipted expenditures in accordance with future regulations and a licence. In addition, Health Canada's broad regulatory power would have, if implemented, applied to nearly all aspects of assisted conception by setting rules for artificial insemination, IVF, and licensing fertility clinics.[14]
- *Surrogacy*: In keeping with the anti-commercialization spirit evident with respect to gametes, the *AHR Act* prohibited paid but permitted unpaid surrogacy. It did not legislate with respect to the enforceability of surrogacy contracts, and made no distinction regarding traditional and gestational surrogacy.
- *Embryonic research:* The *AHR Act* prohibited creating animal-human chimeras or hybrids, creating an embryo from part of another embryo or fetus, and "therapeutic" (non-reproductive) human cloning. It also limited embryonic research to surplus embryos from assisted conception, thus prohibiting the creation of embryos solely for research.
- The *AHR Act* enacted an absolute prohibition on *reproductive human cloning*, and on transplanting a human clone into a human being.

[14] While the Brown Committee recommended ending the practice of donor anonymity, the government did not implement this recommendation in the subsequent legislation because they felt (correctly, in retrospect) that donor identification was provincial jurisdiction (Canada 2002b).

- *Screening, Enhancement, and Manipulation*: The *AHR Act* banned germ-line engineering, non-medical sex selection, and maintaining an embryo outside a woman's body for more than 14 days (ectogenesis). It also prohibited putting human reproductive material into a non-human life form for the purpose of creating a human being, creating chimeras, and creating human-animal hybrids.
- *Parentage*: The Act did not legislate with respect to parentage, a subfield historically administered by provinces due to family law jurisdiction.

While the prohibitions were most notable, the broad regulatory authority granted to the Minister of Health was the most sweeping part of the legislation. However, the ability to create regulations did not mean that such regulations would be immediately forthcoming. To date, Health Canada has only passed one regulation, pertaining to the use of reproductive material without consent. This regulation relates to section 8 of the *AHR Act*, which bans the use of human reproductive material to create embryos, or the use of in vitro embryos for any purpose, without the prior written consent of the donor. Passed in December 2007, the Section 8 Regulations specify the details concerning who must consent, when consent is required, the withdrawal of consent, and the type of information required for donors prior to consent (Baylis and Herder 2009a: 116; Canada 2007). Subsequent regulations have yet to occur, with AHRC referencing the upcoming judicial challenges – described in detail in Chapter 5 – as reasons for delaying their development (Baylis 2013: 232; Norris 2012: 4). Finally, the *AHR Act* included equivalency agreements, which stated that federal law would be withheld if the federal government agreed provincial regulations were "equivalent to those sections and the corresponding provisions of the regulations" (Canada 2004b: s. 68).

The Baird Commission's Influence and the Continued Medical-Moral Ambivalence

There can be little doubt that the Baird Commission had an enormous influence on the *AHR Act*, and that its report thus represents a "critical juncture" for ART policy development in Canada. The Commission's influence on federal legislation was palpable at every stage of the policymaking process, and it was frequently referenced by parliamentarians and Ministers. Early in the process, Liberal cabinet minister Stan Keyes noted that the bill was "based on extensive research and consultations with the Royal Commission on New Reproductive Technologies"; six years later, Canadian Alliance MP and Baird Committee member Rob Merrifield aptly referred to the legislation as "a child of the royal commission on new reproductive technologies" (Canada 1996; Canada 2002a). Both the form and content of the legislation were in line with the Commission's preferences. Indeed, all three of the Royal Commission's overarching recommendations – prohibitions, the creation of a permanent agency to respond to developing technologies, and regulatory capacity (if not outright regulations) – were realized in the legislation.

Why was the Baird Commission so influential? One reason, as Scala suggests, is that an institution's ability to create change is often dependent on the "unique characteristics of the policy field and the policy issue in question" (Scala 2002: 68; see also Atkinson 1993: 45). In his study of Canadian Royal Commissions, Doern (1967: 420) suggest that most fall into one of two categories: "non-recurring issues" related to novel circumstances, and "recurring issues" of generalized social, economic, and/or cultural interest. The Baird Commission seems to straddle both categories. On the one hand, it was in response to a particular set of circumstances – the recent development of assisted reproductive technologies and the desire from interest groups to see some

legislation. Yet it would be a mistake to call assisted reproductive technologies a "non-recurring issue"; indeed, one of the Commission's overarching recommendations was to put in place "permanent mechanisms" that could "provide a flexible and continuing response" to assisted reproductive technologies as they evolved (Canada 1993: 1049). Thus, the Commission dealt with a novel issue, albeit one that would have a continuing impact into the future.

In this sense, the Baird Commission's opportunity for influence was quite wide. Unlike the Royal Commissions on Aboriginal Peoples and the Future of Health Care, it was not working within an existing legislative framework. It is true that the technologies had been around for over a decade and, as such, the Commission's need to accommodate existing practices from the medical communities meant it was not working with a completely blank slate. However, to use the Commission's own language, the field in 1993 was characterized by "chaos" (Canada 1993: 16). There was no federal or provincial legislation in any of the six subfields, and the level of self-regulation varied considerably from depending on the subfield. From a historical institutional perspective, this lack of preceding legislation is especially notable, and makes it clear the Baird Commission was a "critical juncture." Building on Capoccia and Keleman's definition, in the grand scheme of things the Commission's four-year period was a "relatively short" time period; the authority it was granted and its expert status meant there was "a substantially heightened probability that agents' choices will affect the outcome of interest" (2007: 38). The Baird Commission's effect on the outcome of interest was undeniable; its recommendations for prohibitions, a national agency, and regulatory authority all made their way into the legislation, even after four bills, countless

consultations with stakeholders, hundreds of witnesses, an all-party legislative report, and 11 years.

Moreover, having examined the legislative attempts and the debates surrounding it, there is little doubt that the Commission produced "path dependence," which Margaret Levi (1997: 28) describes as follows: "once a country or region has started down a track, the costs of reversal are very high… entrenchments of certain institutional arrangements obstruct an easy reversal of the initial choice." While the legislative process did not necessary produce full-fledged institutionalization in terms of creating robust institutions, the dominant ideas and recommendations were nevertheless reproduced, with the expectation the institutions would soon follow. In Canada, the "path" to ART policy unquestionably began with the Baird Commission. The relative novelty of the field, coupled with a lack of a legislative framework by any level of government, meant that in many ways the Commission was the "first mover" for ART policy in Canada.

As detailed in Chapter 3, the Baird Commission was partial to the "medical-scientific" frame in both its structure and its recommendations. However, this was complicated by its reliance of criminal prohibitions for certain activities, the language for which reflected the "moral" frame. This ambivalence remained throughout all in the legislative debates and committee hearings. On the one hand, there was evidence that Parliamentarians and witnesses treated the issue as health-related. Health Minister Allan Rock noted that "there is enormous potential and great hope here that Canadians can benefit from research in such areas as infertility but also inherited disorders" (Canada 2001a). Subsequent Health Minister Anne McLellan said the legislation "speaks to one of the most fundamental human desires, having a family" and that "there is great merit in

other types of research in the field" (Canada 2002a). Witnesses were, on the whole, supportive of assisted reproductive technologies, and most favoured some kind of regulatory framework. Most members of medical community generally favoured the content of the legislation with the exception of the criminal prohibitions. One Canadian fertility specialist who had testified before the Standing Committee said in 2012 the legislation "reflected the feelings of most people," and that there was "nothing there [physicians] couldn't live with"; another claimed the legislation "hasn't made much of an impact" on physicians' day-to-day dealings with infertile individuals, suggesting the *AHR Act* did not interfere a great deal with clinical practice (Interview 2012b, 2011b).

On the other hand, when it came to prohibited activities, the government's language clearly reflected the moral frame. Health Ministers Allan Rock and Anne McLellan claimed "there must be a higher notion than science alone… that can guide scientific research," and that the prohibitions concerned "activities that Canadians simply will not countenance because they offend our shared values" (Canada, 2001a, 2002a). Deputy Health Minister Ian Shugart claimed the bill reflected the principle that "science is not free from civil society's oversight" (Canada 2001a). As with the Baird Commission, this language was strongest when it came, in the words of former Health Committee Chairperson Bonnie Brown, to "eliminat[ing] commodification and commercialization" (Canada 2001a). To return to the typology for morality policy created by Engeli, Green-Pedersen, and Larsen, the Liberal government's arguments tended to be "unsecular" rather than "religious," insofar as they referred to preserving "fundamental values," "moral standards," and were critical of untrammelled scientific progress (2012c: 32). While Canadian Alliance MPs were more likely than other members to invoke

explicitly religious arguments – particularly regarding the moral status of the embryo – they were, on the whole, more unsecular than religious, citing values, morality, and commodification as rationales for opposing technologies.

True, several witnesses did speak out against the prohibitions, including fertility doctors, law professors, and members of the British Columbia Civil Liberties Association, the Canadian Medical Association and the Canadian Bar Association. Among these witnesses, there was frequent reference to the criminal law, in the words of Dr. Eugene Bereza, as a "blunt instrument" that was incapable of flexibility (Canada 2002d). However, these witnesses were often criticized by MPs. In one particularly poignant exchange, a nurse from sperm bank Xytex Canada described the processes for compensating sperm donors. Canadian Alliance MP James Lunney then thanked her for "painting such a clear picture of where the committee was quite determined we did not want to see this process go" (Canada 2002b). The criminal law remained the preferred legislative instrument for eliminating certain behaviours; as the Brown Committee reported, "[a]n outright statutory ban signals more clearly that certain activities are either unsafe or socially unacceptable" (Canada 2001b: 9). In this, the *Act* was clearly following the Baird Commission.

The *AHR Act* did not follow the path laid down by the Baird Commission in every respect, however. In particular, it moved away from the Baird Commission's model of independent expertise for Assisted Human Reproduction Canada (AHRC), the national regulatory agency. Table 4.2 displays the degree of autonomy given to the agency under the major legislative initiatives.

Table 4.2 Autonomy of the National Regulatory Agency				
	Less Autonomy <---------> More Autonomy			
	No agency; Minister of Health creates regulations	Agency exists, but regulations made by Minister of Health	Agency creates regulations; Minister of Health must approve	Agency creates regulations, fully arms-length
1993 Royal Commission				X
1996 Setting Boundaries			X	
2001 Draft Legislation	X			
2001 Brown Committee		X		
2004 Assisted Human Reproduction Act		X		

As the Table shows, the 2004 *Act* followed the Brown Committee rather than the Baird Commission in subjecting AHRC to government control. Whereas the Commission recommended an arm's-length body outside of Health Canada and accountable to Parliament, the *Act* kept AHRC largely under control under the Minister of Health and Health Canada. The content of regulations would be set by the Minister of Health, who was permitted to "issue policy directions to the Agency concerning the exercise of any of its powers" (Canada 2004b: s. 25(1)). Although some felt this was "misguided" for failing to "recognize one of the major reasons for and benefits of the creation of the *AHR Act* – the creation of an expert body" (Nelson 2005: 1031-1033), it represents the major area where the institutional implications of the *AHR Act* differed from the Baird Commission.

The Persistence of the National Frame

While there can be debate as to whether medical-scientific or moral principles dominated the proceedings, there was no ambivalence with respect to jurisdictional concerns. Allan Rock described the legislation as "surely an area where federal leadership is needed, where the Government of Canada is uniquely positioned to lead, where a consistent approach is needed to deal with national issues that reflect national values" (Canada 2001a). As with the Baird Commission, reference was frequently made to the uniqueness of ARTs. Again, Rock noted "this legislation is like no other. These issues are like no others" (Canada 2001a). "Provincial inability" was another common theme. A former senior civil servant at the Department of Health claimed "no [provincial] jurisdiction was acting in a significant fashion to deal with the fundamental issues," and it was "very evidently a policy and regulatory vacuum" (Interview 2011a). Canadian Alliance MP Preston Manning noted that there "appears to be a lack of desire on the part of the provinces to do it, mainly for political reasons" (Canada 2001a). Chairperson Brown added "no province has rushed in to fill this void… I think they're probably going to be quite happy that someone else is carrying this particular responsibility" (Canada 2002b). This dominant national frame was not limited to MPs. Witnesses were uniformly in favour of a national approach, with not a single witness suggesting that provincial governments could more effectively or efficiently regulate ARTs. Law Professor Martha Jackman represented witnesses' views when she stated, "it is clear that by the total inaction of the provinces in effectively regulating these activities… the provinces, individually and collectively, are unable to effectively regulate this area" (Canada 2001a).

Like the Baird Commission, those involved in the creation of the *AHR Act* recognized that constitutional issues could arise in principle. The addition of equivalency agreements was meant to assuage some of these concerns, but apprehension over the legislation's constitutionality varied depending on partisan stripe. The Brown Committee's majority Liberal report made no mention of constitutional concerns, and in fact worried that "a patchwork might develop" from equivalency agreements (Canada 2001b: 23). The Committee's dissenting reports, by contrast, were more concerned about federal/provincial conflict. The Bloc Québécois urged coordination with the provinces, asserting that "large sectors of the field of medically assisted reproduction are matters of provincial responsibility" (Canada, 2001b: 85). Bloc MP Réal Ménard frequently said the legislation violated provincial jurisdiction, at one point claiming "if the regulatory agency were established, there would be serious incompatibility between… Quebec statutes and the [federal] bill" (Canada 2002d). The Progressive Conservatives asserted that "the provinces and territories should *have* to be involved" (Canada, 2001b: 93, emphasis in original). And the Canadian Alliance expressed concern that "attempted federal regulation of assisted human reproduction facilities may raise constitutional challenges" (80). Preston Manning, the highest-ranking Alliance member of the Standing Committee that reported on the draft legislation, repeatedly pressed witnesses on questions of constitutionality, at one point stating "if this [bill] is passed in the current form, we're going to end up having all kinds of litigation on the regulation of assisted human reproduction, on whether it's a federal or provincial responsibility" (Canada 2001a).

While Manning was prescient in this respect, he was virtually alone among non-Bloc MPs in fearing the federal government lacked the constitutional authority. As one

parliamentary researcher involved with the *AHR Act* remarked, there was satisfaction that the criminal prohibitions created a constitutional "anchor" that would allow the federal government to enact its national regulatory scheme (Interview 2011c). Every single witness except one claimed the federal government has the authority to launch its regulatory scheme, and constitutional lawyers were among the most adamant. Brent Windwick, on behalf of the Canadian Bar Association, stated the legislation "will meet the appropriate legal test for the federal government to assume jurisdiction over the activities it seeks to regulate." Law Professor Timothy Caulfield, drawing explicitly from Supreme Court jurisprudence from *R. v. Hydro-Québec*, claimed the federal government "should retain jurisdiction so long as the regulatory scheme has criminal prohibitions and is aimed at a legitimate public health concern… If the model went forward as proposed, I don't think there's any doubt that the feds would keep jurisdiction." And Law Professor Patrick Healy claimed "the legislation as a whole can properly be characterized as criminal law… because the criminal law power available to Parliament has a rather wide scope" (Canada 2001a).

The lone holdout was Gerald Chipeur, an independent lawyer. He claimed the mere existence of equivalency agreements logically took away "the very basis for the argument a Parliament could make that they needed to incidentally affect health care in order to achieve their objective." Chipeur asserted that, while the prohibitions were valid, the creation of a regulatory agency – even with regulations created by the Minister of Health – could be justified neither by POGG nor by the criminal law power. But Chipeur did not persuade the government. Glenn Rivard from the Department of Justice responded to him directly by claiming, "we're quite satisfied as to the constitutionality of

the legislation" (Canada 2002b). Minister Allan Rock was also "satisfied … as a minister, as a person, as a lawyer, that the draft legislation we put before you would be upheld by the courts if it were challenged on the basis of constitutional competence." And Deputy Minister of Health Ian Shugart claimed "the basis upon which the government is proposing to legislate and regulate in this area is the criminal power," and that "there ought not to be any issue" with regulations related to criminal prohibitions (Canada 2001a)

Interestingly, and unlike the Baird Commission, the constitutional justifications almost all centred on the criminal law, both from the government and from witnesses. While law professors Jocelyn Downie and Martha Jackman both briefly cited the federal government's POGG power (Canada 2001a), all other defenses of federal jurisdiction invoked section 91(27), the federal authority over criminal law, even when discussing the *AHR Act's* regulations. It is not entirely clear why the federal government abandoned POGG, which the Baird Commission relied on as its primary constitutional justification for federal regulations. As described in greater detail in Chapter 5, the development of the Supreme Court of Canada's federalism doctrine likely played a role, as during the 1990s the Court shied away from POGG to justify federal intervention while the criminal law power became something of a "a proxy for national concern" (Baier 2006: 141; see also Snow and Knopff 2012: 6-10). One former civil servant in the Department of Health recalled that he did not believe "at the end of the day the Department of Justice was actually persuaded by the argument that it could be done under Peace, Order, and Good Government" (Interview 2011a). Nevertheless, while most witnesses and government

lawyers relied on the criminal law power, they were convinced that it was a suitable "anchor" for federal authority.

Comparative Policy Design and Competing Frames

At this point, it is useful to return to the comparative literature on policy design, discussed in Chapter 2, to determine the scope of constitutional issues in the *AHR Act*. In their comparative studies of ART, Goggin et al. (2004: 6-8) and Varone, Rothmayr, and Montpetit (2007: 6) note that "policy design" contains five components: goals, instruments, target groups, implementers, and policy rationales. To quote Pierre Pettigrew, the Minister of Health when Bill C-6 was passed, the *AHR Act* had three *goals*: "to protect Canadians using assisted human reproduction to help them build a family, so that their health and safety are not compromised; to prohibit unacceptable practices such as human cloning; and to ensure that research related to assisted human reproduction, which may help find treatments for infertility and serious deceases, takes place within a regulated environment" (Canada 2004a). From the Baird Commission to the *AHR Act*, the goal was always to permit some technologies and restrict others in a manner that would be consistent across the country.

The *AHR Act* also contained three *instruments*, defined as "the tools put at the disposal of the implementers or administrators of authoritative decisions in order to achieve policy objectives" (Goggin et al. 2004: 7): the criminal law, Health Canada's overarching regulatory power, and Assisted Human Reproduction Canada's subsidiary regulatory power to monitor compliance and enforcement, create and administer a licensing framework for controlled activities, and maintain a health data registry. While

the criminal law directly corresponded to the restriction of technologies, Health Canada and AHRC were to act in order to administer both the restrictive and permissive components of the legislation. Third, *target groups* in ART policy typically include clients (patients), medical professionals, researchers, and employees in the fertility industry themselves (Goggin et al 2004: 8). In Canada, the *AHR Act*'s prohibitions on compensation had the effect, partly intended and partly unintended, of restricting access for patients of assisted conception by limiting the pool of available donors and surrogates. This also affected fertility clinics and consulting services, some of whose work was rendered illegal by the criminal prohibitions. The regulatory authority, meanwhile, was meant to target physicians by introducing rules for licensure, data collection, and enforcement. Finally, the *AHR Act* targeted researchers involved with embryos and human reproductive material by placing limits of the supply and use of available material.

The major constitutional conflict that would develop, however, was that *implementers* of the *AHR Act*, defined as "the public and/or private actors in charge of taking measures to implement the policy instruments" (Varone, Rothmayr, and Montpetit 2007: 6), would all be federal actors. Self-regulatory medical organizations and provincial governments essentially were left out of the implementation, with responsibility falling largely to Health Canada, AHRC, and, with respect to prosecuting criminal offenders, the Royal Canadian Mounted Police (RCMP). The final rub came with *policy rationales*, which are the "expressed justifications" for the components of the overall policy design (Goggin et al 2004: 2007: 6). As the analysis of committee hearings and parliamentary debates in this chapter demonstrates, these rationales were expressed in terms of both content and jurisdiction. In terms of content, broadly speaking, the

rationales for criminal prohibitions were avoiding the commodification of human life, the exploitation of women and children, and the commercialization of reproduction. While some individual MPs evoked religious arguments, government and committee recommendations were largely "unsecular," referring to fundamental values and morality (see Engeli, Green-Pedersen, and Larsen 2012). With respect to regulations, the rationales were to allow the development of research and the creation of new families within certain regulatory boundaries. Yet another rationale, one dealing with jurisdiction and national equity, was ever-present: to have uniform standards for Canadians across the country. As Allan Rock stated, the goal was to create a "comprehensive pan-Canadian approach that would not follow the patchwork situation that exists in the United States" (Canada 2001a).

What is most remarkable when analyzing the policymaking process from 1993 to 2004 – from the Baird Commission to the *AHR Act* – is the extent to which these five variables remained almost entirely the same. This period was characterized in part by the proliferation, normalization, and increased use of ARTs, as well as the advance of research that even resulted in Dolly the Sheep, the first animal to be cloned using somatic cell nuclear transfer. While there was little public opinion research on ARTs in Canada during this period, there has been a gradual liberalization of views concerning the acceptability of ARTs in the Western world over the last two decades, including in Canada (University of Alberta Health Technology & Policy Unit 2013: 71; Greenaway 2002; Kovacs et al. 2003). And yet the goals, instruments, target groups, implementers, and policy rationales described above were almost the same for the Baird Commission and for the federal government, with the one exception that under the final legislation, the

implementer responsible for actually creating regulations would be the Minister of Health, not the national agency. While several interest groups – notably physicians' organizations – opposed legislation early in the policy process (Montpetit 2004), the *AHR Act* was ultimately passed with most actors viewing it as a compromise (Jones and Salter 2007).

I have argued above that the Commission's report acted as a "critical juncture" because of a combination of its relative authority and expertise, the legislative vacuum at all levels of government, and the collective uncertainty regarding the technologies. Yet it is also worth noting that this path-dependent period, which reinforced the Baird Commission's recommendations, was likely stabilized by the state of party politics at the time. From 1993-2004, the Liberal Party had a majority of seats in the House of Commons. As a centre-left party with pro-business leanings, the Liberals *as a party* did not have a particular policy agenda concerning ARTs; as Montpetit notes, their own internal documents offered "no indication of preferred policy directions on ART" (2004: 79). My own analysis in this chapter demonstrates that their preferred direction was to crawl forward and implement as many of the Royal Commission's recommendations as possible. However, while the Liberals' "big tent" has included conservative and progressive members with respect to morality policies such as abortion and same-sex marriage (see Flanagan 1997; Myers 2008), its members uniformly support a strong central government. As future leader Michael Ignatieff said to a national convention in 2005, the Liberal Party's "first task as a party is to preserve the national unity of Canada… Federal Liberals say yes to strong provinces, but no to a balkanized Canada… We stand for one country, not 10" (Ignatieff 2005). While it has been accused at times of

lacking a coherent ideology – of campaigning from the left and governing from the right – the Liberal Party has for decades supported national programs and a strong federal government (Clarkson 2005: 269). It is thus no surprise that in the face of ambivalence concerning the medical-scientific and moral frames, the governing Liberals uniformly adopted the national frame during the legislative process.

Conclusion

In this and the previous chapter, I have demonstrated how the Baird Commission and the federal government sought comprehensive legislation to produce two conflicting goals: to simultaneously promote assisted reproduction while prohibiting its more sinister aspects. These two goals were reflected in legislative language that, not surprisingly, relied on two contradictory "frames": assisted reproductive technologies as a medically beneficial set of behaviours and practices (the medical-scientific frame), and as a set of technologies that required criminal prohibition (the moral frame). In this vein, it is helpful to conceive of the *AHR Act* as containing a "division of labour" between regulated activities (justified by the medical-scientific frame) and prohibited activities (justified by the moral frame). To tie the two goals together, federal policymakers, starting with the Baird Commission, produced an additional frame as a policy rationale: assisted reproductive technologies as a policy requiring national, rather than provincial attention (the national frame). While there was a division of labour, the work required the same labourer.

This was a constitutionally risky proposition, and one that, as the next chapter will demonstrate, did not produce the goals the actors sought. It is a mistake, however, to suggest that such decisions were made with bad intentions, or with complete foresight of

what would subsequently transpire. As Paul Pierson notes, when studying the institutional development of public policies, "rather than assuming relative efficiency as an explanation, we have to go back and look" (2004: 47). In the last two chapters, I went back and looked. I traced the development of the federal government's assisted reproductive technology policy, using a textual analysis of the Baird Commission, legislative debates, and committee hearings leading up to the 2004 *AHR Act*. I found that the Baird Commission structured the debate over ART policy to suggest that federal regulation of the entire area (with the exception of parentage) was preferable, feasible, and constitutional. The federal government, itself made up of a Liberal Party that has been partial in its recent history to national initiatives, built on the positive feedback by a lack of provincial legislation and endorsed the Commission's centralized preferences. Over the years, the dominant idea of a national policy was recreated as the only solution.

That the Baird Commission influenced the *AHR Act* is not a controversial proposition, nor is it controversial to suggest that it was unwise, in retrospect, for the federal government to adopt this centralized model. This chapter does show, however, that the federal government's framework was not a foregone conclusion. As Pierson notes, "many alternatives to the outcome in question might have been possible, and a dynamic of positive feedback may have institutionalized a particular option even though it originated by accident" (2004: 47). Given jurisdictional uncertainly, the Commission could have opted for a provincial frame – as it did for parentage policy and the admissibility of surrogacy arrangements. However, it made the deliberate choice to go forward with the national frame, in spite of weak jurisprudential support that would soon come to the surface.

The next chapter explores how these the three frames – medical-scientific for beneficial practices, moral for "evils" requiring suppression, and national for everything – remained important until the final act in Canada's federal ART tragedy: the Supreme Court of Canada's 2010 *Reference re Assisted Human Reproduction Act*. As it turns out, the period from 1993-2004 was also a busy period for the Supreme Court of Canada, which readjusted its doctrine in a way that made the federal government's constitutional justifications even more precarious. In particular, the Court's gradual downplaying of the "national concern" branch of the Peace, Order, and Good Government (POGG) clause left the federal government without the major piece of constitutional ammunition that the Baird Commission cited in 1993. I turn now to this jurisprudential shift.

CHAPTER FIVE:

THE *AHR ACT* GOES TO COURT –

THE SUPREME COURT REFERENCE AND THE POLICY STATUS QUO

The previous chapters demonstrate that, from 1989-2004, the primary policymakers for assisted reproductive technology (ART) policy in Canada were at the federal level. Beginning with the Baird Commission, nearly every policymaker believed the federal government must legislate with respect to every subfield of ART policy, with the exception of parentage. Provincial governments and self-regulating medical organizations were largely left on the sidelines. And as many federal MPs, civil servants, and witnesses involved in the legislative process made clear, most provinces seemed reluctant to act in any meaningful way concerning ARTs. In spite of constitutional jurisdiction over health care, most provinces did not show any clear desire to act.

While most MPs were aware that ARTs touched on health concerns, the inclusion of equivalency agreements were designed explicitly to assuage the concerns of the provinces. True, there was opposition from familiar opponents of federal legislation: Bloc Québécois MPs condemned the legislation as an unconstitutional intrusion into provincial jurisdiction, and at one point Quebec Minister of Health François Legault (then of the governing Parti Québécois) wrote a letter claiming the legislation was incompatible with over twenty Quebec statutes (Canada 2002c). However, as one MP who served on the Brown Committee remarked, this was hardly uncommon rhetoric from an explicitly separatist party: "go to any committee on health care in any context, and the Bloc always says 'that's provincial jurisdiction'" (Interview 2011d). The federal government did not simply hand-wave such threats away, nor did it intentionally intend to call Quebec's

bluff. At committee, one government lawyer flatly responded to Bloc MP Réal Ménard "there is no incompatibility between Quebec legislation that touches on these issues and federal legislation" (Canada 2002d). All but one constitutional expert who testified before the federal government agreed. The federal government was entirely confident that it had the legislative authority to act, and that if challenged in court, it would win.

Given the Bloc's statements and an open letter from the Quebec government opposing the legislation, it was no surprise when, in 2006, the government of Quebec – now led by the federalist Liberal Party – launched an official legal challenge, in the form of a reference procedure, that the *AHR Act* violated provincial jurisdiction over health care. What was more surprising from the federal government's perspective was that Quebec won – first unanimously in the Quebec Court of Appeal, and then by a 5-4 margin in the Supreme Court of Canada. The result, which struck down most federal regulatory authority contained in the *AHR Act*, surprised the legal community, infuriated policymakers across the country, and threw the ART ball into the provinces' court. This chapter explains how this happened and asks a simple question: why did the Supreme Court of Canada strike down legislation that its creators were so confident would withstand constitutional scrutiny?

The answer, I suggest, is twofold. First, from 1993-2004 the Supreme Court of Canada's federalism jurisprudence shifted in such a way that made the Baird Commission's constitutional justifications even more tenuous. Over several cases – all of which actually upheld federal legislation – the Court rejected the "national concern" branch of the Peace, Order, and Good Government (POGG) power under section 91 of the *Constitution Act*, *1867*, which had been the Baird Commission's primary

constitutional justification for federal action (see Baier 2006; Snow and Knopff 2012). This meant the federal government ended up using one constitutional instrument (the criminal law power) to justify large parts of legislation that had originally been assumed to be justified through an altogether different one (POGG).

Second, and relatedly, the framing strategies employed by federal policymakers from the Baird Commission to the *AHR Act* also framed the way a majority of justices came to understand assisted reproductive technologies. Like the Baird Commission, the federal government adopted ambivalent justifications for the legislation: beneficial aspects were framed using medical-scientific discourse, and negative aspects with moral discourse. This implied a "division of labour" within the legislation itself, albeit one in which the same labourer – the federal government – would do all the work. In the Supreme Court *Reference*, a majority of Justices referred precisely to this idea, drawing from the Baird Commission and the legislative debates to draw a clear distinction between morally harmful prohibited practices and medically beneficial activities that would be subject to regulation and licensing. In the absence of the "national concern" branch of POGG as a constitutional justification, the federal government's framing strategy left it even more constitutionally suspect than it would have in 1993. The Supreme Court's growing reluctance to use POGG as a justification for national action meant that, by framing many aspects of the legislation as what I call "medical but national," the federal government had set itself on a collision course with the judiciary.

This chapter unfolds in three sections. I first discuss the jurisprudence and secondary literature concerning federalism in the Supreme Court of Canada, especially developments from 1993-2004. My analysis demonstrates that the Court had indeed

moved away from POGG to the criminal law as a weaker proxy for "national concern." I then discuss the two cases in which Quebec challenged the *AHR Act*: *Attorney General of Québec v. Attorney General of Canada* (2008) in the Quebec Court of Appeal and then the *Reference re Assisted Human Reproduction Act* (2010) in the Supreme Court of Canada. I suggest that, although there were doctrinal differences among the Supreme Court justices, the roots of the primary disagreement stem from way in which the different courts perceived the purposes of the legislation, and that these purposes depended heavily on framing throughout the legislative history. I also conclude that, whatever one's opinion of the *efficacy* of federal legislation, the Supreme Court majority provided a more faithful reading of the influence of the Baird Commission on the legislative process than the dissenting opinion. Based on existing jurisprudence, the Supreme Court came to the right decision.

The third and final section of this chapter examines the reaction to the Supreme Court decision among policy experts, which can be summed up as "general outrage." I look at some of the key assumptions that underpin this outrage, and suggest they require reconsideration. In particular, the six-part typology described in Chapter 2 demonstrates that the federal government remained active in many aspects of ART policy. More importantly, as subsequent chapters attest, the provinces and self-regulatory medical organizations have created policy in many of the six ART subfields, resulting in a far greater policymaking role than most commentators allow.

Federalism in the Supreme Court, 1993-2004: A Shift in Emphasis

Sections 91 and 92 of the *Constitution Act, 1867* describe the heads of power through

which federal and provincial governments may legislate, but these constitutional provisions are described in broad, general terms; as Gerald Baier notes, the structure of the Canadian Constitution "effectively put the enumerated powers in competition with one another… with some exceptions, for every federal grant of power, there is a provincial grant that might be characterized in such as way as to justify provincial control over a roughly similar matter" (2006: 126). In Canada, judicial review has become the most definitive, if not the most common, mechanism for resolving disputes between governments. The British-administered Judicial Committee of the Privy Council (JCPC) had the final authority to determine such issues for much of Canada's early history, but following the abolition of appeals to the JCPC in 1949, the Supreme Court of Canada has been the final stop for judicial review of federalism disputes.

The history of federalism adjudication in Canada is long and complicated; it has been the subject of much debate, analysis, and criticism. While there is considerable dispute about the extent to which the JCPC *caused* decentralization (see Baier 2006; Cairns 1971; Saywell 2002; Vaughan 2010), there is a consensus that during the JCPC's tenure as court of last resort from 1867-1949, provincial authority grew while federal authority diminished. Most early federalism disputes concerned several broadly-worded clauses in the *Constitution Act*, 1867: the "Peace, Order, and Good Government" (POGG) clause; the federal government's authority over trade and commerce (section 91.2); provincial authority over property and civil rights (92.13); and matters of a local or private nature (92.16). In these disputes, the provinces fared better; as Baier summarizes, "[t]he JCPC largely interpreted the POGG and trade and commerce clauses narrowly and the civil rights power expansively… [it] clearly favoured the provinces in doing so"

(Baier 2006: 56). By several accounts, Canada became one of the most decentralized federations in the world. And although many scholars hoped the federally-appointed Supreme Court would reverse the trend by systematically favouring Ottawa, most commentators agree that this did not happen; both Baier (2006) and Russell (1985) have referred to the Supreme Court's federalism jurisprudence as "balanced."

In this "balanced" federal framework, the Baird Commission initially relied on POGG as its primary justification for federal action, which gave the federal government a "clear basis for seeking national action" due to the "profound importance" of ARTs (Canada 1993: 18-19). The Commission's reliance on POGG was already questionable in 1993, as the Supreme Court had generally allowed the federal government to rely on POGG only in two situations: when federal legislation responds to a "national emergency," or when it addresses an area of "national concern." The *Assisted Human Reproduction Act*, whatever the tone of some of its proponents, was not primarily meant to address a national emergency. However, beginning with the 1976 *Reference Re Anti-Inflation Act*, the Court had allowed "national concern" to justify federal legislation implicating provincial jurisdiction in matters sufficiently "distinct" and limited in scope that the overall federal balance remains undisturbed – for example, the creation of the National Capital Region (*Munro v. National Capital Commission* 1966). Along with distinctiveness, the Supreme Court has also endorsed the "provincial inability" test, when the federal government is allowed to act if the provinces are unable to achieve the same purpose working together (see Baier 2006: 128-142; *R. v. Crown Zellerbach* (1988).

However attractive "national concern" may have been to supporters of the *AHR Act*, there was in fact no guarantee that the federal legislation would actually be upheld

on that basis. From the *Reference re Anti-Inflation Act* (1976) up to 1993, the Court's "national concern" jurisprudence had been ambiguous and conflicted. The test had been used as often to deny federal jurisdiction as to sustain it, and decisions in either direction typically involved narrow majorities prevailing over substantial dissents. A single, comprehensive, national policy on ART issues was thus constitutionally risky. Nevertheless, the Commission clearly considered the risk worth taking, and it bet heavily on the national concern branch of POGG. As Table 5.1 demonstrates, the combination of "medical-scientific" and "national" framing strategies – the medical-but-national rationale – was constitutionally unstable, at least insofar as it included the kind of medically beneficial health care that fell within provincial jurisdiction.

Table 5.1
Framing Assisted Reproductive Technologies

		Jurisdiction	
		National	**Sub-National**
Policy Rationale	**Moral**	Stable	Unstable
	Medical-Scientific	**Unstable**	Stable

What the Commission could not know was that after 1993 the Court would begin avoiding POGG (including the "national concern" branch) as a potential support for disputed federal legislation. Even when constrained by such criteria as "provincial inability," the national concern test came to be seen as too much of a threat to the Court's project of balanced federalism, leading the justices to rely more heavily on other grants of federal power. In particular, the federal criminal law power (91.27) became one of the Court's favoured alternatives to POGG as a justification for federal legislation. Beginning after *Ontario Hydro v. Ontario* (1993), in which the court upheld federal employee-

government relations legislation on the basis of POGG, "[w]hen the court has been faced with the opportunity to choose between criminal law and the POGG power, it has increasingly opted for the former" (Baier 2006: 142).

As documented by Baier, this occurred primarily in a string of cases throughout the 1990s – coincidentally, the time during which different iterations of the *AHR Act* were being debated and justified in Parliament. In *RJR-MacDonald Inc. v. Canada* (1995), a majority of justices "dispensed with a POGG analysis almost entirely," and instead upheld federal tobacco legislation under the criminal law power, a strategy Baier calls "much less controversial" than using POGG (2006: 139). Two years later, in *R. v. Hydro-Québec* (1997), the Court "turned away from POGG even more resolutely than it had in *RJR-MacDonald*," again signaling unease at the potentially expansive scope of the "provincial inability test" (*Ibid.*: 140). In the *Reference re Firearms Act*, the Court similarly upheld federal gun control legislation for having only "incidental" effects on the on provincial jurisdiction, after which it determined it was "unnecessary" to consider whether it fell within the POGG power (2000: para. 59). Finally, in *R. v. Malmo-Levine* (2003), a case concerning the constitutionality of the federal government's marijuana ban, the court continued its "pattern of avoiding POGG arguments when a criminal law justification is available" (Baier 2006: 142).[15]

On its face, this jurisprudence made it unclear whether the federal *AHR Act* would withstand constitutional scrutiny. Although Supreme Court Justices had moved from POGG to the criminal law, majorities still upheld federal legislation in each case – in

[15] In both *RJR-MacDonald* and *Malmo-Levine*, the court subsequently considered whether the federal legislation, having been declared constitutional on federalism grounds, nevertheless violated the *Canadian Charter of Rights and Freedoms*. The Supreme Court struck down parts of the federal government's legislation in *RJR-Macdonald* as a Charter violation, but upheld the marijuana ban from *Charter* scrutiny in *Malmo-Levine*.

fact, until the *Reference re Assisted Human Reproduction Act* (2010), the Supreme Court had not struck down federal legislation for violating the division of powers for 30 years (since *Labatt Breweries of Canada Ltd. v. Canada* 1980). Baier himself asserted in 2006 that it was "too early" to determine whether the criminal law power had simply become a "proxy" for the national concern component of POGG (141). However, in spite of a string of victories at the Supreme Court of Canada, the federal government ought to have noticed – and, as its strategy in court demonstrates, certainly did notice – that it had lost the constitutional instrument most amenable to defence of the *AHR Act*. Baier was prescient in predicting that the federal government's winning streak could not simply continue forever, claiming the criminal law power likely had a "more restricted scope" than POGG's national concern doctrine (2006: 142).

Whether because of the Commission's weak constitutional justifications or because of the shift in Supreme Court jurisprudence, there are signs that the federal government was aware that POGG was no longer the best instrument to justify the *AHR Act*. As described in Chapter 4, almost every legal witness, including government lawyers, relied on the criminal law power rather than POGG as the specific constitutional *instrument* by which the legislation would be justified. However, the *language* used to justify that instrument still reflected the national concern branch of POGG. Ever since *Reference re Validity of Section 5(a) of the Dairy Industry Act* (1949, also known as the "Margarine Reference"), the Supreme Court has stated that criminal legislation must be include a valid criminal purpose and attach a punishment. This means that legislation justified on the criminal law power will be far more effective if based on the "moral" frame – eliminating "evils." However, the federal government was clearly ambivalent

concerning the moral and the medical-scientific frames throughout the creation of the *AHR Act*. By contrast, there was no ambivalence concerning the "national" frame, which bears many similarities to constitutional arguments regarding "national concern." "Federal leadership," "a lack of desire on the part of the provinces," and fears of a "patchwork" dominated the way legislators framed the legislation (Canada 2001a; Canada 2001b: 23). The federal government was well aware that its arsenal of constitutional weapons had been depleted. By the time the case made its way to the Quebec Court of Appeal in 2007, the federal government did not even bother to invoke POGG, and instead relied entirely on its criminal law power.

Quebec Court of Appeal Ruling

While there were some rumblings about the *AHR Act's* constitutionality throughout the legislative process, most provincial governments did not express any desire to legislate in this field. Quebec was the lone exception: the provincial government wrote several letters to the federal Minister of Health insisting that the Act's regulatory aspects were unconstitutional, and several federal Bloc Québécois MPs (in particular Health Committee member Réal Ménard) frequently claimed the legislation violated provincial authority over health (Canada 2002c, 2002d). This, as it turns out, was no bluff. In 2007, three years after the *AHR Act* passed, the government of Quebec launched a reference in its Court of Appeal to clarify the constitutionality of the federal legislation. At the same time, Quebec Health Minister Philippe Couillard tabled Bill 23, *An Act respecting clinical and research activities relating to assisted procreation*, in the National

Assembly. Although this bill played no part in either court decision, it was re-introduced and eventually passed as Bill 26 in 2009.[16]

While Quebec did not challenge the majority of the criminal prohibitions in the federal scheme, it asserted that virtually every regulatory provision was provincial jurisdiction under sections 92(7), 92(13), 92(16), and 93 of the *Constitution Act*, *1867*. The reference question asked whether sections 8 to 19, 40 to 53, 60, 61 and 68 of the *AHR Act* were *ultra vires* (beyond the authority of) Parliament. These sections included:

- Certain prohibited activities, including the consent to use reproductive materials and the use of gametes obtained from a minor (sections 8-9)
- All the "controlled" activities, which were only permitted if conducted in accordance with federal regulations and a license. This included the use of human reproductive material; storage of gametes and embryos; combining genes from different species (transgenics); and reimbursement of expenditures for gamete donation, surrogacy, and the "maintenance or transport" of embryos (sections 10-13)
- Privacy and information management provisions (sections 14-19)
- Certain administrative manners pertaining to licensing controlled activities (sections 40-44) and inspection and enforcement (sections 45-53)
- The provision of penal sanctions (offences and punishment) to the extent they related to the impugned provisions (sections 60-61)
- Equivalency agreements to the extent they related to the impugned provisions

[16] The legislation contained many provisions similar to the regulatory components of the *AHR Act*, including licensing, reporting, a research ethics committee, and ministerial authority to create regulations. It also provided for public funding of IVF under the provincial health insurance scheme. As of 2013, Quebec's publically-financed health care now pays for three stimulated or six un-stimulated IVF cycles (Downie and Baylis 2013; see also Chapter 7).

(section 68) (*Reference re Assisted Human Reproduction Act* 2010: paras. 141-155; Ogbogu 2011: 155-157)

Most of the Act's criminal prohibitions, contained in sections 5-7, were not challenged. In June 2008, the Quebec Court of Appeal issued its reference opinion. All three justices unanimously sided with the Government of Quebec, ruling that all the impugned provisions were unconstitutional. In practice, this would have removed from the federal government its entire regulatory and licensing power, which is to say virtually every power that did not relate to an outright criminal prohibition (and even a few outright prohibitions contained in sections 8-9).

A few things of note stand out in the Court of Appeal's decision. First, as mentioned above, was the fact that the federal government relied entirely on its criminal law power, dispensing entirely with POGG as part of its justification. In doing so, it relied on the "double aspect" doctrine, whereby "both levels of government may legislate on different aspects of the same matter, such as health" (*Attorney General of Quebec* 2008: para. 25). According to the federal government, the impugned provisions were intended to protect vulnerable persons, public morality, and health and safety. Or, as the Court of Appeal summarized, that "unsafe or ethically reprehensible access to assisted reproduction constitutes an 'evil' that requires the legislative intervention of Parliament" (para. 38). This was the moral frame *par excellence*; without the ability to use POGG's "national concern" doctrine, the federal government had to downplay the extent to which the legislation had relied on the medical-scientific frame at all.

Second, although the federal government did not employ POGG as an argument, the Quebec Court of Appeal rejected it anyway. The Court denied that ARTs constituted

a "national emergency," saying "if there was [an emergency] at the time of the Baird Commission, it is no longer present, since fifteen years have passed between the first intervention at the House of Commons on medically assisted reproduction and the enactment of the Act" (para. 79). Likewise, it claimed the national concern doctrine could not apply, as the *AHR Act* only sought only to protect individual users of and children born through assisted reproductions, not the "national interest." It warned that courts must resist "the temptation to legitimize the Act out of a desire for uniformity across the country" (para. 80). Thus, by rejecting POGG, the Court of Appeal rejected the federal government's "national" frame out of hand.

With the federal government omitting its POGG argument and the Court of Appeal rejecting it anyhow, the case focused on whether the impugned provisions were in "pith and substance" health care (provincial) or criminal law (federal). As would a majority of justices in the Supreme Court of Canada, the Quebec Court of Appeal relied on a close reading of the legislative history of the Act to inform its opinion (paras. 3-17, 115-139). This included lengthy excerpts from the Baird Commission and Ministers of Health. Drawing from this evidence, the Court of Appeal was convinced that the *AHR Act* contained "two main parts," which were, on the one hand, "a formal and complete prohibition of certain practices" and, on the other, support for "desirable" practices that "promote fertility and, consequently, the creation of new families" (paras. 118-119). It effectively endorsed a division of labour within the *AHR Act*, whereby the prohibited and non-prohibited activities were designed to address qualitatively different issues.

The Court of Appeal allowed that the federal government could criminally prohibit the "evils" associated with ARTs; it accepted that certain components of the legislation –

namely, the unchallenged federal prohibitions in sections 5-7, which covered aspects such as paid surrogacy, human cloning, non-medical sex selection, and germ-line engineering – were designed to do precisely that. However, the impugned provisions themselves – controlled activities and the licensing, inspection, and enforcement related to those activities – were designed "not to prohibit wrongful acts but to ensure that … desired and encouraged activity is carried out properly" (para. 128). The criminal law was not the proper instrument for adopting national standards for beneficial practices: "The appropriateness of a single piece of legislation applying to Canada as a whole and regulating a permitted and recognized activity is not a purpose that confers criminal law jurisdiction." For the purposes of constitutional analysis, it did not matter "whether the Act is good or bad, or whether it achieves its objectives or not"; rather, all that mattered was "whether its purpose is criminal in nature," which it decidedly was not (para. 137). According to this particular court, the criminal law would not act as a proxy for national concern.

A Divided Supreme Court Rules

While the Quebec government was pleased with the initial outcome, most parties involved knew that the case would go to the Supreme Court of Canada, which soon granted the federal government leave to appeal. There were early indications that the case was especially difficult for the court. As with everything pertaining to ART policy in Canada, the case had a long gestation period: the Court originally heard the case in April 2009, and did not rule for 20 months.[17]

[17] In 2012 the average time between hearing and judgment was 6.3 months; over the last decade, the court has averaged 5.9 months (Supreme Court of Canada 2013: 4).

In the case, the governments of Alberta, Saskatchewan, and New Brunswick intervened on behalf of the government of Quebec, although these provinces did not have any forthcoming legislation tabled.[18] The Canadian Conference of Catholic Bishops and the Evangelical Conference of Canada, two conservative religious organizations, intervened on behalf of the federal government. The arguments were the same as those posed to the Quebec Court of Appeal; Quebec claimed the impugned provisions were of pith and substance related to health care under sections 92(7), 92(13), 92(16), and 93[19] of the *Constitution Act*, *1867*; the federal government countered that these provisions were necessary to proper functioning of the criminal prohibitions, and thus a valid use of the federal government's criminal law power (91(27)). Once again, the federal government did not attempt to justify the legislation under the Peace, Order, and Good Government (POGG) power, as the Baird Commission had recommended.

In December 2010, a divided (4-1-4) Supreme Court of Canada issued a 163-page decision in *Reference re Assisted Human Reproduction Act* (2010). The Court's majority largely accepted Quebec's argument, and found most of the *AHR Act*'s controlled activities and regulatory authority were *ultra vires* the Parliament of Canada. While the decision contained many legal and doctrinal disagreements, the fundamental debate among the justices concerned the overall purpose, or "pith and substance," of the legislation. Here, policy framing throughout the legislative process proved crucial. The Court was divided with respect to whether the controlled activities and regulatory

[18] Dr. Michael Awad, a Red Deer physician trained in ARTs and licensed to practice with the College of Physicians and Surgeons of Alberta, intervened on behalf of the government of Quebec. Dr. Awad claimed that he could not practice in his field, because the *AHR Act* required that he obtain a license, but the federal government had not made the proper regulations for licensure (Mitchell 2011: 646, 650).

[19] All nine justices rejected Quebec's assertion that the *AHR Act* violated section 93 (education) with respect to health professionals (para. 261).

authority were designed to provide a "good" or limit an "evil"; whether, in effect, the government's legislative authority stemmed from the medical-scientific or the moral view of assisted reproductive technologies.

Chief Justice McLachlin (writing for herself and Justices Binnie, Fish, and Charron) agreed with the federal government's submission, and held that the legislation was primarily designed to create a number of prohibitions supported by a few incidental regulations. Interestingly, and unlike the other five justices, she examined the impugned provisions in the context of the legislation as a whole. For the Chief Justice, the *AHR Act* was primarily designed to "prohibit practices that would undercut moral values, produce public health evils, and threaten the security of donors, donees, and persons conceived by assisted reproduction" (*Reference Re Assisted Human Reproduction Act* 2010: para. 255). "The dominant thrust" of the legislation was prohibitory, as it was "essentially a series of prohibitions, followed by a set of subsidiary provisions for their administration" (paras. 24-25).

McLachlin's method – reading the legislation as a whole, then subsequently determining the constitutionality of individual provisions – led her to accept that the *AHR Act* "incidentally permits beneficial practices through regulations"; however, this incidental permission did not render the Act unconstitutional (para. 30). After determining that the Act as a whole reflected the moral frame, she went through the impugned provisions individually, and found they were all tied to the overall scheme of prohibiting an "evil": privacy and information management provisions were "closely tied" to valid criminal prohibitions; licensing was "directly related … to prohibiting harmful and immoral conduct, while excepting beneficial activity"; inspection and

enforcement provisions were "part and parcel" of the overall prohibitory scheme; and the offences and rules for punishment "simply provide the penal sanctions that are necessary for criminal law provisions" (paras. 146, 149, 150, 155). McLachlin also held that the equivalency agreements, were indicative of a "flexible approach to federal-provincial cooperation, which is appropriate to modern federalism" (para. 1152). The group of four justices led by McLachlin would have upheld the *AHR Act* in its entirety as a valid exercise of the criminal law power.

Justices LeBel and Deschamps (writing for themselves and Justices Abella and Rothstein), by contrast, supported the medical-scientific frame as a rationale for the controlled activities, information gathering, and federal licensing authority. Unlike Chief Justice McLachlin, they examined the impugned provisions individually, rather than the *AHR Act* as a whole. They found the fundamental purpose of these impugned provisions was to set national standards for "a specific type of health services provided in health-care institutions by health-care professionals" (para. 227). Just like the Court of Appeal, Justices LeBel and Deschamps frequently referenced the Baird Commission. In doing so, they found the Act's non-criminal components did not concern "an evil needing to be suppressed," but instead "a burgeoning field of medical practices and research that … brings benefits to many Canadians" (para. 251).

These justices effectively saw a division of labour between prohibited (harmful) and non-prohibited (medically beneficial) components of the legislation. The criminal prohibitions did "not depend on the existence of the regulatory scheme," but were able to "stand alone… regardless of whether a scheme regulating other activities existed" just as "the regulation of activities associated with assisted human reproduction [does] not

depend on other activities being prohibited completely." For evidence, the Justices pointed to the 1996 legislative proposal, which contained only prohibitions, Bill C-47 (paras. 276-277). Moreover, LeBel and Deschamps claimed the provision for equivalency agreements did not remedy the legislation's "constitutional defects," insofar as provincial regulation would be "tolerated only if the provinces in question adhere to the federal scheme" (para. 272). While the unchallenged criminal prohibitions were certainly a valid exercise of the federal criminal law power, this second group of four justices would have struck down all the Act's controlled activities, as well as the licensing, inspection, and enforcement pertaining to those activities, upholding the Quebec Court of Appeal decision in its entirety. They would have left intact only sections 60 and 61, insofar as those punitive measures applied to unchallenged criminal prohibitions in sections 5-7 (para. 281).

Justice Cromwell, at that time the most junior Justice on the Court, cast the decisive vote. He generally agreed with Justices LeBel and Deschamps that most of the impugned provisions fell under provincial jurisdiction over health, as they "permit[ted] minute regulation of every aspect of research and clinical practice" and were not used to "simply prohibit 'negative practices'" (para. 286). However, he found three impugned provisions – concerning donor consent, the age of consent and reimbursement for donor- and surrogacy-related expenditures – were sufficiently criminal in nature to qualify as criminal law (para. 289). Thus, he upheld sections 8, 9, 12, 19, and 60, as well as several other provisions only insofar as they related to the constitutionally valid provisions.[20] While Justice Cromwell sided with aspects of both groups of justice, his decision generally adopted Justices LeBel and Deschamps' analysis; as Graeme Mitchell notes,

[20] These included sections 40(1), (6) and (7), 41 to 43, 44(1) and (4), 45 to 53, 61 and 68 (para. 294).

LeBel and Deschamps' opinion "represents the majority view on matters of doctrine," while Cromwell's opinion "is dispositive and governs the result" (2011: 640). Cromwell's vote invalidated most of the *AHR Act's* controlled activities and regulatory provisions, leaving a void yet to be filled by most provinces concerning many facets of assisted reproductive technology policy.

The Court Gets it (Just About) Right

This description of the case demonstrates that the most fundamental disagreement, which coloured all other analysis, concerned the pith and substance of the impugned provisions. The methods the Justices employed led to different conclusions. Chief Justice McLachlin agreed with the federal government that the purpose and effect of the legislation was to ban certain practices associated with assisted reproduction that constituted a public health "evil," and that any beneficial activities were incidental to those prohibitions. LeBel and Deschamps, by contrast, read the impugned provisions individually, and found that they were designed primarily to set national standards for health care in order to promote fertility and help build families. In effect, McLachlin thought the *AHR Act as a whole* was designed to eliminate evils, while Justices LeBel and Deschamps recognized that the legislation had two different goals: eliminating harmful practices through prohibitions and promoting beneficial health outcomes through regulation, data gathering, and licensure. Justice Cromwell's vote largely concurred with the LeBel and Deschamps opinion, although it moved a few activities from the "beneficial" to the "harmful" category.

There are several reasons why the LeBel and Deschamps/Cromwell combination produced the proper outcome. The first has to do with constitutional doctrine. The primary doctrine over which the justices disagreed was the "ancillary powers" doctrine which, first articulated by Chief Justice Dickson in *General Motors of Canada Ltd. v. City National Leasing* (1989), claims impugned provisions must be read *by themselves*, rather than as part of the overall scheme: "The issue is not whether the Act as a whole is rendered *ultra vires* because it reaches too far, but whether a particular provision is sufficiently integrated into the Act to sustain its constitutionality" (*General Motors* 1989). This logic produces a three-part test: first, whether the impugned provisions "intrude" on provincial powers; second, whether the Act as a whole is valid; and third, if the answer to the first two questions is yes, "whether the impugned provision is sufficiently integrated" with the overall legislative scheme (*Ibid.*). According to this doctrine, impugned provisions should be analyzed first, the legislative scheme second. However, by "assessing whether the entire statutory scheme [was] … a valid exercise of federal power and not whether the impugned provisions intrude on provincial legislative powers," Chief Justice McLachlin's analysis "chang[ed] the order of analysis," and in doing so "depart[ed] from the post-[[*General Motors*] applications of the ancillary powers doctrine" (Ogbogu 2011: 169-170, 173).

Second, Chief Justice McLachlin's decision to lump all of the legislation into having one purpose, beyond its lack of basis in legislative history, lacks clarity. As Ubaka Ogbogu notes, McLachlin's statement that Quebec was challenging the "bulk" of the *AHR Act* is what led her to reverse the order or analysis for the ancillary doctrine. However, McLachlin provides no guidance as to "what constitutes the 'bulk' of a

statute"; indeed, Quebec challenged fewer than half of the Act's provisions and left the vast majority of the criminal prohibitions unchallenged (Ogbogu 2011: 172). As Ian B. Lee notes, it is not "immediately obvious that the licensed sphere will be much smaller than the prohibited sphere, or that the obligations of licensees are not substantial" (2012: 480). One might add that, if the criminal prohibitions constitute the "dominant thrust" of the Act, as the Chief Justice found, then a decision that leaves those prohibitions intact did not even affect the bulk of the legislation. Either way, Ogbogu is certainly correct that the "the bulk of legislation inquiry seems imprecise and unprincipled, and is likely to produce conflicting readings of what makes up almost all of a statute" (2011: 172).

Third, there must be limits to the extent to which the criminal law can simply be used as a "proxy" for national concern. In the words of John D. Whyte, it is problematic when the criminalization of *beneficial* activities "takes the form of regulating through a public agency and adopts the regulatory instruments of investigation, standard setting through regulations, granting licences and administrative approvals" (2011: 52). Criminal law, as an instrument, usually includes an absolute prohibition. However, if criminal conduct can only be determined "after an administrative determination," it is not at all clear that this activity falls within the criminal law power, even if such regulation could be construed as an area of national concern. As in the Supreme Court *Reference*, "it will often be the case that the conduct being regulated falls within provincial jurisdiction" (Whyte 2011: 52). This is especially true with respect to the licensing requirements contained in the *AHR Act*, which certainly intrude on medical licensing, an area under provincial jurisdiction. As Lee notes, it is one thing to declare an aspect of assisted reproduction to be a criminal offence; "it is another thing to assume control over all

assisted reproduction activities by requiring them to be carried out under a federal licence" (Lee 2012: 492).

Constitutional doctrine aside, the Chief Justice's analysis also failed to give proper weight to the legislative history of the *Act*, particularly in her dismissive portrayal of the Baird Commission's influence. McLachlin gave the Commission's recommendation little if any weight, claiming it was a mere "policy analysis" that did little to inform the efforts behind the *Assisted Human Reproduction Act*: "the fact that the Baird Commission may have referred to positive aspects of assisted reproduction technology… does not establish that these benefits were the focus of Parliament's efforts" (2010: para. 29). In principle, this could be true; however, as Chapters 3 and 4 of this dissertation demonstrate, the Baird Commission was central to every stage of legislative development. McLachlin and her colleagues did not need to undertake a detailed qualitative analysis to determine the extent to which the Baird Commission influenced the legislation; even a cursory study shows that at every stage of the legislative process, Parliament relied on the Commission, in the end producing legislation that was remarkably similar to its recommendations. Commissioners frequently appeared as witnesses before committee, lauding the legislation. The federal government referenced the Commission at every single stage of legislative development, and one MP even referred to the legislation as a "child of the Royal Commission" (Canada 2002a). LeBel and Deschamps correctly criticized McLachlin's account for containing "no factual basis whatsoever" and being "contrary to the usual approach to constitutional analysis" (para. 177).

Moreover, regardless of the Baird Commission's influence, government statements demonstrate that the goal of the legislation was not simply to eliminate evil practices. The influential 2001 Brown Committee report was called *Building Families*, not *Eliminating Harmful Behaviour*. It is worth quoting former Health Minister Pierre Pettigrew's description of the three goals of the legislation in 2004: "to protect Canadians using assisted human reproduction to help them build a family, so that their health and safety are not compromised; to prohibit unacceptable practices such as human cloning; and to ensure that research related to assisted human reproduction, which may help find treatments for infertility and serious deceases, takes place within a regulated environment" (Canada 2004a). In addition to criminalizing certain harmful behaviour, the goal of the legislation was to implement national standards in the area of reproductive technology, even when those standards intruded on provincial jurisdiction over health. Provincial inaction and a desire for national standards may be laudable goals but, in the words of Justices LeBel and Deschamps, "[n]either a desire for uniformity nor the very novelty of a medical technology can serve as the basis for an exercise of the federal criminal law power" (2010: para. 255).

While the LeBel/Deschamps opinion gives a more precise reading of the legislative history of the Baird Commission, Justice Cromwell's slight alteration is also a welcome development. While Cromwell has been criticized for being "Delphic" and not adequately articulating his reasoning in his brief opinion (Mitchell 2011: 654-646), his decision to uphold the outright prohibitions in sections 8 and 9 (the use of reproductive material without donor consent and the use of reproductive material from a minor) seems reasonable, as those prohibitions fit the "traditional" definition of crime (Lee 2012: 492).

Moreover, the section 12 regulation permitting reimbursement of expenditures, which Cromwell also upheld, is directly connected to the prohibition contained in section 6; as federal government lawyer Glenn Rivard noted, this provision is consistent with the intent of the criminal prohibition, the objective of which was "to prevent any financial gain" from being a gamete donor or surrogate (Canada 2004a). Lee is correct in suggesting that LeBel and Deschamps, and the Quebec Court of Appeal, did go slightly too far in their analyses of these prohibitory components (2012: 492).

Thus, from a doctrinal and legislative-historical perspective, a bare majority of the Court seems to have got the case just about right. Indeed, the legal commentary on the case has been largely positive about the majority opinion (Mitchell 2011; Ogbogu 2011; Posyniak 2011; Whyte 2011), although a few commentators have quibbled with certain details (Hogg 2012; Lee 2012; Newman 2011). However, when it comes to commentary about the decision's implications – about how on-the-ground regulation of ARTs must now occur – the reaction from those other than legal experts has been almost uniformly negative.

Commentary on the Supreme Court Decision: General Outrage

The *Reference re Assisted Human Reproduction Act* was of no small consequence. Rarely, if ever, has the Supreme Court struck down so much of a piece of legislation so comprehensive or so long in the making. In practical terms, a majority of justices held that the provinces have sole authority to regulate the transfer and storage of human reproductive material, non-criminal research combining human and nonhuman material, oversight and licensing of fertility clinics, and the creation and maintenance of patient

databases. Assisted Human Reproduction Canada was gutted, with virtually all of its regulatory functions rendered unconstitutional; having "lost much of its *raison d'être*," it was wound down in 2012 and subsumed into the broader Health Canada structure (Baylis and Downie 2013: 197). Over twenty years after the Baird Commission began its work on creating a national framework, the Supreme Court had, in the eyes of many, set much of ART policy in Canada back to square one and, in the eyes of some, even left Canada in a worse situation than it was in 1989 (see Baylis 2011).

The reaction was general outrage. Academics, health law experts, and media commentators quickly condemned the decision, with one newspaper claiming Canada's attempts to regulate the fertility industry had "collapsed in ruins" (Victoria Times-Colonist 2011). There was a concern, articulated by law professor Vanessa Gruben, that provinces would be unable to protect women and children. Patricia Baird, the chair of the 1993 Royal Commission, claimed the decision would "lead to a patchwork of clinical standards." Others feared the outbreak of "fertility tourism," with an op-ed in the Canadian Medical Association Journal concerned that women "may opt to travel to a province that permits multiple implantations" for *in vitro* fertilization (all cited in Eggertson 2011). Some feared that, apart from the federal government's criminal prohibitions, ART policy was now largely unregulated. Other than legislation pertaining to surrogacy and parentage transfer, only Quebec, which in 2009 created legislation containing ART regulations tied to universal health insurance coverage for IVF, has any assisted-conception legislation (Quebec 2009).[21] The other nine Canadian provinces have

[21] Quebec has several Civil Code provisions (articles 11-25 and 541) and other pieces of legislation that concern ART, including *An Act respecting Clinical and Research Activities relating to Assisted Procreation* (Quebec 2009). See *Reference Re Assisted Human Reproduction Act* 2010, paras. 222-224. These are described in detail in chapters 6 and 7.

yet to produce a legislative response, and as a result many scholars were concerned that "in some provinces there will be no legislation, and therefore no regulatory oversight of practices that may be unsafe for the mother or the eventual offspring" (Hogg 2012: section 18-34). In short, many feared a return to the "the Wild West culture of the past" that characterized the early days of ART (Baylis 2011: 319; see also Blackwell 2010; Kirkey and Tibbetts 2010; Toronto Star 2010).

These responses to the Supreme Court decision share three assumptions: first, provinces are unable and/or unwilling, individually or collectively, to effectively regulate ART policy; second, provincial variation in ART policy is suboptimal; and finally, outside of Quebec, the non-prohibited aspects of ART policy are effectively unregulated. The first two are normative assumptions that can be traced back to the Baird Commission, while the third, an empirical assumption, downplays existing federal and provincial policies in several subfields and ignores the work of medical self-regulatory organizations. First, with respect to provincial inability, there is ample evidence that subnational governments, either individually or collectively, are capable of regulating ART policy both in Canada and elsewhere. Quebec has introduced a comprehensive ART policy scheme (including health insurance coverage for IVF), which addresses surrogacy, assisted conception, and parentage. In most other provinces, parentage and the legality of surrogacy contracts are governed by a combination of provincial legislation and common law (see Chapter 6). Thus, Canadian provinces are more than capable of regulating in many subfields of ART policy.[22] However, although "not all provinces have been

[22] Comparative evidence also demonstrates that substantial subnational regulation is possible. For example, Australia's experience with decentralized ART policy shows that sufficient subnational collaboration and harmonization can occur through intergovernmental institutions, competitive federalism, policy learning, and non-governmental guidelines (National Health and Medical Research Council 2007).

reticent," it does appear that most provinces have been reluctant to create ART legislation that addresses the assisted conception subfield specifically (Mitchell 2011: 667).

Moreover, contrary to the hopes of the Baird Commission, just because something is administered by the federal government does not mean it will be administered more competently or effectively. Assisted Human Reproduction Canada is a case in point; it did virtually nothing in the way of monitoring, enforcement, and licensing during its six years of existence. The legislation, in short, produced limited institutionalization and no comprehensive regulatory framework. AHRC's inactivity may be explained in part by anticipation of the Supreme Court decision, and while some of the blame can be laid at the hands of the RCMP (which is responsible for enforcing the prohibitions) or Health Canada (which has issued only a single regulation in the decade following the *AHR Act's* passage), Françoise Baylis is largely correct that "[f]ew (if any) will mourn the passing of this agency," which quite simply "did not deliver on its major responsibilities" (2012: 511). While the national frame was dominant from the Baird Commission to the passage of the *AHR Act*, the existence of this frame never sufficiently moved from the realm of ideas to the realm of institutions. Ideational frameworks exert path dependence and can have lasting effects, but when they interact with the "organization of politics," institutionalization is not guaranteed.

Second, provincial variation is a natural consequence of Canada's decentralized health care structure, and the *AHR Act* had done nothing to change this. "Fertility tourism" in the broadest sense was hardly absent prior to the ruling. A current list of fertility clinics in Canada shows that there are 46 clinics in Ontario – the city of Toronto alone has 17 – compared with one each in Saskatchewan, Manitoba, Nova Scotia, and

Prince Edward Island (Infertility Network 2013). Because procedures such as IVF require expensive equipment and medical expertise, assisted reproductive technologies will always be more accessible in certain areas, whether the authority to enact regulations falls under federal or provincial jurisdiction. Although patients can conceivably travel to provinces that provide more liberal procedures, if a given procedure is considered ethical, this is no reason to disapprove of province-to-province variation – and if something is considered unethical, the federal government can always criminally proscribe it. As with other areas of public policy, provincial differences could even lead to the emergence of best practices. To take one example, Quebec's decision to fund IVF could provide evidence of whether it is a good (or bad) idea to allocate scarce health care resources to this area, serving as a model (or not) to other provinces (see Baylis 2013; Gerson 2012).

Finally, ART policy outside of Quebec is not unregulated. Even after the Supreme Court case, the *AHR Act* still contains prohibitions that cover five ART subfields: assisted conception (payment for gametes); surrogacy (payment); embryonic research (the creation of embryos for non-research purposes as well as certain types of embryonic research); reproductive human cloning (a total ban); and screening, enhancement, and manipulation (germline manipulation, ectogenesis, and non-medical sex selection). Some commentators (Downie and Baylis 2013) have criticized the federal government for not properly enforcing the prohibitions in the face of blatant violations. However, after years of inactivity on the policing front, there are signs the federal government has started to enforce the prohibitions: In 2012, the RCMP raided a fertility consulting firm for allegedly brokering commercial transactions for surrogacy, and the owner Leia Picard subsequently pleaded guilty and accepted a $60,000 fine (Blackwell 2013a, 2013b).

The federal government also continues to play an important role in updating its prohibitions. First, the federal government has created one regulation pertaining to the AHR Act, the Consent to Use (section 8) regulation in 2007, which stipulates when human gametes can and cannot be used. In 2012, when it transferred all of Assisted Human Reproduction Canada's remaining responsibilities to Health Canada, the federal government also amended section 10 of the *AHR Act*. The amendments removed controlled activities requiring a license, and added a new prohibition forbidding the importation, distribution, and use of human reproductive material unless that material has met a number of safety requirements that will be laid out in future regulations (Norris 2012: 10). Tellingly, the government inserted a clause at the beginning of the new section indicating that its purpose was to "reduce the risks to human health and safety," thereby unambiguously adopting the moral frame to remove any constitutional uncertainty concerning the goal of the prohibitions. The section is not yet in force and regulations have not yet been created (Canada 2012: s. 716; Downie and Baylis 2013: 228).[23] While it is unclear why the federal government has decided delay its framework, the government is certainly aware that it has the authority to act on its prohibitions.

Additional federal policies, outside of the *AHR Act,* also exist for the following:

- Health Canada inspects fertility clinics every three years;
- There is a federal directive for the Processing and Distribution of Semen for Assisted Conception, created in 1996 and updated in recently in 2006 (Canada 2006);

[23] As Downie and Baylis (2013: 228-229) describe, "once the section is in force and regulations have been made, the distribution, making use, or importation of fresh eggs for reproductive purposes will be limited to those who are the spouse, common-law partner or sexual partner of the providers… the distribution, making use, or importation of eggs for reproductive purposes will be limited to frozen eggs from sources and through processes that can meet the health and safety requirements."

- The federal *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS), created in 1998 and updated in 2010, governs funding for research involving humans and embryos (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada 2010);
- Also in 2010, the Canadian Institutes for Health Research (CIHR), a federal granting agency, updated its *Guidelines for Human Pluripotent Stem Cell Research* (Canadian Institutes for Health Research 2010).

Together, these federal rules, guidelines, and prohibitions set additional rules for ethical acceptability concerning several practices in the subfields of *assisted conception, embryonic research, reproductive human cloning*, and *screening, enhancement, and manipulation*. Moreover, the federal government is not the only policymaker in the ART realm. Subsequent chapters will explore the myriad regulations currently in place from provincial governments, professional medical organizations, and even courts.

Conclusion

After fifteen years of hand wringing at the Baird Commission and in Parliament, federal policymakers could have been forgiven for thinking their hard work was done with the passage of the 2004 *Assisted Human Reproduction Act*. However, the tragedy that became Canada's assisted reproductive technology policy had one final act. Quebec quickly challenged the legislation for violating provincial authority over health, and in 2010 a majority of the Supreme Court justices agreed with their claim. Most non-criminal aspects of the legislation were struck down, Assisted Human Reproduction Canada

closed up shop, and analysts lamented the fact that Canadian ART policy had returned to "the Wild West."

This chapter examined how Canada came to an outcome that, by the standards of the Baird Commission and the Liberal government that passed the *AHR Act*, was clearly sub-optimal. Why were federal policymakers and experts so wrong about the extent to which the *AHR Act* could be justified as valid criminal law? To be sure, the Baird Commission did not deliberately introduce a constitutionally unstable framework, nor did subsequent federal actors simply ignore the legal advice they received. As Béland and Cox note, "policy ideas lend themselves to many, sometimes conflicting, interpretations" (2011: 9). The Commissioners and their staff certainly acted in good faith, making policy recommendations that they felt best suited the rapidly emerging field of assisted reproductive technologies in Canada. The Commission's intentions were genuine. Yet, especially at the early stage of policy development, policy frames and policy choices can lead to unintended consequences: "[e]ven where actors may be greatly concerned about the future in their efforts to design institutions, they operate in settings of great complexity and high uncertainty. As a consequence, they will often make mistakes" (Pierson 2004: 15). With 20/20 hindsight, I believe the Baird Commission made a mistake. Its decision to frame certain assisted reproductive technologies as medical issues requiring national policy led it down a risky road, and its own constitutional analysis severely overstated the federal government's authority to regulate in this area.

Yet this was not a foregone conclusion, particularly given the Supreme Court's closely divided decision. Indeed, another factor explaining the disjuncture between the Commission and federal government's certainty concerning the constitutionality of

federal legislative was the Court's jurisprudence. The Supreme Court's decisions in the 1990s and early 2000s – precisely the time during which the *AHR Act* was being created – was also a factor. Throughout this period, the Supreme Court moved away from accepting the "national concern" test derived from the federal authority to make legislation for the "Peace, Order, and Good Government" (POGG) of Canada, increasingly relying on the more limited criminal law power instead. By the time national concern had faded into the background of constitutional jurisprudence, the federal government nevertheless accepted and implemented the advice it received from the Baird Commission. This is yet another example of a public policy producing unintended consequences because "the factors that gave it an original advantage have long since passed away" (Pierson 2004: 47). While the constitutional "advantage" of a centralized framework was always a tricky proposition, this changing jurisprudence nonetheless contributed to the Supreme Court decision.

In the context of this changing jurisprudence, the most important factor explaining the outcome is the federal framing strategy articulated in chapters 3 and 4, which loomed large throughout proceedings at both the Quebec Court of Appeal and the Supreme Court of Canada. From the Baird Commission to the *AHR Act*, federal policymakers had articulated the need for national legislation by relying on two discourses: the medical-scientific frame, by which the legislation sought to promote beneficial activities; and the moral frame, by which the legislation sought to eliminate harmful behaviour by preventing commodification, exploitation, and threats to human dignity. They were wedded together under a "national" frame, whereby the federal government was the policy actor best suited to address these dual goals. These framing strategies reappeared

in the courts, which were primarily concerned with the "pith and substance," or primary purposes, of the non-criminal aspects of the *AHR Act*. In both cases, a majority of justices relied on legislative history and held that the Act had a dual purpose – to prohibit harmful practices and promote beneficial ones – and that the impugned provisions dealt solely with the latter. The federal government tried, in this case in vain, to defend the *AHR Act* as legislation that primarily targeted "evils"; Chief Justice McLachlin and three other justices bought this argument largely by downplaying the importance of legislative history. But a majority of justices rejected this moral frame, holding the federal government should be solely responsible for policing harmful practices associated with ARTs, and that provinces ought to regulate the beneficial practices. The majority opinion, relying in part on Justice LeBel and Deschamps' opinion and in part of Justice Cromwell's opinion, effectively found that the dual purposes of the *AHR Act* mandated a division of labour by provincial and federal governments.

However, the Supreme Court Reference is not the end of Canada's ART policy story. While many have lamented that Canadian ART policy now constitutes the "Wild West" – an odd claim given the continued existence of criminal prohibitions – this understates the role played by provincial governments, medical associations, and even courts. As such, it provides an opportunity to explore the extent to which these other policymakers have created policy both before and after the Supreme Court decision. The next chapters move beyond the federal government, exploring what action other policymakers have taken with respect to ARTs. I begin with two subfields over which provincial governments have been exercising policymaking authority for quite some time: surrogacy and parentage.

CHAPTER SIX:

SURROGACY AND PARENTAGE POLICY IN THE PROVINCES

Following the Supreme Court decision, many scholars have characterized Canadian ART policy as largely unregulated. While the previous chapter demonstrated that some federal authority still exists in the field, there exists no comprehensive national policy of the sort the Baird Commission and the federal government intended. In 2013, Assisted Human Reproduction Canada closed down, and Health Canada has initiated few regulations in its absence. Enforcement of criminal prohibitions has been, in the eyes of many, underwhelming. After the 2010 Supreme Court Reference put the ball in the provinces' court, there has been limited provincial legislative action. Perhaps as a result, few studies have examined provincial regulation of ARTs (for exceptions, see Busby and Vun 2010; Cooper 2013; L'Espérance 2013).

As this chapter and the next will attest, however, there is much to be gained from a closer look at provincial ART policy, particularly keeping in mind the framework introduced in Chapter 2. Assisted reproductive technology is a wide-ranging policy field that contains six distinct subfields, three of which – assisted conception, surrogacy, and parentage – fall mostly or exclusively within provincial jurisdiction. Consider the example of a child conceived via donor gametes using assisted conception, gestated by a surrogate, and transferred to the custody of intended parents. In this situation all three policy subfields will be implicated. First, assisted conception policy concerns rules for fertility clinics and the use of reproductive material. The many matters surrounding conception itself – the origin of donor gametes, the number of embryos that can be legally transferred into the surrogate, the strictness of rules regarding licensing of fertility

clinics, the number of times a man can donate sperm, the age at which a woman can legally receive IVF, and the extent to which fertility treatment is covered by the government – all fall within the largely provincial policy subfield of assisted conception. Next, the extent to which the surrogate can be paid, the legal distinction between traditional and gestational policy, and the validity and enforceability of surrogacy arrangements fall within the surrogacy policy subfield, which also lies primarily within provincial jurisdiction. Finally, during and after the birth process, both the rules for who can become a parent and the processes used to transfer parentage, even in the context of a surrogacy arrangement, fall within the clearly provincial subfield of parentage policy.

As it turns out, when scholars refer to a lack of provincial policy concerning assisted reproductive technologies, they are almost always referring to assisted conception (the topic of chapter 7), which, outside of Quebec, has not been legislated by provincial governments. However, in the other two provincial subfields – surrogacy and parentage (the subject of this chapter) – there is considerable provincial regulation in Canada. Half of the provinces have some form of surrogacy legislation and most have rules for parentage, whether created by legislation or the common law. While these regimes have been receiving some attention from legal scholars of late (Burpee 2009; Busby and Vun 2010; Cameron, Gruben, and Kelly 2010; Kelly 2009; Nelson 2013a, 2013b), they have been largely ignored by the comparative and Canadian political science literature on ARTs. The purpose of this chapter is to direct the scholarly focus on assisted reproductive technologies towards these areas of provincial jurisdiction.

In this chapter I address the surrogacy and parentage subfields individually, explaining what distinguishes them conceptually. While the patchwork of Canadian laws

in this area has frustrated commentators in favour of reform, the myriad ways in which provinces have addressed these subfields actually provide conceptual clarity that supplements the typology created in Chapter 2. After defining the two subfields, I create a framework by which to measure policy variation between jurisdictions within each subfield. This framework makes a new contribution to the literature on ARTs, as it enables scholars to distinguish between surrogacy and parentage policy and facilitates greater cross-national and intra-national comparison. I then apply this framework to surrogacy and parentage policy within each Canadian province. In keeping with the comparative ART literature, I give each province a score in terms of policy permissiveness, with permissiveness defined simply as fewer legal barriers for intended parents. In addition to highlighting where policy reforms have been most prominent, this demonstrates the considerable variation that exists between Canadian provinces in these fields.

This chapter's analysis of the Canadian provinces demonstrates a few points. First, when it comes to surrogacy and parentage, Canadian provinces are not "unregulated." There exists considerable regulation, and the general trajectory of policy change has been towards gradual permissiveness. Second, given provincial variation in terms of surrogacy and parentage policy, it is difficult to deny that these subfields of ART policy represent the "patchwork" that so many critics lament. As these subfields rest most definitively under provincial jurisdiction – even the Baird Commission recognized this – this variation is unsurprising. However, while I have been largely agnostic about the content of ART policy throughout this dissertation, I concur with critics of provincial action that these two subfields in particular ought to be subject to clear legal rules,

regardless of the permissiveness of those rules. When it comes to questions as fundamental as a child's legal parents, surely statutory certainty is preferable to the *ad hoc*, expensive, and time-consuming judicial process.

Finally, although I argue legal certainty is preferable to judicial decision-making, the absence of such certainty in these two subfields further demonstrates the importance of the courts as policymakers in their own right. When legal rules surrounding surrogacy and parentage are absent or unclear, judicial policymaking increases. In several provinces, individual judicial decisions have effectively set the rules for surrogacy and/or parentage in the absence of government policy; in others, they created the impetus for reform. Studying surrogacy and parentage policy provides yet another example of how studying different policymaking institutions can enrich our study of Canadian ART policy, and indeed of ART policymaking more generally.

Provincial Dominance of Surrogacy and Parentage Policy

There is much the provinces do not do with respect to assisted reproductive technologies. In three subfields – human cloning, embryonic research, and screening and manipulation – there is effectively no provincial legislation, largely because the federal government has introduced a number of absolute bans in the *Assisted Human Reproduction Act* (*AHR Act*). With respect to *embryonic research*, the *AHR Act* prohibits the creation of animal-human chimeras or hybrids, the creations of an embryo from part of another embryo or fetus, non-reproductive or "therapeutic" human cloning, and the creation of embryos solely for research. It contains an absolute prohibition on *reproductive human cloning*, and it prohibits transplanting a human clone into a human being. Finally, with respect to

screening, enhancement, and manipulation, it bans germ-line engineering, non-medical sex selection, ectogenesis, and using human reproductive material in a non-human life form to create chimeras or hybrids. With the federal government largely covering these three areas, it is not surprising that provinces have yet to act. Because human cloning is subject to an absolute ban, provinces cannot regulate it. And while there is not an *absolute* ban on all aspects of screening, enhancement, and manipulation or embryonic research, the breadth of the federal bans makes it unlikely that provinces would seek to regulate the small areas – such as preimplantation diagnosis – for which the *AHR Act* leaves room.

By contrast, provincial authority over health care and family law does permit the provinces a wide range of legislative and regulatory capability concerning ARTs, particularly in the wake of the 2010 Supreme Court decision. Some of this authority was recognized as early as 1993. While the Baird Commission's recommendations were dominated by its "national" frame, I noted in Chapter 4 that the Commission "could have opted for a provincial frame – as it did for parentage policy and the admissibility of surrogacy arrangements." The Commission called for "family law reform to clarify and standardize in all provinces the parentage of children born as a result of donor insemination," including provisions that egg and sperm donors have no parental rights. It also recommended that provinces and territories amend family laws to make surrogacy arrangements "unenforceable against the gestational woman" regardless of whether payment occurred (Canada 1993: 489, 595, 600). As it turns out, in the two subfields over which the Baird Commission accepted the provinces had primary jurisdiction, the past

twenty years has seen the most activity from provincial governments (and, at times, courts).

Perhaps more than any two subfields of assisted reproductive technology policy, surrogacy and parentage are conceptually related. However, it is possible to distinguish between laws concerning surrogacy and those concerning parentage when we consider that parentage policy occurs *last* temporally. Once governments have determined the rules governing assisted conception and the validity/enforceability of surrogacy arrangements, they *then* deal with who are listed as parents, and how parentage can be transferred or added. This chapter follows this temporal sequence, treating surrogacy first and then parentage.

Surrogacy Policy in Canada

Surrogacy is a method of achieving assisted reproduction through a private social and legal arrangement in which a woman gestates and bears a child to be raised by someone else. It is the assisted-reproduction option typically used when a woman lacks a viable uterus, or when a single man or gay couple are attempting to have children (Snyder and Byrn 2005: 637). When governments make policy concerning surrogacy, they effectively deal with three mutually exclusive issues: whether the surrogate is genetically related to the child; whether the surrogate is paid or unpaid; and whether surrogacy arrangements are enforceable.

In Canada, surrogacy policy involves both criminal law and family law, and as such is regulated by a combination of federal and provincial legislation (Nelson 2013b: 328). Of the three components of surrogacy, the federal government has addressed only

payment: section 6 of the *AHR Act* bans paying, offering to pay, or advertising "consideration" to a would-be surrogate. It also bans acting as an intermediary, paying an intermediary, or counselling someone under 21 years of age to be a surrogate. However, the law includes a provision that allows reimbursement of surrogacy-related expenditures, as long as that reimbursement is in accordance with federal regulations (Canada 2004: ss. 6, 12). Although those regulations have not yet been created, Health Canada has confirmed that surrogates "are currently allowed to be reimbursed for actual expenses they may incur," although they cannot be compensated for the act of surrogacy itself (cited in Downie and Baylis 2013: 229).

However, federal law addresses neither the validity or enforceability of surrogacy arrangements nor the distinction between traditional and gestational surrogacy. In fact, no level of government has legislated concerning traditional and gestational surrogacy. However, there is considerable evidence that traditional surrogacy – in which the surrogate is genetically related to the resulting offspring – is uncommon in Canada. In 2001, fertility lawyer Sherry Levitan claimed that traditional surrogacy was "not done" in Canadian fertility clinics, with physicians unwilling to perform insemination and lawyers unwilling to draft a surrogacy agreement (Canada 2001a). In 2011, another Canadian fertility lawyer confirmed in an interview that "traditional surrogacy is quite rare," and that her firm did not create traditional surrogacy arrangements (Interview 2011e). Traditional surrogacy can be achieved in the privacy of one's home, as in the famous case of Cathleen Hachey, a New Brunswick surrogate who conceived using a syringe and donor sperm, and whose intended parents subsequently backed out of the agreement

(CBC News 2011).[24] While traditional surrogacy is uncommon in Canada, it is not illegal, and the extent to which a traditional surrogacy arrangement can be used to influence parentage transfer depends on the rules regarding genetic association in each province's parentage legislation (see below).

In terms of surrogacy policy, the major point of province-to-province variation in Canada concerns the enforceability of surrogacy arrangements – a pre-birth agreement between a surrogate and one or more intended parents that the intended parent(s) will raise the child. The purpose of a surrogacy arrangement is to enable successful transfer of parentage from the birth mother to the intended parents with as few legal roadblocks as possible. It is a recognition of new family forms prominent in the age of ARTs; as Australian surrogacy expert Jenni Millbank (2011: 78) states, transferring legal parentage to intended parents "is justified by and consistent with a functional family approach to relationship law," one that "legitimizes non-nuclear relationships that share the essential characteristics of traditional relationships" (Harvard Law Review Association 1991: 1641).

Thus, surrogacy arrangements are by definition permissive insofar as they move beyond traditional forms of family formation. However, the rules surrounding surrogacy arrangements can be more or less permissive depending on how they address *validity* and *enforceability*. Validity concerns whether surrogacy arrangements have any legal standing, and can thus be used to expedite parentage transfer. If surrogacy arrangements

[24] Hachey, from Bathurst, New Brunswick, was interested in being a surrogate and found a British couple online who were looking for a surrogate. The couple visited her and signed a contract, and Hachey performed home insemination using the intended father's sperm. She became pregnant with twins. However, Hachey was subsequently notified via text message that the couple had split up, and no longer wished to raise the children. She was able to find a Nova Scotia couple willing to adopt the children (CBC News 2011).

are invalid, the intended parents may still raise the child, but will have to navigate a given jurisdiction's adoption regime. Enforceability, meanwhile, concerns what happens in the presence of a dispute. If, after birth, the surrogate and the intended parent(s) all agree that the intended parent(s) should raise the child, then enforceability does not matter – at this point, the type of parentage transfer rules determine the transfer process, which all parties want. However, if a surrogate changes her mind and decides she wants to raise the child, enforceability becomes crucial.

Table 6.1
Surrogacy Arrangements in Canada

Restrictive <----------> Permissive				
1. **Invalid**	**2.** **Valid** **Unenforceable**	**3.** **Valid** **Enforceability unclear**	**4.** **Valid** **Enforceable, w/ exceptions**	**5.** **Valid** **Enforceable, no exceptions**
Quebec	Alberta	Nova Scotia Newfoundland British Columbia	(Florida) (Nevada)	(Ukraine)

Erin Nelson has aptly described Canadian provincial law concerning surrogacy arrangements as "unsettled," because validity and enforceability of those arrangements varies from province to province (2013b: 328). In Table 6.1, I posit a five-column scale of the permissiveness of surrogacy arrangements and locate the five Canadian provinces with legislation. The Canadian examples cluster from the restrictive to the middle portion of the table. Quebec is at the most restrictive end of the spectrum (column 1): according to Article 541 of the Civil Code of Québec, surrogacy arrangements are null and void, and they are thus neither valid nor enforceable. Alberta's legislation is next on the restrictiveness scale: while surrogacy arrangements are valid in order to speed up parentage transfer, the *Family Law Act* states that they are not enforceable; if the

surrogate changes her mind, she will keep the child. British Columbia, Nova Scotia, and Newfoundland and Labrador, the other three provinces with surrogacy legislation, are slightly more permissive than Alberta; in each jurisdiction, surrogacy arrangements are valid, but their enforceability is unclear (column 3). British Columbia's *Family Law Act* (2011) states that a surrogacy arrangement *alone* cannot satisfy the requirement for a parentage order (more on that below) but that it "may be used as evidence of the parties' intentions with respect to the child's parentage if a dispute arises after the child's birth" (British Columbia 2011: 29.6). Thus, unlike Alberta and Quebec, British Columbia law contemplates the potential enforceability of an agreement in the case of a dispute.

Neither Nova Scotia nor Newfoundland and Labrador specifically stipulate whether surrogacy agreements are enforceable, but both mention such agreements in the context of a parentage order. Newfoundland's *Vital Statistics Act* (2009) provides a provision to register intended parents in the case of a court order, which makes surrogacy arrangements valid. Thus, in theory, Newfoundland's legislation grants more opportunities than Alberta's for the surrogate to "change her mind" if she decides to keep the child. This has yet to be tested in court. Nova Scotia's *Birth Registration Regulations* (2007) allow a court to make a declaratory order granting legal parentage to the intended parents, and provides a number of stipulations. To be valid, the surrogacy arrangement has to be planned prior to conception, and one intended parent must have a genetic link to the child. Busby and Vun (2010: 30) contend that "[t]he regulation does not expressly require the surrogate's post-delivery consent to the order or even that she be given notice that an order is being sought," suggesting that in Nova Scotia, surrogacy arrangements may be enforceable (see also Busby 2013: 298). However, this is likely an incorrect

reading of the regulation: section 5(2)(c) states that a condition for parentage transfer is that "the woman who is to carry and give birth to the child does not intend to be the child's parent." The regulation says nothing about this being limited to a pre-birth agreement; rather, this suggests that the surrogate must still consent post-birth. Because the legislation does not explicitly state that such agreements are unenforceable – and because there is disagreement amongst scholars about the extent to which it is enforceable – I place Nova Scotia in the same category as British Columbia and Newfoundland: valid, with unclear enforceability (column 3).

At the other end of the spectrum, the most permissive surrogacy arrangements are both valid and legally enforceable without exceptions (column 5); the arrangement is effectively treated as a "contract," and once a surrogate signs up for an arrangement, she cannot changes her mind and decide to raise the child. This is the case in Ukraine (one of the few jurisdictions to treat surrogacy as a contract), where the government "presumes the intended parents' parentage, severs the claims of the surrogate mother and her husband, and surrogate-born children are not citizens of the Ukraine despite their in-country birth" (Busby 2013: 293). However, fully valid and enforceable surrogacy arrangements with no exceptions are quite rare; instead, most jurisdictions that have valid and enforceable surrogacy arrangements – such as Florida and Nevada – deny parental rights to *gestational* surrogates but not *traditional* surrogates (Nelson 2013a: 254). These states fall into column 4, wherein agreements are enforceable with exceptions. Other exceptions may include the requirement that one or more intended parent must be related to the child.

A lack of clarity, whether in the form of unclear legislation or the absence of legislation – as in the other five Canadian provinces – leaves considerable room for judicial interpretation about enforceability in the case of a dispute. While there have been several high-profile disputes between surrogates and intended parents abroad – most notably, the *Baby Cotton* and *Baby M* cases in the United States and the United Kingdom in the mid-1980s (*Re Baby M* 1988; *Re C (A Minor) (Wardship: Surrogacy)* 1985) – there has only been one major contested case involving the enforceability of a surrogacy arrangement in Canada: *H.L.W. and T.H.W. v. J.C.T. and J.T.* (2005) in the Supreme Court of British Columbia. In this case, H.L.W. agreed to act as a traditional surrogate for Mr. and Mrs. T. using Mr. T.'s sperm, meaning she was genetically related to the child. The T.'s also agreed to compensate H.L.W. After disputes concerning both the extent of compensation and the contact H.L.W. would have with the child, she opted not to consent to the child's adoption, instead deciding that she and her husband, T.H.W., would raise the child – in effect, she changed her mind after the arrangement had been agreed upon. Despite the fact that H.L.W. was genetically related to the child and that she was listed as the birth mother on the child's registration, the court's preliminary decision refused the surrogate and her husband access to the children, pending trial. The judge's main rationale was that the child had to that point (aged three months) been raised by his intended parents, and that the child's best interests were served by continuing in the same care pre-trial. A trial decision was not reported, suggesting the outstanding issues were resolved out of court (Boyd 2007: 79; Busby and Vun 2010: 31-32).

As Boyd (2007: 79) notes, in this case two factors "seemed to carry weight": the pre-birth surrogacy arrangement, and "the genetic father's wish to complete his family by

having children, whereas the genetic/birth mother and her husband already had four children." Because the decision was pre-trial and the judge's primary concern was the child's best interests, it cannot be construed simply as enforcing a surrogacy arrangement as if it were a contract. Moreover, there are several reasons that this case is unlikely to act as a precedent. First, it involved traditional (genetic) surrogacy, not gestational surrogacy. As noted above, traditional surrogacy is very rare in Canada, and many fertility clinics will not engage in the practice. Second, the surrogacy arrangement was commercial, insofar as the surrogate was paid – indeed, part of the dispute centred on payment. This would be illegal in Canada today, but because the arrangement took place before the passage of the *AHR Act* in 2004, it was legal at the time. Third, and most importantly, British Columbia subsequently amended its *Family Law Act* in 2011. This legislation accepts the validity of surrogacy arrangements and does not necessarily render them unenforceable; however, it explicitly states that the surrogacy arrangement cannot, by itself, satisfy the conditions for transfer of parentage. In the future, the enforceability of surrogacy arrangements in British Columbia will depend much more on judicial interpretation of the *Family Law Act* than the *H.L.W.* case.

Other surrogacy cases have arisen in Canada, but these have not dealt with the enforceability of surrogacy arrangements; instead they have concerned birth registration, declarations of parentage, and access disputes *between* intended parents, each of which fit more properly into the subfield of parentage (discussed in the next section).[25] It is fair to say that with respect to the enforceability of surrogacy arrangements, judicial precedent has offered nothing in the way of certainty to fill this

[25] A different Quebec case, which also predates the *AHR Act*, involved a dispute in which a traditional surrogate was awarded custody and the intended parents were not. In this particular case, the surrogate was the biological mother of the *intended* mother, further complicating matters (Boyd 2007: 79).

void. At the same time, legislation can certainly constrain judicial activity, as a 2009 Quebec case attests. In *X, sub. nom Adoption -091* (2009), a Quebec court refused to recognize the validity of a surrogacy arrangement. In an attempt to get around the Civil Code provision, the surrogate had left the "mother" line on the birth registration blank, had named the intended father as the commissioning father, and did not oppose an application by the intended mother to adopt the child. However, the court held that "the child does not have the right to a maternal affiliation at any price" and that permitting the adoption would "require willful blindness" to the attempt to skirt the letter of the law (para. 77-78; cited in and translated by Busby and Vun 2010: 29-30). The situation was not helped by the fact that the intended parents had agreed to pay $20,000 to the surrogate, which was technically a criminal violation of the federal *AHR Act*. No federal criminal charges were laid against the intended parents, and it is unclear how the adoption was subsequently resolved. Nevertheless, this demonstrates that courts will function within the confines of the law, and that legislative certainty – such as declaring surrogacy agreements null and void – shapes judicial decision-making.

Parentage Policy in Theory: Making Distinctions

Parentage policy concerns both the eligibility presumptions regarding who can become a legal parent, and the process would-be parents must navigate in the context of ARTs. Above, I noted that legislation permitting surrogacy arrangements is by definition permissive because they reject traditional biological rationales of family formation. The same can often be said for parentage policy in the context of ARTs. Because of long-standing common law rules based on the traditional heterosexual family, the absence of

parentage legislation produces a restrictive framework by default; even after the advent of ARTs, the legal presumption in most regimes traditionally holds that the birth mother and her husband or male partner (if any) are the child's legal parents (Busby 2013: 289). Because parentage policy involves the "potential disengagement of biology from parenting," legislation is *required* to increase permissiveness: the law becomes a vehicle for permitting new families, enabling jurisdictions to "adapt their legal regimes to changing modes of family formation that flow from the availability of ARTs" (Nelson 2013b: 335).

Nelson has argued, with some justification, that "parentage laws are the most important and the least-often considered" subfield of ARTs (Nelson 2013b: 334). They are also probably the most complicated. Creating a framework by which to measure jurisdictional variation is thus difficult, but not impossible. In the context of ARTs, parentage policy is implicated in two situations: when a child is conceived in the context of a surrogacy arrangement and when a child is conceived using donor gametes (whether eggs, sperm, or both). The simplest way to describe this distinction is in terms of the birth mother's parental intentions. If, prior to conception, the birth mother does *not* intend to parent the child, then we are talking about parentage in the context of surrogacy. If the birth mother intends to parent the child – irrespective of whether she bears a genetic relation to that child – we are talking about parentage policy in the context of assisted conception. Depending on the jurisdiction, parentage policy for a child conceived via donor gametes or surrogacy can be the same or different (Nelson 2013b: 336). However, in terms of creating a framework by which to compare and contrast jurisdictions, I treat them as distinct areas.

Before describing this distinction in greater detail, it is worth noting that the following discussion occurs in the context where there is no dispute among the parties concerning parentage transfer. In the context of surrogacy, this means that there is no dispute between the surrogate and the intended parent(s). This can occur either because the surrogate is willing to go ahead with parentage transfer (i.e., she has not changed her mind) or because surrogacy arrangements are fully enforceable and the surrogate has no claim to parentage (i.e., she cannot change her mind). Likewise, in the case of assisted conception, I assume the absence of the kinds of disputes that occasionally arise when a sperm or egg donor makes a claim to parentage that is disputed by the birth mother. In other words, when speaking of parentage transfer and parentage addition in the rest of this chapter, I only consider those situations when all parties agree about who should be parents, but must navigate legislation, regulations, and common law rulings in order to achieve their desired outcome.

Parentage in the Context of a Surrogacy Arrangement

The problem that parentage policy sets out to answer in the context of a surrogacy arrangement is how the state recognizes intended parents. In addressing this question, jurisdictions typically introduce a number of *eligibility* requirements and *procedural* options that affect the ease of parentage transfer. Eligibility requirements concern who can be an intended parent, while procedural options concern the steps the intended parents (once considered eligible) must go through. These dimensions of parentage transfer in surrogacy situations are displayed in Table 6.2, which measures policy

permissiveness, defined as fewer legal barriers for intended parents: the higher the score, the more permissive the legal regime.

Table 6.2
Parentage in the Context of Surrogacy

	Eligible Intended Parents					
	Man and Woman	**Two Women**	**Two Men**	**One Woman**	**One Man**	**More than 2 Parents**
Pre-Birth	4	4	4	4	4	4
Post-Birth	2	2	2	2	2	2
None (Default Adoption)	0	0	0	0	0	0

Genetic Relation Required?
NR = Not Required (+-0)
FP = Female Parent (-1)
MP = Male Parent (-1)
EP = Either parent (-1)
BP = Both parents (-1)

Different jurisdictions can introduce a variety of eligibility requirements for parentage transfer, including age, residence, and background checks on intended parent(s). [26] However, the most common eligibility requirement relates to the type of intended parents. Here the six main eligibility options are arrayed along the Table's X-axis: a heterosexual couple; a lesbian couple; a gay male couple; a single woman; a single man; and more than two parents. Obviously, the more of these categories that a

[26] Millbank (2011) identifies the following conditions for successful parentage transfer, alone or in combination, in the Australian states and territories: the surrogate must be over a certain age; the surrogate has already given birth to a child; the intended parent(s) must be over a certain age; the intended parent(s) must be married or in a *de facto* relationship for a certain period of time; the intended parent(s) must be "classified" as infertile; they must be "fit and proper" parents; the intended parent(s) must reside within the jurisdiction; all or some parties must undergo a criminal record check; and all parties must have undergone counselling and/or received legal advice (179-183). In part because of the lack of legislative reform, and in part because the federal government has already made surrogacy policy in relation to age and compensation, there are far fewer requirements in Canada.

jurisdiction deems eligible as intended parents in a legal surrogacy arrangement, the more "permissive" that jurisdiction is with respect to surrogacy.

The main procedural question is when parentage transfer occurs. Here the three options are displayed on the Table's Y-axis: parentage transfer can occur pre-birth, post birth, or not at all. Pre-birth parentage transfer (the top row of the Y-axis) is the most permissive option and can only occur if surrogacy arrangements are fully enforceable. In this instance, the surrogate is given no authority to decide to keep the child even if she bears a genetic relation, and the intended parent(s) need not overcome any additional barriers in order to achieve parentage. As Snyder and Byrn note, with such a pre-birth "contract," the intended parents "are determined to be the legal parents of the child *before* the child's birth, thereby giving them *immediate and sole access to* and control over the child and its postnatal care and medical treatment when it is born" (2005: 634, emphasis added). In such an arrangement, the intended parents' names also go on the original birth records, avoiding the need to amend the child's birth certificate.

In Table 6.2, a pre-birth parentage transfer is given a permissiveness score of 4 for each of the eligibility categories along the X-axis to which it applies. In a jurisdiction allowing pre-birth parentage transfer for all six categories, this would result in a total permissiveness score of 24. This is the Table's highest possible "permissiveness" score on the surrogacy issue. By contrast, a jurisdiction that made only heterosexual couples eligible intended parents in surrogacy arrangements would get a permissiveness score of 4 if it provided for pre-birth parentage transfer to the intended heterosexual couple.

The second possibility on the table's Y-axis is post-birth parentage transfer. Under this model, common in the United Kingdom and many Australian states, a

surrogacy arrangement is not treated as an enforceable contract; however, it can be used to "speed up" the process to full parentage. In contrast to pre-birth contracts, post-birth transfers are deliberately designed to make the surrogate's choice paramount; as Millbank notes, "the consent of the birth mother must be both informed and continuing," and her interests are protected by "enhancing her ability to control the pregnancy and birth process" (2011: 178). The default presumption is typically that the surrogate (and often but not always her partner) has parental rights over the child, and that if she elects to keep the child, parentage transfer will not occur. However, assuming the surrogate does not elect to keep the child, in the post-birth model, the surrogate's willingness to relinquish legal control of the child begins a process – sometimes arduous, time-consuming, and expensive[27] – to get the intended parent(s)' names on the child's birth record and "terminate her presumptive parental rights to the child" (Snyder and Byrn 2005: 638). At the end of this process, the intended parent(s) will have full legal parentage,[28] typically conferred via court declaration.

In Table 6.2, post-birth parentage transfer is given a score of 2 for each category to which it applies. Thus, a jurisdiction that allowed for post-birth parentage transfer in all six eligibility categories along the X-axis would receive a permissiveness score of 12, while a jurisdiction that permitted transfer only to heterosexual couples (and only post-birth) would receive a score of 2.

[27] In the UK and the Australian Capital Territory (ACT), for example, the court must examine a number of eligibility requirements (see note #26), and the child must be between six weeks and six months old (Millbank 2011: 179).

[28] Some jurisdictions permit transfer of custody without transferring full legal parentage – akin to a form of legal guardianship. In Australia, for example, federal courts can grant a "parental responsibility" order, which authorizes intended parents "to make educational and medical decisions for the child and allow for the issue of a passport"; however, such orders do not grant official parental status, do not endure after the child turns 18, and preclude many other things, such as the presumption of inheritance or automatic family relationship with grandparents (Millbank 2011: 175).

Finally, the most restrictive procedural option for parentage in the context of surrogacy is to prevent any parentage transfer from occurring. This takes place when surrogacy arrangements are invalid in general, or if they are invalid because of the ineligibility of the intended parents' relationship status along the table's X-axis. With this option, the surrogate (and often her partner) remain the legal parents of the child. No special presumption is given to intended parents because they have signed an agreement or even because they have a genetic connection to the child. Instead, the only option is for the intended parents to adopt the child according to the jurisdiction's normal adoption rules, which might themselves have eligibility rules like those along the Table's X-axis. For example, a jurisdiction that does not permit two gay men to adopt a child in general would not allow them to adopt the child of an arranged surrogate. This is yet another example of how, in the absence of legal reforms to parentage, the legislative status quo is often the most restrictive option. In Table 6.2, this restrictive, no-transfer option is given a score of 0 for any of the eligibility categories to which it applies in a jurisdiction.

A case study can be used for clarification. In Table 6.3, I use Western Australia – chosen because of the many stipulations in its legislation – as an example. In Western Australia, as in all Australian states, there are no pre-birth surrogacy contracts. Western Australia's *Surrogacy Act* (2008) does allow for post-birth parentage transfer in the context of surrogacy. However, the only intended parents eligible to apply for a parentage order are a heterosexual couple (in a married or *de facto* relationship) or a single woman.[29] The intended parents do not have to be genetically related to the child, although

[29] Additional requirements are that the intended parent(s) are medically unable to conceive, that the surrogate has already given birth to a child and is at least 25 years of age, and that one of the intended parents is 25 years of age. The parentage order must be launched between 28 days and 6 months after the child is born.

such relation can negate the requirements for counselling and legal advice (Western Australia 2008: s. 21.5).

Table 6.3
Eligible Intended Parents – Western Australia (Surrogacy)

	Man and Woman	Two Women	Two Men	One Woman	One Man	More than 2 Parents
Pre-Birth						
Post-Birth	2 (NR: +/- 0)			2 (NR: +/- 0)		
None (Default Adoption)		0	0		0	0
Column Score	2	0	0	2	0	0
Total	**4**					

Genetic Relation:
NR = Not Required (+-0)
FP = Female Partner (-1)
OP = one of multiple other parents (-1)

For all other types of intended parents, there is no possibility of a parentage order, and they must go through Western Australia's adoption system to have any hope of legal parentage. Thus, Western Australia's final permissiveness "score" out of a possible 24 is 4, as it receives 2 points each for a post-birth surrogacy transfer for a heterosexual couple and a single woman (neither of which require a genetic relation to the child) and zero for all the rest.

While this framework does not capture all of the potential eligibility requirements a jurisdiction could introduce, it does provide a mechanism by which one can measure the permissiveness of parentage policy in the context of surrogacy according to the eligibility and procedural requirements that are most common – the type of intended

parents, their genetic relation to the child, and the timing/availability of a parentage order. Moreover, it can also be used to measure "parentage addition" in the context of assisted conception, a topic to which I now turn.

Parentage in the Context of Assisted Conception

In a surrogacy arrangement, the birth mother, at least at the time of conception, does not intend to raise the child. By contrast, parentage in the context of assisted conception occurs when the birth mother *does* intend to raise the child. The eligibility question for parentage in the context of assisted conception is who qualifies as *other* intended parent(s) in addition to the birth mother (whose parental status is everywhere assumed, even if – depending on the kind assisted conception[30] – she is not genetically related to the child). The issue is one of "parentage addition" rather than of "parentage transfer."

The issue of parentage addition obviously does not arise if the birth mother intends to raise a child conceived via assisted conception alone. Nor does it arise if she intends to raise the child with her male partner. The default assumption in all jurisdictions is that the birth mother and her male partner are the legally recognized parents. Even in a jurisdiction that bans assisted conception entirely, the fact that children are not "screened" for genetic connection after birth means that the default presumption will always apply. No parentage addition procedure is thus necessary in such cases.

The parentage addition issue thus arises only if the birth mother intends to raise her child with a single female partner or with more than two other parental partners.

[30] With assisted conception, there are a variety of methods the birth mother can use – including artificial insemination (AI), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), and assisted hatching (AH) – some of which result in the birth mother having a genetic relation to her child, and some of which do not (Nelson 2013b: 239-240).

These two potential types of additional parents constitute the X-axis of Table 6.4. As in the case of parentage *transfer* in surrogacy situations, parentage *addition* can occur pre-birth, post-birth, or not at all, as shown in the Y-axis of Table 6.4 The third of the options on the Y-axis ("none") applies default adoption rules instead of explicit "parentage addition" rules. Where parentage addition *is* possible either pre-birth or post-birth, a jurisdiction can be additionally restrictive by stipulating that a single female partner or one of a group of other parents must share a genetic relation to the child, as shown by items at the bottom of the table.

Like parentage in the context of surrogacy, Table 6.4 uses a 4-2-0 score for pre-birth, post-birth, or "none," with the requirement for a genetic relation meaning "1" is subtracted from the overall score.

Table 6.4
Parentage Addition in the Context of Assisted Conception

	Eligible Intended Parents (In addition to birth mother)	
	Female Partner	**Two or More Other Partners**
Pre-Birth	4	4
Post-Birth	2	2
None (Default Adoption)	0	0
Genetic Relation: NR = Not Required (+-0) FP = Female Partner (-1) OP = one of multiple other parents (-1)		

It is possible to combine the analyses of parentage transfer in situations of surrogacy and parentage addition in cases of assisted conception to measure a jurisdiction's overall parentage policy in terms of permissiveness. Table 6.5 does this by adding the two

columns of Table 6.4 to Table 6.2. In addition to the six parentage "transfer" possibilities for surrogacy, there are two potential parentage "addition" possibilities for assisted conception: a female partner, and two or more additional parents. With eight categories of eligible intended parents and a possible 4 points per category, the highest possible score – in the most permissive regime imaginable – would be 32.

Table 6.5
Parentage Transfer/Addition in Theory

	Eligible Intended Parents (Surrogacy)						**Eligible Intended Parents (Assisted Conception)**	
	Man and Woman	**Two Women**	**Two Men**	**One Woman**	**One Man**	**More than 2 Parents**	**Female Partner**	**2+ Parents**
Pre-Birth	4	4	4	4	4	4	4	4
Post-Birth	2	2	2	2	2	2	2	2
None (Default Adoption)	0	0	0	0	0	0	0	0
Score								
Total								

Genetic Relation Required (Surrogacy)?	**Genetic Relation Required (Assisted Conception)**
NR = Not Required (+-0) FP = Female Parent (-1) MP = Male Parent (-1) EP = Either parent (-1) BP = Both parents (-1)	NR = Not Required (+-0) FP = Female Partner (-1) OP = one of multiple other parents (-1)

Earlier, in Table 6.3, I analyzed the example of Western Australia's surrogacy policy. If we now add that jurisdiction's parentage policy, we get the results in Table 6.6. With respect to assisted conception, Western Australia does not allow more than two parents; however, as of 2002, the *Artificial Conception Act* stipulates that the birth mother's same-sex partner, having consented to her partner's assisted conception, is

"conclusively presumed to be a parent of the unborn child" – effectively a pre-birth assumption without the need to determine genetic relation. When one adds the 4 permissiveness points in this cell to the 4 surrogacy points already noted in Table 6.3, Western Australia's final permissiveness "score" out of a possible 32 is 8. Having created this system for measuring parentage permissiveness, I now compare the permissiveness of parentage policy in the Canadian provinces.

Table 6.6
Parentage Transfer/Addition in Western Australia

	Eligible Intended Parents (Surrogacy)						**Eligible Intended Parents (Assisted Conception)**	
	Man and Woman	**Two Women**	**Two Men**	**One Woman**	**One Man**	**More than 2 Parents**	**Female Partner**	**2+ Parents**
Pre-Birth							4 (NR: +/- 0)	
Post-Birth	2 (NR: +/- 0)			2 (NR: +/- 0)				
None (Default Adoption)		0	0					0
Score	2	0	0	2	0	0	4	0
Total	**8**							

Genetic Relation Required (Surrogacy)?	**Genetic Relation Required (Assisted Conception)**
NR = Not Required (+-0) FP = Female Parent (-1) MP = Male Parent (-1) EP = Either parent (-1) BP = Both parents (-1)	NR = Not Required (+-0) FP = Female Partner (-1) OP = one of multiple other parents (-1)

Parentage Policy in the Canadian Provinces

Unlike surrogacy, parentage is the sole purview of the provinces in Canada. Provinces have jurisdiction over the regulation of contracts, all parenting issues, adoption, birth registration, and custody/access excluding situations involving divorce. Moreover, each province and territory has a law stating that decisions regarding custody and access are made with the "best interests of the child" in mind (Busby and Vun 2010: 28). However – and in contrast to Australia, where there has been considerable (though not complete) harmonization of parentage procedures in recent years (Millbank 2011) – the Canadian provinces' attempts to address parentage in the context of surrogacy and assisted conception have been piecemeal and sporadic. As Nelson notes, "[e]ven among the provinces that have taken steps to address this issue in legislation, there is no consistency as to where the rules are found, their precise content or how they might be interpreted" (2013b: 338). Drawing from the framework constructed above, this section attempts to make some sense of the existing provincial parentage policies.

A brief word on the ordering of the rest of this chapter. Rather than describe each province in order from east-west or west-east, I begin with provinces whose rules are the most robust and clear (Quebec, Alberta, and British Columbia), then move on to provinces with simpler or incomplete legislation (Newfoundland and Labrador, Nova Scotia, Manitoba, and Prince Edward Island), and conclude with provinces whose parentage regimes are, in whole or in part, governed by decisions resulting from litigation (Ontario, Saskatchewan, and New Brunswick).[31] The primary reason for this ordering is that by beginning with the jurisdictions that provide the most legal clarity, it is easier to

[31] Of the territories, only the Yukon has any rules for parentage transfer. Its provisions are similar to Prince Edward Island.

understand the framework I develop to measure permissiveness. Moreover, describing provinces in this order also highlights the importance of differences between legislative and judicial rules, a difference that has hitherto been largely papered over in the existing Canadian literature (see Busby and Vun 2010; Cameron, Gruben, and Kelly 2010; Kelly 2009; Nelson 2013a, 2013b). Finally, it should be noted that legal robustness does not mean always permissiveness – indeed, Quebec's surrogacy regime has the clearest rules, but by declaring surrogacy arrangements invalid, it is far from the most permissive.

Parentage in Quebec

Article 541 of Quebec's *Civil Code* makes surrogacy arrangements null and void, and courts have interpreted this provision quite strictly. The surrogate retains legal custody over the child, and parentage cannot be transferred from her to another woman, regardless of whether that woman is genetically related to the child. There is thus no pre- or post-birth possibility for parentage transfer to two women, one woman, or more than two parents. Quebec law also does not permit more than two parents. Parentage transfer to intended parents can occur, however, when an intended father is genetically related to the child (L'Espérance 2013: 36). In three contexts – if the intended parents are one man, two men, or a man and a woman – parentage transfer can be initiated *if one man is genetically related to the child*. This is easiest in the case of a single father: the surrogate simply has to write down the name of the genetic father on the birth certificate and relinquish her rights to parenthood. By contrast, if two men want to parent the child, the same situation takes place, and the genetically-related man will be the sole parent of the child. The male couple will then ask for a parental order from the courts, which they can

receive if they are married, can prove that one of them is genetically related to the child, that they did not pay the surrogate, and that it is in the best interests of the child. At this point, the court still exercises discretion to refuse the parentage order (L'Espérance 2012). Finally, in the case of a intended parents that are a man and a woman, the process is the same, with the exception that courts will typically ask fertility clinics to testify that the reproductive procedures were ethical and that there was no payment. In the 2009 case listed above (*X, sub. nom Adoption -091*), the Court did not recognize the intended mother as a legal parent because payment had occurred. This again demonstrates that in Quebec judges still exert considerable discretion when transferring parentage.

Table 6.7
Parentage in Quebec

	Eligible Intended Parents (Surrogacy)						**Eligible Intended Parents (Assisted Conception)**	
	Man and Woman	**Two Women**	**Two Men**	**One Woman**	**One Man**	**More than 2 Parents**	**Female Partner**	**2+ Parents**
Pre-Birth							4 (NR)	
Post-Birth	1 (MP)		1 (EP)		1 (MP)			
None (Default Adoption)		0		0		0		0
Score	1	0	1	0	1	0	4	0
Total	**7**							

Genetic Relation Required (Surrogacy)?	**Genetic Relation Required (Assisted Conception)**
NR = Not Required (+-0) FP = Female Parent (-1) MP = Male Parent (-1) EP = Either parent (-1) BP = Both parents (-1)	NR = Not Required (+-0) FP = Female Partner (-1) OP = one of multiple other parents (-1)

As Audrey L'Espérance points out, all of this makes surrogacy a risky proposition in Quebec, not least because the invalidity of surrogacy arrangements means that if the surrogate changes her mind, the intended parent(s) will be out of luck – although the genetic link between father and child could create a custody dispute (L'Espérance 2013: 36). Indeed, in a confidential interview, one fertility lawyer said that this law has contributed to many Quebec-based parties completing surrogacy arrangements in the province of Ontario, as the province of birth determines legal parentage on the birth certificate (Interview 2011e). In spite of the very tenuous nature of such transfer, the possibility of post-birth parentage transfer does exist in Quebec for a heterosexual couple, a gay male couple, and a single man – provided the man is genetically related to the child (see Table 6.7).

In contrast to Quebec's restrictive surrogacy law, it was the first jurisdiction in the country to introduce permissive rules regarding parentage in the case of assisted conception. In 2002, Quebec extended the presumption of paternity to a spouse of either sex (married or civil union), thereby recognizing that a child can have two female parents (Nelson 2013b: 339). Because this is a presumption of paternity, it is effectively a pre-birth parentage addition. Quebec's ground-breaking legislation is based on the principle of a "parental project involving assisted procreation," which "exists from the moment a person alone decides or spouses by mutual consent decide, in order to have a child, to resort to the genetic material of a person who is not party to the parental project." It also stipulates that merely contributing genetic material (sperm or eggs) "for the purposes of a third-party parental project" does not create any parental obligation (Quebec 1991: Art.

538). Finally, it does not permit multiple parents. Quebec thus scores a 7 out of a possible 32 on the permissiveness scale (see Table 6.7).

Parentage in Alberta

In 2005, two lesbian co-mothers successfully challenged Alberta's *Family Law Act*, which limited the default parentage presumption in the case of assisted conception to the birth mother's "male partner." In *Fraess v. Alberta* (2005), Justice Clarke of the Alberta Court of Queen's Bench found that the legislation violated section 15 of the *Canadian Charter of Rights and Freedoms* and could not be saved by section 1. He "read in" additions to the legislation that made it gender neutral, thus permitting the presumption of lesbian parentage. In 2010, Alberta overhauled its legislation to make it consistent with this judicial interpretation.

As Nelson (2013b: 339) notes, Alberta's legislation "deals explicitly with the complexities of a wider variety of circumstances than most Canadian jurisdictions." With respect to surrogacy, Alberta starts with the assumption that the legal parents are the birth mother (the surrogate) and the child's *genetic* father – not the surrogate's partner. The *Family Law Act* then permits transfer of parentage, whereby the genetically-related intended father's partner can be declared the parent of the child and the surrogate be declared *not* to be the child's parent. Unlike Quebec, this is also the case if a *female* intended parent can prove that the eggs of embryo used in surrogacy came her from own genetic material. If the court is satisfied that the child is genetically related to one of the intended parents and the surrogate consents post-birth, the court will grant the application that the intended parent(s) are the child's parents (Nelson 2013b: 339-340). Because the

surrogate agrees to relinquish her parental rights, this means that in five of the six possible eligible intended parents scenarios, parentage transfer can occur (see Table 6.8). However, as in Quebec, genetic relation matters: if a child is born to a surrogate and neither of the parents are genetically related, the surrogate and her partner (if the partner consented) are the child's legal parents.

Table 6.8
Parentage in Alberta

	Eligible Intended Parents (Surrogacy)						**Eligible Intended Parents (Assisted Conception)**	
	Man and Woman	**Two Women**	**Two Men**	**One Woman**	**One Man**	**More than 2 Parents**	**Female Partner**	**2+ Parents**
Pre-Birth							4 (NR)	
Post-Birth	1 (EP)	1 (EP)	1 (EP)	1 (FP)	1 (MP)			
None (Default Adoption)						0		0
Score	1	1	1	1	1	0	4	0
Total	**9**							

Genetic Relation Required (Surrogacy)?	**Genetic Relation Required (Assisted Conception)**
NR = Not Required (+-0) FP = Female Parent (-1) MP = Male Parent (-1) EP = Either parent (-1) BP = Both parents (-1)	NR = Not Required (+-0) FP = Female Partner (-1) OP = one of multiple other parents (-1)

In all cases, the application for parentage transfer must be made within 30 days of the birth of the child. Although the legislation states that once an application is granted the intended parents will be deemed legal parents "at and from the time of the birth of the child," the requirement that the surrogate consent means that all parentage transfers occur

post-birth, rather than being treated as a contract. As noted above, surrogacy arrangements are valid but not enforceable in Alberta. This means that if the surrogate does not consent to the parentage order – if she decides to keep the child – then she is listed as the sole parent. Pre-birth consent in the form of a surrogacy agreement cannot be used as post-birth consent, although it can be used as consent for the non-genetic parent (Busby and Vun 2010: 30; Nelson 2013b: 340). Finally, the legislation prohibits courts from transferring parentage if the result would leave the child with more than two parents.

With respect to assisted conception, the parents are the birth mother and the man who provided sperm or an embryo, provided it was for his own reproductive use. As in Quebec (and in all other provinces who have legislated in this area), this prevents third-party donors from having parental obligations. In the case of a birth mother who has a female partner, the birth mother and her partner are presumed to be parents of the child provided her partner was in a "conjugal relationship of interdependence of some permanence with the birth mother at the time of the child's conception" and consented to assisted conception (Alberta 2009: 8(1)(3)(i)). No application for parentage addition needs to be made. This is the remedy that the parents in the *Fraess* case sought. As with surrogacy, a child cannot have more than two parents (see Table 6.8).

Parentage in British Columbia

British Columbia is the most recent province to legislate with respect to parentage. In 2011, British Columbia amended its *Family Law Act* to include provisions for both surrogacy and assisted conception. With respect to surrogacy, the intended parent(s) –

regardless of sex, number (1 or 2), or genetic relation – are deemed parents if there is a written agreement that the surrogate does not wish to parent the child, that she intends to surrender the child, and that the intended parents wish to parent the child. For this parentage transfer to occur, the surrogate must consent post-birth.

Table 6.9
Parentage in British Columbia

	Eligible Intended Parents (Surrogacy)						**Eligible Intended Parents (Assisted Conception)**	
	Man and Woman	**Two Women**	**Two Men**	**One Woman**	**One Man**	**More than 2 Parents**	**Female Partner**	**2+ Parents**
Pre-Birth							4 (NR)	
Post-Birth	2 (NR)	2 (NR)	2 (NR)	2 (NR)	2 (NR)	2 (NR)		
None (Default Adoption)								0
Score	2	2	2	2	2	2	4	0
Total	**16**							

Genetic Relation Required (Surrogacy)?	**Genetic Relation Required (Assisted Conception)**
NR = Not Required (+-0) FP = Female Parent (-1) MP = Male Parent (-1) EP = Either parent (-1) BP = Both parents (-1)	NR = Not Required (+-0) FP = Female Partner (-1) OP = one of multiple other parents (-1)

Unlike Quebec and Alberta, British Columbia does not declare surrogacy arrangements invalid; while a pre-conception surrogacy arrangement alone cannot satisfy the requirements for parentage transfer – explaining why surrogacy transfer is not treated as a "pre-birth" in Table 6.9 – it can be used as "evidence of the parties' intentions with respect to the child's parentage if a dispute arises after the child's birth" (British Columbia

2011: 29(7)(b)). Thus, the British Columbia legislation directly acknowledges the possibility that a dispute can arise and that judicial discretion will play a significant role in potential cases.[32]

Unlike Alberta, British Columbia's *Family Law Act* does not prohibit parentage transfer involving more than two parents – in fact, it explicitly recognizes the possibility, allowing courts to declare three parents in two situations: when the surrogate and two intended parents have an agreement to raise the child together, or when a donor, the surrogate, and the surrogate's partner have an agreement to raise the child together. Although section 30 of the legislation does use the word "donor," as long as all three parties agree to the order, there is no requirement for DNA testing; hence, in Table 6.9, no genetic relation is required. In February 2014, the first such case was reported after a lesbian couple and a known sperm donor were all placed on a child's birth certificate (Subdhan 2014). The legislation also, in recognition of international and inter-provincial surrogacy arrangements, sets out conditions under which courts must recognize extraprovincial parentage orders (2011: ss. 34-35).[33]

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[32] It is worth noting that the judiciary has had an impact on parentage policy in British Columbia. In *Rypkema v. H.M.T.Q. et al.* (2003), Madam Justice Gray of the Supreme Court of British Columbia granted the intended parents, both of whom were genetically related to the child born through an unpaid surrogacy arrangement, legal parentage over the child instead of the surrogate (who consented throughout the process). Subsequently, in *B.A.N. v. J.H.*, Justice Metzger of the same court granted parentage to intended parents. In this case, the child was genetically related to the intended father, but not the intended mother – the embryo was created by fertilizing a known donor's egg with the intended father's sperm. Neither the surrogate nor the egg donor opposed the intended parents' petition. According to the intended parents' affidavit, British Columbia's Vital Statistics Agency had set out rules for registering a birth following a surrogacy arrangement, which involved getting a post-birth court declaration. Thus, in the five-year interim between *Rypkema* and *B.A.N.* – what Karen Busby (2013: 296) calls the "*Rypkema* regime" – without any legislative initiative, the civil service had drafted internal regulations to be consistent with the *Rypkema* judgment. British Columbia's 2011 amendments to the *Family Law Act* have effectively superseded these common law cases.

[33] As Nelson (2013b: 341) summarizes, "if a Canadian order is in place, the court must recognise it … if a non-Canadian order in in place, the court must recognise if at least one of the parents was habitually resident in or had a real or substantial connection with the foreign jurisdiction." In both cases, courts can decline the order in the case of fraud or if new evidence occurs. In the context of a foreign parentage

Parentage in the case of assisted conception in British Columbia is relatively simple. The birth mother and the consenting partner are parents provided they are in a "marriage-like relationship," regardless of whether they have a genetic relation to the child, thus meaning no parentage addition is required (British Columbia 2011: 27(3); Nelson 2013b: 340-341). Although the Act recognizes the possibility for three parents in the context of a surrogacy arrangement, it does not do so in the context of assisted conception (2011: s.27). Thus, while British Columbia permits a child to have three parents through parentage transfer, it only does so if the mother is deemed a "surrogate" as described in s. 29(2) of the legislation, which includes a written agreement between parties. The legislation also contains a provision saying that a donor is not a parent merely by donating genetic material. Altogether, the permissive factors with respect to surrogacy – no genetic relation required, multiple parents, and the availability of post-birth transfer and addition – means British Columbia ranks a 16 on the parentage permissiveness scale, higher than any other Canadian province.

Parentage in Newfoundland and Labrador

Newfoundland and Labrador's legislation permits parentage orders in the case of both surrogacy and assisted conception. According to the *Vital Statistics Act*, when a child is born through a surrogacy arrangement, the registrar general will register the child's "intended parents" provided a court issues a parentage order under the *Children's Law Act* (or an adoption order under the *Adoption Act*). The language is gender-neutral; although the law uses the plural "intended parents," there is nothing in the either the

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declaration, the court is given broad discretionary power to decline it if it is "contrary to public policy" (British Columbia 2011: 36(3)(c)).

Children's Law Act or the *Vital Statistics Act* that suggests there must be two intended parents. By contrast, the exclusion of any mention of more than two parents means one can safely presume courts cannot issue declarations of parentage to two or more parents. Parentage orders can be sought before the parents are born and, as Busby and Vun (2010: 30) note, "the consent of the surrogate mother is not expressly required." As in British Columbia and Quebec, there is neither a "post-birth contract" nor a "veto" option for the surrogate.

Table 6.10
Parentage in Newfoundland and Labrador

	Eligible Intended Parents (Surrogacy)						**Eligible Intended Parents (Assisted Conception)**	
	Man and Woman	**Two Women**	**Two Men**	**One Woman**	**One Man**	**More than 2 Parents**	**Female Partner**	**2+ Parents**
Pre-Birth							4 (NR)	
Post-Birth	2 (NR)	2 (NR)	2 (NR)	2 (NR)	2 (NR)			
None (Default Adoption)						0		0
Score	2	2	2	2	2	0	4	0
Total	**14**							

Genetic Relation Required (Surrogacy)?	**Genetic Relation Required (Assisted Conception)**
NR = Not Required (+-0) FP = Female Parent (-1) MP = Male Parent (-1) EP = Either parent (-1) BP = Both parents (-1)	NR = Not Required (+-0) FP = Female Partner (-1) OP = one of multiple other parents (-1)

In the case of "artificial insemination" (which likely covers other forms of assisted conception),[34] the birth mother's partner will be deemed the "father or other parent" provided there is written consent of both parents. Nothing in the legislation requires genetic relation, which gives Newfoundland a comparatively high 14 on the permissiveness scale (see Table 6.10).[35]

Parentage in Nova Scotia

In 2007, Nova Scotia created the *Birth Registration Regulations*, which apply to the *Vital Statistics Act*. These regulations concern both assisted conception and surrogacy. With respect to surrogacy, the Regulations enable a court to make a declaration of parentage registering the intended parents and removing the surrogate as long as the agreement was made pre-conception, was initiated by the intended parents, and one of the parents has a genetic link to the child. Section 5(2)(c) states that a condition for parentage transfer is that "the woman who is to carry and give birth to the child does not intend to be the child's parent," which suggests if the surrogate decides she does want to raise the child, the transfer will not go through, and the surrogate (and her partner, if any) will remain legal parent(s) of the child.[36] For assisted conception, if the birth mother is married, her spouse is the child's other parent; if she is unmarried but has a partner who wishes to be the parent, her partner must file a statutory declaration with the birth registrar

[34] The legislation's rather outdated terminology of artificial insemination ignores other forms of assisted conception that enable a woman to become pregnant, such as gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), and assisted hatching (AH). However, the legislation will likely recognize these other methods as being on par with artificial insemination, thus enabling birth registration.

[35] It is worth noting that, for all its permissiveness, surrogacy in the sparsely-populated province is rare. In a 2010 magazine article, surrogacy lawyer Nancy Lam wrote that she was not aware of any declarations of parentage that had actually occurred in Newfoundland and Labrador (Lam 2013).

[36] As noted above, Busby and Vun (2010: 30) differ in their interpretation of the requirement for post-birth surrogate consent.

acknowledging that he/she wishes to parent the child with the birth mother. The regulation permits this form of parentage addition either before or after the birth. Like Newfoundland and Labrador, the legislation says nothing about single parents or multiple parents, so I presume that single intended parents are permissible, while more than two intended parents are not. The requirement for a genetic link in all surrogacy situations gives Nova Scotia's otherwise permissive legislation an identical score to Alberta's.

Table 6.11
Parentage in Nova Scotia

	Eligible Intended Parents (Surrogacy)						**Eligible Intended Parents (Assisted Conception)**	
	Man and Woman	**Two Women**	**Two Men**	**One Woman**	**One Man**	**More than 2 Parents**	**Female Partner**	**2+ Parents**
Pre-Birth							4 (NR)	
Post-Birth	1 (EP)	1 (EP)	1 (EP)	1 (EP)	1 (EP)			
None (Default Adoption)						0		0
Score	1	1	1	1	1	0	4	0
Total	**9**							

Genetic Relation Required (Surrogacy)?	**Genetic Relation Required (Assisted Conception)**
NR = Not Required (+-0) FP = Female Parent (-1) MP = Male Parent (-1) EP = Either parent (-1) BP = Both parents (-1)	NR = Not Required (+-0) FP = Female Partner (-1) OP = one of multiple other parents (-1)

Parentage in Manitoba

Unlike the five provinces listed above, Manitoba's legislation contains no surrogacy provisions. However, s. 3(6) of the *Vital Statistics Act* does provide information for birth

declarations in the case of artificial insemination. When a child is born as a result of artificial insemination (which, like Newfoundland and Labrador, likely includes any form of assisted conception), the birth registration will list the birth mother and her spouse (defined as "cohabiting with her in a conjugal relationship of some permanence") as the "father or other parent," thus permitting two female parents. There is no provision for more than two parents.

Table 6.12
Parentage in Manitoba

	Eligible Intended Parents (Surrogacy)						**Eligible Intended Parents (Assisted Conception)**	
	Man and Woman	**Two Women**	**Two Men**	**One Woman**	**One Man**	**More than 2 Parents**	**Female Partner**	**2+ Parents**
Pre-Birth							4 (NR)	
Post-Birth								
None (Default Adoption)	0	0	0	0	0	0		0
Score	0	0	0	0	0	0	4	0
Total	**4**							

Genetic Relation Required (Surrogacy)?	**Genetic Relation Required (Assisted Conception)**
NR = Not Required (+-0) FP = Female Parent (-1) MP = Male Parent (-1) EP = Either parent (-1) BP = Both parents (-1)	NR = Not Required (+-0) FP = Female Partner (-1) OP = one of multiple other parents (-1)

Nelson (2013b: 339) recognizes an important distinction between "birth registration" and legal parentage, suggesting it is unclear whether the law will "recognize the persons named as the parents on the birth registration as the legal parent of the child." However, from my reading of the legislation, there is nothing that says the birth mother's partner

will not be granted parentage – indeed, it seems odd that the legislation would permit amendment of birth registration but deny parentage to the birth mother's partner. Because it is a presumptive assumption of parentage, I consider it pre-birth.

Manitoba is one jurisdiction, along with Quebec, where litigation to change surrogacy procedures was unsuccessful. In *J.C. v. The Queen (Dept. of Vital Statistics)* (2000), the Court of Queen's Bench rejected an application that would have compelled hospital staff to recognize the intended parents as the child's legal parents following a surrogacy birth. Even though the surrogate and her husband supported the application, Justice Keyser held that the legislature had deliberately excluded pre-birth declaratory orders for maternity from the *Manitoba Family Maintenance Act*, and he rejected the application. The judge did, however, indicate that a declaration of parentage with respect to the genetic mother could potentially be made *after* the birth was registered, though he himself did not make that declaration, as the facts of the case preceded the birth of the child. Overall, there is no evidence that such orders can or have been made in Manitoba.

Parentage in Prince Edward Island

In Prince Edward Island, Canada's smallest province, the *Child Status Act* also contains provisions for assisted conception but not surrogacy. The legislation states that the birth mother will be the mother of the child regardless of whether she is its genetic mother, thus effectively precluding surrogacy arrangements. It also states that a donor is not a parent by virtue of donating gametes (Nelson 2013b: 339).[37] The Act also stipulates that when a child is conceived via assisted conception, the birth mother's partner is the other

[37] Similar provisions exist in the Yukon territory.

legal parent. The legislation's gender-neutral language means this presumption of parentage applies pre-birth.

Table 6.13
Parentage in Prince Edward Island

	Eligible Intended Parents (Surrogacy)						**Eligible Intended Parents (Assisted Conception)**	
	Man and Woman	**Two Women**	**Two Men**	**One Woman**	**One Man**	**More than 2 Parents**	**Female Partner**	**2+ Parents**
Pre-Birth							4 (NR)	
Post-Birth								
None (Default Adoption)	0	0	0	0	0	0		0
Score	0	0	0	0	0	0	4	0
Total	**4**							

Genetic Relation Required (Surrogacy)?	**Genetic Relation Required (Assisted Conception)**
NR = Not Required (+-0) FP = Female Parent (-1) MP = Male Parent (-1) EP = Either parent (-1) BP = Both parents (-1)	NR = Not Required (+-0) FP = Female Partner (-1) OP = one of multiple other parents (-1)

Parentage in Ontario

Ontario legislation does not include any specific provisions for surrogacy. As L'Espérance notes, there is a complicated process by which intended parent(s) can be listed on the child's birth certificate: they must seal a Statement of Live Birth with their names on it, delay the child's birth registration, conduct genetic tests to prove they are genetically related to the child, and hope a Family Court will review the file and make a declaration of parentage (2013: 36). Although in such an arrangement this would be quicker than formal adoption, it is not recognized in legislation and relies in large part on

the discretion of the Court. Therefore, for the purposes of comparison, Ontario does not have a clear legal procedure in place to ensure parentage in the context of surrogacy arrangement – certainly not to the extent of the seven provinces listed above. With the recognition that the complicated legal process described by L'Espérance could be initiated, I nevertheless select "none" for the six eligible intended parent situations for surrogacy in Ontario. Moreover, as Fiona Kelly notes, while litigation has enabled same-sex second parent adoption in Ontario, this is not done through a parentage order (2009: 191).

Table 6.14a
Parentage in Ontario – Legislation Only

	Eligible Intended Parents (Surrogacy)						**Eligible Intended Parents (Assisted Conception)**	
	Man and Woman	**Two Women**	**Two Men**	**One Woman**	**One Man**	**More than 2 Parents**	**Female Partner**	**2+ Parents**
Pre-Birth							4 (NR)	
Post-Birth								
None (Default Adoption)	0	0	0	0	0	0		0
Score	0	0	0	0	0	0	4	0
Total	**4**							

Genetic Relation Required (Surrogacy)?	**Genetic Relation Required (Assisted Conception)**
NR = Not Required (+-0) FP = Female Parent (-1) MP = Male Parent (-1) EP = Either parent (-1) BP = Both parents (-1)	NR = Not Required (+-0) FP = Female Partner (-1) OP = one of multiple other parents (-1)

Surrogacy nevertheless can and does occur in Ontario. One Ontario surrogacy lawyer suggested that her firm writes up four surrogacy arrangements each month, and estimated that there were 15 surrogacy contracts per month in province-wide (Interview 2011e). Moreover, her description of the process – in which the Statement of Live Birth is sealed, the intended parents make an application for a legal declaration of parentage in court, and the Deputy Registrar with Births Deaths and Marriages takes a position – echoes that described above by L'Espérance. However, insofar as I have defined permissive parentage policy as occurring in jurisdictions that "adapt their legal regimes to changing modes of family formation that flow from the availability of ARTs" (Nelson 2013b: 335), this process in Ontario certainly does not fit that description. With respect to assisted conception, Ontario's *Vital Statistics Act* does recognize that the birth mother and an "other parent" can be presumed to be parents by default in situations of when "conception occurred through assisted conception" (Ontario 1990: 2(1); see Table 6.14a). This change occurred in response to a Charter challenge to the legislation, much like what happened in Alberta (*Rutherford v. Ontario (Deputy Registrar General)* 2006).

However, Ontario proves that a legislative vacuum does not necessarily mean a legal vacuum. In the absence of clear legal rules, the common law governs. The Ontario Superior Court of Justice case *M.D. et al. v. L. L. et al.* (2008) involved a situation in which two heterosexual intended parents ("M" and "J") used their own genetic material (and hence were both genetically related to the child) and entered into a surrogacy arrangement with a surrogate ("L") and her husband ("I"). The surrogate's name had to be placed on the birth certificate, and all four parties sought a declaration that the intended parents were the only parents of the child. Justice Nelson ruled that "it is

possible for the court to declare a person not to be the mother of a child when she is, in fact, the mother of that child under a statute," and that there was a "gap" in the *Vital Statistics Act* "that does not operate in the child's best interests, insofar as the inferential definition of 'mother' impedes the court's jurisdiction to declare a person not to be the mother of a child" (para. 61). Interestingly, Justice Nelson did not mandate genetic testing, even though both intended parents claimed a biological connection to the child: "genetic testing is not a prerequisite to the court exercising its jurisdiction to make a declaration of non-paternity" (para. 46). Justice Nelson thus granted the declaration of parentage.

Table 6.14b
Parentage in Ontario – Legislation and Common Law

	Eligible Intended Parents (Surrogacy)						**Eligible Intended Parents (Assisted Conception)**	
	Man and Woman	**Two Women**	**Two Men**	**One Woman**	**One Man**	**More than 2 Parents**	**Female Partner**	**2+ Parents**
Pre-Birth							4 (NR)	
Post-Birth	2 (NR)*							2 (NR)*
None (Default Adoption)		0	0	0	0	0		
Score	2	0	0	0	0	0	4	2
Total	**8**							

Genetic Relation Required (Surrogacy)?	**Genetic Relation Required (Assisted Conception)**
NR = Not Required (+-0) FP = Female Parent (-1) MP = Male Parent (-1) EP = Either parent (-1) BP = Both parents (-1) * Common law ruling, not legislation	NR = Not Required (+-0) FP = Female Partner (-1) OP = one of multiple other parents (-1) * Common law ruling, not legislation

While this case did not amend the *Vital Statistics Act*, it nevertheless should act as a precedent for future cases. However, unlike legislation, it is unclear about the extent to which the case will apply in other scenarios, such as one where there was only one intended parent, two male or female intended parents, or no genetic relation between the intended parent(s) and the child. Thus, Table 6.14b does include a tentative "Not Required" Post-Birth for a man and a woman, although this may not apply in all cases. Because it stems from a judicial decision, I include an asterisk.

One other case in Ontario may also have set a precedent: *A.A. v. B.B.* (2007). In this case, a lesbian couple (A.A. and C.C.) wanted to have a child genetically related to C.C. They used their male friend B.B's sperm to impregnate C.C. Subsequently, A.A. and C.C. raised the child, with the recognition that B.B. would play a smaller parental role in the child's life. However, under Ontario law, the birth mother and the genetic father were the child's legal parents (the child was born before the 2009 amendments to the *Vital Statistics Act*). When the child was two, A.A. applied for a declaration that she was the child's parent *in addition* to B.B. and C.C. On appeal, Justice Rosenberg also held that there was a gap in *Children's Law Reform Act* (CLRA), and used his *parens patriae* power to add A.A. as the child's third parent. His rationale is worth quoting at length:

> Present social conditions and attitudes have changed. Advances in our appreciation of the *value of other types of relationships and in the science of reproductive technology* have created gaps in the *CLRA*'s legislative scheme. Because of these changes the parents of a child can be two women or two men. They are as much the child's parents as adopting parents or "natural" parents. The

> *CLRA*, however, does not recognize these forms of parenting and thus the children of these relationships are deprived of the equality of status that declarations of parentage provide (para. 35, emphasis added).

Interestingly, Justice Rosenberg rejected the argument that the legislative gap was deliberate, holding "[t]he Legislature did not foresee for the possibility of declarations of parentage for two women," which was "a product of the social conditions and medical knowledge at the time" (para. 38). He thus granted that a child can have three parents, making Ontario the first jurisdiction – prior to British Columbia's legislation – to allow this. However, as Kelly notes, it is not clear whether this applies "beyond the individual facts of the case"; as with *M.D.*, the legislation was not amended. Presumably, to have a three-parent family in Ontario, one would need to go through litigation. Moreover, the case "does not address legal parentage at birth," and instead "requires parents to initiate a legal process after the child is born" (2009: 193). For these reasons, Ontario's possibility for three parents in the case of assisted conception, in addition to being tenuous because it stems from a judicial decision, can only be done with a post-birth use of a court's *parens patriae* power.

Table 6.14b demonstrates the importance of judicial precedent for determining parentage law, as Ontario's permissiveness total jumps from 4 to 8. What is most striking about Ontario is that all three permissive features of its parentage policy stem from judicial decisions. *Rutherford* enabled lesbian co-mothers to be presumed as default "other parents," and eventually produced amended legislation; *M.D.* granted parentage to intended parents genetically related to a child born through a surrogacy arrangement; and *A.A.* allowed a child born through assisted conception to have three lesbian parents.

Whether the latter two cases will result in legislative change, or the extent to which they will act as precedents, is unclear.

It may seem odd that Ontario has only a moderately more permissive score than Quebec (8 as opposed to 7) even though, as indicated above, there is evidence many Quebec-based intended parents are choosing to have their surrogacy arrangements take place in Ontario. The fact that surrogacy arrangements are null and void in Quebec is undoubtedly part of the story, but another is that parentage declarations are often sealed, and thus the case law concerning parentage policy is not always open to the public. Fertility lawyers may point their clients toward other provinces or even individual judges in order to achieve permissive outcomes, but because declarations are sealed, these outcomes may not be reflected in "official" policy. In January 2014, Ontario fertility lawyer Sara Cohen openly lamented the fact that one judge had been moved to another court and would thus no longer be hearing parentage declarations. As Cohen noted, "[a]pplications for declarations of parentage in Ontario are almost always sealed. For this reason (and others), we have very little accessible caselaw" (2014). An individual judge or group of judges with a permissive approach to parentage policy, particularly in a province with unclear public policy, can end up making a big difference. Overall, the Ontario experience speaks to how, in the absence of legislation, the judiciary will continue to play a crucial role in parentage policy going forward.

Parentage in Saskatchewan

Saskatchewan amended its *Vital Statistics Act* in 2009 to include the term "other parent" as someone "cohabiting with the mother or father of the child in a spousal relationship at

the time of the child's birth and who intends to participate as a parent in the upbringing of the child" (Saskatchewan 2009: s. 2(1)). This allows the birth mother's female partner to be a legal pre-birth parent in the case of assisted conception. However, Saskatchewan legislation does not recognize parentage with respect to surrogacy, and there is no provision for more than two parents.

Table 6.15
Parentage in Saskatchewan – Legislation and Common law

	Eligible Intended Parents (Surrogacy)						**Eligible Intended Parents (Assisted Conception)**	
	Man and Woman	**Two Women**	**Two Men**	**One Woman**	**One Man**	**More than 2 Parents**	**Female Partner**	**2+ Parents**
Pre-Birth							4 (NR)	
Post-Birth			1 (EP)*					
None (Default Adoption)	0	0		0	0	0		0
Score	0	0	1	0	0	0	4	0
Total	**5**							

Genetic Relation Required (Surrogacy)?	**Genetic Relation Required (Assisted Conception)**
NR = Not Required (+-0) FP = Female Parent (-1) MP = Male Parent (-1) EP = Either parent (-1) BP = Both parents (-1) * Common law ruling, not legislation	NR = Not Required (+-0) FP = Female Partner (-1) OP = one of multiple other parents (-1)

Like Ontario, British Columbia, and Alberta, litigation has affected parentage policy in the context of surrogacy in Saskatchewan. In *W.J.Q.M. v. A.M.A.* (2011), two gay men who had engaged in a surrogacy arrangement with a surrogate sought a

declaration to remove the birth mother's name from the child's birth registration and have their names included. The child was conceived using donor sperm from one of the men ("John")[38] and an anonymous egg donor. The surrogate, Mary, did not dispute the order. There were no prior precedents in Saskatchewan but, drawing from other provincial cases in Canada, Justice Ryan-Froslie was satisfied that the surrogate was not the child's "biological mother" based on the *Children's Law Act*, and that "neither the applicants nor Mary ever intended that Mary would assume any parental rights or obligations" (para. 25). She thus granted a declaration that the two men were the legal parents, and Mary was not. Because the case involved statutory interpretation, it will likely serve as a precedent. However, the important role played by Mary's non-genetic relation to the child suggests that this might not apply in cases of traditional surrogacy; following the case, the men's lawyer claimed "[t]here would have been a greater risk for us, in making the application, of being unsuccessful" were Mary genetically related to the child (Brean 2011). As with Ontario, the extent to which the case would apply other scenarios – only one intended parent, two female intended parents, a heterosexual couple, and/or no genetic relation between the intended parent(s) and the child – is unclear. For consistency, I only apply the score of "1" to the case as litigated, giving Saskatchewan a score of 5 on the permissiveness scale.

Parentage in New Brunswick

There is no legislation regarding surrogacy or assisted conception in New Brunswick. Neither the *Vital Statistics Act* nor the *Family Law Act* makes any provision for parentage transfer in either procedure although, like other provinces, gay and lesbian parents have

[38] The case used pseudonyms for all parties.

been able to adopt in New Brunswick since 2004 (it was the last province to permit same-sex adoption). As in Ontario, most parentage policy movement in New Brunswick has occurred because of case law. The first relevant case in New Brunswick was a Labour and Employment Board decision regarding assisted conception: *A.A. v. New Brunswick* (2004). In this case, one of the parents (B.B.) had a child after artificial insemination from an anonymous donor, but the Department of Health and Wellness would not register B.B.'s female partner[39] (A.A.) as the second parent.

Table 6.16
Parentage in New Brunswick – Legislation and Common law

	Eligible Intended Parents (Surrogacy)						**Eligible Intended Parents (Assisted Conception)**	
	Man and Woman	**Two Women**	**Two Men**	**One Woman**	**One Man**	**More than 2 Parents**	**Female Partner**	**2+ Parents**
Pre-Birth							4 (NR)*	
Post-Birth	1 (BP)*							
None (Default Adoption)		0	0	0	0	0		0
Score	0	0	0	0	0	0	4	0
Total	**5**							

Genetic Relation Required (Surrogacy)?	**Genetic Relation Required (Assisted Conception)**
NR = Not Required (+-0) FP = Female Parent (-1) MP = Male Parent (-1) EP = Either parent (-1) BP = Both parents (-1)	NR = Not Required (+-0) FP = Female Partner (-1) OP = one of multiple other parents (-1) * Common law ruling, not legislation

[39] This case preceded *Reference re: Same-sex Marriage* (2004) and, as such, the legal recognition of same-sex marriage in New Brunswick.

The Board found the couple had faced discrimination against according to section 5(1) of the New Brunswick's *Human Rights Act* and awarded damages. In the 2010 case *J.A.W. v. J.E.W.*, the Court of Queen's Bench allowed a parentage order in the case of surrogacy, wherein a woman had carried a child to term for her sister and sister's husband. The judge made note of the fact that the child was genetically related to both of his intended parents, claiming "the Legislature intended to vest [the court with] jurisdiction so as to allow for declarations of parentage based on biology" (2010: para. 18). It is thus unclear whether the same judge would have permitted a parentage order to other (non-heterosexual) intended parents, or indeed to those without a genetic connection to the child. New Brunswick has not amended its legislation to reflect either decision.

Table 6.17
Parentage in the Provinces

Restrictive <----------> Permissive						
4	**5**	**7**	**8**	**9**	**14**	**16**
MB PEI	NB* (0) SK* (4)	QC	ON* (4)	AB NS	NL	BC
* In part because of common law (legislative score in parentheses)						

Overall, while parentage policy is regulated to some degree in every province, such regulation is uneven. Table 6.17 demonstrates the degree of variation in terms of permissiveness. Using the measure developed in this chapter, provinces range from a low of 4 (three provinces) to a high of 16 (British Columbia) on a possible 32 point-scale of parentage permissiveness (with 32 being the most permissive). Legislation – or the policy status quo resulting from litigation – varies with respect to the possible number and sex of the intended parents, the extent to which they must be genetically related to the child,

and the timing of parentage addition or transfer. The implications of such variation are discussed in the next, concluding section.

Conclusion

This chapter began with the argument that in order to understand the true nature of ART policy in Canada, it was necessary to examine provincial policy concerning surrogacy and parentage, areas which have been largely ignored in the Canadian and comparative political science literature. I began by drawing conceptual boundaries between surrogacy and parentage. Surrogacy policy involves rules regarding payment, the genetic relation of the birth mother to the child, and the validity and enforceability of written surrogacy arrangements. Parentage policy, by contrast – whether in the context of surrogacy or assisted conception – concerns both the eligibility of intended parents and the procedural barriers they face to become parents. Logically speaking, surrogacy policy can condition parentage policy, insofar as the validity and enforceability of surrogacy arrangements will affect the extent to which parentage transfer/addition can take place. In keeping with the comparative ART literature (Bleiklie, Goggin, and Rothmayr 2004; Engeli, Green-Pedersen, and Larsen 2012a; Montpetit, Rothmayr, and Varone 2007a), I argue that both surrogacy and parentage policies can be measured in terms of permissiveness vs. restrictiveness, with permissiveness defined as having fewer legal barriers for intended parents. Canada's provincial diversity in this regard is instructive for comparative analysis, insofar as the ten different frameworks illustrate the various ways in which legislation can inhibit or promote policy permissiveness.

In addition to its comparative utility, the framework adds nuance to understanding Canada's overall ART policy mix. Using my permissiveness scale, I measure the extent to which both surrogacy and parentage policy vary from province to province. The first major conclusion is that, at least in terms of surrogacy and parentage, ART policy in Canada is not "unregulated," nor does it resemble the "Wild West." Most provinces have some form of a legal status quo, whether by legislation or common law, regarding surrogacy and/or parentage. There exists considerable regulation, some of which – particularly in Alberta, Quebec, and British Columbia – provides clarity for surrogates, their partners, and intended parents. Moreover, most of this policy change has occurred in the last five years. For many scholars, the inconsistency and slow pace of policy change in the provinces has been maddening. Some may feel the courts or the legislatures have got it wrong. Yet in spite of all this, it is fair to say that policy is gradually catching up with the reality of ARTs. In some provinces it is the result of legislative action; in some provinces, a well-timed judicial decision; in some provinces, both. Slowly – very slowly – but surely, the general trend among the provinces has been towards greater policy permissiveness. Canada's permissiveness is especially striking compared with other common-law jurisdictions such as the United Kingdom and Australia; Canada has attached comparatively "few evidentiary, substantive, or procedural requirements to surrogacy-related parentage applications" whereas those jurisdictions have implemented "expensive, invasive, time-consuming, and ineffective post-delivery processes" (Busby 2013: 300, 289).

This chapter's second conclusion is thus that some of the Baird Commission's worst fears were in many ways realized. While the Commission recognized that

parentage was provincial jurisdiction, it nevertheless urged interprovincial collaboration to "clarify and standardize in all provinces the parentage of children born as a result of donor insemination" (Canada 1993: 489). "Matters so important to women and children," the Commission argued, "in terms not only of their health but of *their legal status and how they are viewed*, cannot differ from province to province" (xxxvi, emphasis added). Twenty years later, there is considerable variation between provinces with respect to the legal status of children born through ARTs, and there have been no intergovernmental attempts to harmonize policy between provinces. The greatest inconsistency occurs with respect to surrogacy arrangements. As we saw in Table 6.1, only five provinces have legislation that addresses surrogacy arrangements, and in three of those (British Columbia, Nova Scotia, and Newfoundland and Labrador) the enforceability of these arrangements remains unclear. With respect to parentage policy, just about every imaginable parentage arrangement is covered, particularly when taking into account the gender and number of intended parents. This provincial variation means it is certainly accurate to describe Canadian ART policy in the provinces as a patchwork, as many scholars have.

The third conclusion, consistent with other chapters in this dissertation, is that the courts have played a particularly prominent role in the development of surrogacy and parentage policy across the provinces. In Alberta, British Columbia, and Ontario (in part), challenges to existing parentage provisions provided the impetus for legislative reform. In Saskatchewan, New Brunswick, and Ontario (in part), they serve as the status quo in the absence of subsequent legislative reform. True, not all judicial challenges result in permissive reform: in *J.C. v. The Queen* (2000), a Manitoba judge rejected a parentage

claim, and in *X, sub. nom Adoption -091* (2009), a Quebec court reaffirmed Quebec's strict approach to surrogacy. However, particularly in the absence of legislation, litigation strategies have typically nudged policy towards permissiveness, especially when pertaining to surrogacy. This is consistent with the comparative evidence on judicial policymaking, which suggests courts will promote legal change by "asserting individual rights and liberties against traditional social values" in moral conflicts (Tatalovich and Daynes 2003: xxvii). While the existing legislative context certainly shapes those decisions, court challenges will continue to play an important role with respect to assisted reproductive technologies in Canada.

Finally, this analysis lends considerable weight to the argument that statutory law – whether permissive (British Columbia) or restrictive (surrogacy in Quebec) – has the advantage of setting clear rules and boundaries for prospective parents, decreasing the possibility of expensive litigation. In this primarily empirical dissertation, I have made no claims about the normative desirability of a permissive or restrictive framework. There exists a host of bioethical arguments concerning the effects of pre-birth surrogacy contracts and multiple parents on children and patients, which can be evaluated on their own merits (Anderson 2000; Downie and Baylis 2013; Harris 2000; McLachlan and Swales 2000; Shanley 2007; Somerville 2007). Regardless of whether one desires permissive or restrictive policy, however, the evidence suggests that legislation is far more desirable than piecemeal judicial change. As Nelson (2013b: 336) notes, statutory rules for parentage afford a "significant advantage" because of the "clarity they afford"; in the absence of clear rules, intended parents must resort to the courts, where "judges are

placed in the position of applying rules that were not fashioned to deal with families creating ARTs."[40] The result, both between and within provinces, is legal uncertainty.

This chapter has made the case that considerable, if uneven, provincial regulation exists in the ART subfields of surrogacy and parentage, and that the existing Canadian political science literature has overlooked these fields. Some may claim that parentage and surrogacy are peripheral to ARTs, and that they are not as important as, for example, rules governing fertility clinics. However, parentage and surrogacy have tremendous implications for non-traditional families and individuals considering the use of ARTs. The rules in place – whether by legislation or judicial decisions – can inhibit or promote the creation of new families. They can provide legal certainty for parents, create security for surrogates, and prevent legal disputes. They ought not be ignored. Canada in particular is an excellent case study, as its various rules at the provincial level can provide evidence for or against adopting particular policies.

[40] This argument has been made since the early days of ARTs, when Peter Bowal claimed surrogacy policy "too important to be left to the judges" (1983: 34).

CHAPTER SEVEN:

MANY ACTORS, MANY POLICIES –

ASSISTED CONCEPTION POLICY IN CANADA

Having addressed the subfields of surrogacy and parentage – and having made the case for their relevance as distinct subfields of ART policy – it is necessary to acknowledge that most commentators' problems with provincial ART policy concern neither surrogacy nor parentage. Instead, criticism of Canadian ART policy stems from a lack of regulation in the subfield that is most commonly used to speak for ART policy as a whole: assisted conception. When commentators refer to ARTs in Canada as the "Wild West" (Downie and Baylis 2013) or an "unregulated nightmare" (Guichon, Giroux, and Mitchell 2008), they are not talking primarily or even secondarily about parentage or surrogacy. Françoise Baylis, Canada's most vociferous critic of government inaction over ARTs, has been especially critical of lax rules regarding multiple embryo transfer, which can lead to health consequences associated with multiple births (Baylis 2011: 318). According to legal scholars Vanessa Gruben and Angela Cameron (2011), these health problems include "pre-eclampsia, gestational diabetes, anemia and premature labour" for pregnant women, and "low birth weight and prematurity" for their children. Gruben and Cameron (along with Baylis) have made similar claims regarding the collection and management of health reporting information, which is "vital to ensuring that these children receive important genetic health information about their biological heritage" (Gruben and Cameron 2011; see also Baylis 2011, 2013).

All of these features – rules for fertility treatments, donors, information collection, and licensing requirements – fall into the subfield of assisted conception policy, which I

define quite broadly. In Chapter 2, I refer to this subfield as rules that cover the use of technology to enhance the prospects of reproductive success, whether for individuals with difficulty conceiving naturally, those with heritable diseases, single mothers, or sexual minorities. Public policy in this subfield can be further subdivided into three overlapping areas. First, there are rules meant to affect the behaviour of one particular "target group": medical professionals. These include licensing and inspection requirements, rules for the use and transfer of human reproductive material, and rules regarding clinical practice. These rules cover the permissibility of all assisted conception procedures, including artificial insemination (AI), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), and assisted hatching (AH). Second, there are rules meant to affect the behaviour of another "target group": donors, patients, and, by implication, children born through assisted conception. These include, primarily, rules for the donation of human gametes (egg and sperm), which typically consist of screening requirements, limits on the number of donations permitted, the identification of donors, and the maintenance of databases. Third, there are rules regarding patient health-insurance coverage. In this instance, the "target group" is primarily patients or "clients" of ARTs, but these policies also affect the behaviour of medical professionals. Here I simply include the coverage of costs associated with assisted conception treatments and fertility drugs. This can be done through direct coverage of a particular type of assisted conception and/or drugs (as in Quebec with IVF) in a public system, or through rules that mandate private insurers to cover assisted conception procedures and/or drugs (as in several American states).

There is considerable overlap between these three components of assisted conception, which is why they are all themselves part of an integrated subfield. Rules mandating the creation or maintenance of patient databases, for example, will affect both the behaviour of medical professionals and patients, while rules limiting the donation of human reproductive material will have a direct impact on the business of the fertility industry – for example, a complete ban on multiple sperm donations could have a pronounced effect on the supply of reproductive material, affecting private practice. And rules regarding patient coverage will certainly affect the behaviour of both physicians and patients by increasing patient access to these technologies and providing medical practitioners with a steady business supply. While the policy areas can be separated in part by the "target group" they seek to affect, the interests of physicians and patients are typically intertwined when it comes to assisted conception policy.

This chapter examines who regulates assisted conception in Canada and how they regulate it. I find that the federal government, provincial governments, professional medical organizations, and courts are all involved in some form of policymaking, albeit to different degrees. While the federal government is constrained by the Supreme Court's ruling in 2010, it nevertheless continues to regulate and prohibit in a few select areas. Provinces, meanwhile, have done very little in terms of assisted conception, with the exception of Quebec, whose legislation provides a valuable case study. Outside of Quebec, the vast majority of the policymaking is done by national specialist medical organizations, who have been effectively ceded policymaking power by provincial medical colleges. Finally, a provincial lower court decision in British Columbia concerning donor identification, although eventually overturned on appeal, demonstrates

the extent to which courts have the capability to produce policy in this subfield and to compel other policymakers to act.

This chapter draws several conclusions. First, for Canadian and comparative scholars, examining the policy outputs from other governmental and non-governmental institutions provides a richer understanding of ART policymaking. Several policymakers have created functioning public policy in this subfield and, after examining these additional policymakers, it is clearly incorrect to refer to assisted conception policy in Canada as "unregulated." Second, Quebec's comprehensive assisted conception framework demonstrates that provinces have the capacity to regulate this subfield. Indeed, combined with Quebec's legislation concerning surrogacy and parentage, it suggests that provinces may be more effective than the federal government at integrating several ART subfields into a coherent framework.

Yet as with much else in Canadian politics, describing assisted conception policy requires a Quebec-shaped asterisk. While provinces have the capability to regulate assisted conception, nine out of ten have chosen not to. Because national specialist associations in particular have created a number of clinical guidelines, my third conclusion is that provinces have been reticent to create assisted conception policy in part because there are strong institutional incentives to avoid it. ARTs are a controversial and expensive policy field, and assisted conception is no exception. What medical professionals have done is create *enough* self-regulation to constitute effective public policy, negating the obvious need for government intervention. The absence of any major controversies and the continued emergence of best practices – such as the recent decline in multiple birth rates – provides little incentive for provincial governments to act in this

subfield. While Quebec had its own unique circumstances that prompted the provincial government to act – and British Columbia was nearly forced into action by a judicial decision – the reluctance of other provinces to legislate seems to confirm Varone, Rothmayr, and Montpetit's (2007: 11) prediction that medical professionals will self-regulate as a strategy to influence and prevent state intervention.

Government Regulation of Assisted Conception: The Quebec Exception

Even after the Supreme Court decision in 2010, the federal government retains an active, if considerably reduced, role in assisted conception policy. To begin, the criminal prohibitions contained in the *AHR Act* remain, and several of these prohibitions pertain to assisted conception. These prohibitions are designed primarily to target the behaviour of would-be patients and donors. Section 7 of the Act bans any "offer to purchase or advertise for the purchase of" sperm, eggs, or embryos. Sections 8 and 9 also ban the use of human gametes without informed consent and ban the use of such gametes from a minor. Moreover, in 2007, Health Canada created its one regulation concerning the consent to use human reproductive material. These "section 8" regulations specify who must consent, when consent is required, when consent can be withdrawn, and the type of information donors must receive before they can meaningfully consent (Canada 2007).

The federal government has also shown that it intends, albeit very slowly, to update the *AHR Act* concerning the use of human reproductive material. In 2010, the Supreme Court found section 10 of the *AHR Act* – which concerns the use of human reproductive material – unconstitutional, but the federal government subsequently amended it in 2012 to emphasize a criminal purpose: "to reduce the risks to human health

and safety." As Downie and Baylis summarize, the new section, which is not yet in force and must be read in concert with not-yet-created regulations, provides several provisions that limit the use, distribution, and importation of human eggs for reproductive purposes to "the spouse, common-law partner or sexual partner of the providers." In practice, this means the use, importation, and distribution of eggs for the purposes of reproduction "will be limited to frozen eggs from sources and through processes that can meet the health and safety requirements." Once the section comes into force, it will be illegal to use, distribute, or import eggs that do not meet a series of health requirements (2013: 228-231). These amendments primarily target medical professionals, who must incur additional costs and time when importing materials. However, these changes will also affect patients, who will likely be passed on the costs incurred by medical professionals and will also benefit from presumably superior health standards. In addition to this "minimal regulatory aspect" regarding gamete testing, Health Canada also remains responsible for administering regulations concerning the reimbursement for gamete donation, although it has not yet created said regulations (Nelson 2013b: 258).

As described in Chapter 5, there are several other small federal provisions regarding assisted conception. The *Processing and Distribution of Semen for Assisted Conception Regulations* ("semen regulations") prohibit the importation and distribution of semen unless it has undergone rigorous testing, screening, and a period of quarantine. Health Canada also inspects fertility clinics every three years, and the inspection process is fairly rigorous; as one fertility physician said in an interview, "they come here looking for trouble" (Interview 2012b). Yet it is fair to say that most federal regulation of assisted conception takes place at the margins, away from the day-to-day work in fertility clinics

of attempting to achieve pregnancy. The federal government's role is essentially limited to a directive regarding the processing of semen, mandatory inspection of fertility clinics by Health Canada, and limits on compensation for human gametes. After the 2010 Supreme Court decision, provinces have jurisdiction over "the regulation of a specific type of health services provided in health-care institutions by health-care professionals to individuals who for pathological or physiological reasons need help to reproduce" (*Reference re Assisted Human Reproduction Act* 2010: para. 227), which constitutes the vast majority of the assisted conception subfield.

However, as Nelson (2013b: 260) notes, while provincial governments engage in "some regulation" of assisted conception, this regulation is "neither comprehensive nor integrated." Indeed, most provinces engage in minimal regulation. Outside of Quebec, no province or territory has implemented assisted conception policy in any comprehensive manner. The only exceptions are with respect to health-insurance coverage: several provinces include artificial insemination (AI) or intrauterine insemination (IUI) under their health insurance, including British Columbia, Saskatchewan, Ontario, Quebec, Prince Edward Island, and Newfoundland and Labrador. Certain in-hospital medical procedures related to IVF, such as blood tests, ultrasounds, and diagnostic tests may also be covered. However, the most costly components of assisted conception – such as IVF, ICSI, fertility drugs, gamete and embryo storage, and PGD – are not covered outside of Quebec (University of Alberta Health Technology & Policy Unit 2013: 69). Ontario fully covered IVF under public insurance from 1985-1994 provided it was performed in a public hospital, but since that time it has covered only the first three cycles of IVF in the case of blocked fallopian tubes, which occurs in only 1% of the cases of infertility

(L'Espérance 2013: 124). In 2010, Manitoba introduced the Fertility Treatment Tax Credit, which permits patients to claim up to $20,000 in eligible expenses from fertility drugs and treatment for a maximum credit of $8,000 (Manitoba 2013). Some provincial governments have also commissioned studies to explore the extent to which they should engage in ART policymaking, but these have not yet led to policy action. In 2009, an Expert Panel on Infertility and Adoption, chaired by future Governor General David Johnston, recommended that Ontario cover three cycles of IVF. However, this never came to fruition (Ontario Ministry of Children and Youth Services 2009). Likewise, in February 2013, the Government of Alberta commissioned a nearly 500-page study from the School of Public Health at the University of Alberta to examine whether the province should regulate and fund assisted conception procedures (University of Alberta Health Technology & Policy Unit 2013). The government has yet to officially respond.[41]

Thus, outside of Quebec, there is only minimal coverage in Ontario and a tax credit in Manitoba. However, Quebec's comprehensive regime, which has been integrated with its Civil Code provisions regarding surrogacy and parentage policy, is worth exploring in detail because it demonstrates the extent to which provinces have the capacity to make policy. In June 2009, Quebec's National Assembly passed *An Act respecting Clinical and Research Activities relating to Assisted Procreation*. This Act regulates "most clinical activities on assisted reproduction, including IVF procedures, pre-implantation genetic diagnosis, related research activities, and the licensing and

[41] In 2013, Guichon, Mitchell and Doig conducted email correspondence with government officials in Ontario, British Columbia, Alberta, Manitoba, and Nova Scotia, and concluded "none has plans to regulate assisted human reproduction or is prepared to report that it has such plans" (323).

monitoring of clinical procedures" (Ogbogu 2011: 180).[42] In terms of its provisions designed to target physician behaviour, the legislation is encompassing. It provides that assisted conception must be provided in licensed centres that must provide annual reports, with licenses issued by the Minister of Health and Social Services. The legislation also grants licensing and general regulatory powers to the Minister, and mandates that centres must be accredited by a body recognized by the Minister.

Quebec legislation does not contain explicit regulations concerning the donation of gametes, although its legislation does require fertility centres to produce annual reports on activities and maintain databases on success rates. Moreover, it has no regulation concerning donor identification, meaning it is *de facto* regulated by internal rules from the Collège des médecins du Québec (CMQ), which maintains donor anonymity. In 2010, Quebec passed the *Regulation respecting clinical activities related to assisted procreation*, which defines acceptable clinical practices. The regulation limits preimplantation genetic diagnosis to the identification of serious diseases and abnormalities and mandates free and informed consent for donors and patients. Most importantly, it contains conditions for single embryo transfer (SET) during IVF by limiting embryo transfer to SET during normal circumstances, permitting up to two embryos for women aged 36 and up to three for women 37 years or older (2010: s. 17). Quebec brought in these regulations with the explicit goal of reducing IVF multiple pregnancies from 30% to 5% (L'Espérance 2013: 26). Finally, Quebec's regime includes patient coverage. In 2010, it amended its *Regulation respecting the application of the Health Insurance Act*, which stipulates procedures covered under Quebec's public health

[42] Its research-related provisions mandate that any "research project on assisted procreation activities" or on embryo research be vetted by a research ethics committee. However, these provisions are not yet in force (Quebec 2009: ss. 8, 17).

insurance scheme. The regulation covers the costs for assisted conception procedures, which include preimplantation genetic diagnosis, ovarian stimulation, egg retrieval, embryo transfer, sperm storage extraction, assisted hatching, ICSI, artificial insemination, and three cycles of IVF for all women of childbearing age. Quebec's Prescription Drug Insurance Plan also covers assisted-conception medication (L'Espérance 2013: 26).

The way the Quebec legislation was framed provides some clue as to why it was passed. As Christopher Cooper (2013: 2) notes, Quebec politicians largely framed ARTs in a way that "emphasized the ethical dangers," and hence the need for greater government intervention. In particular, the inherent dangers associated with multiple pregnancies – both for mothers and children – were tied to the need for state funding. The two were essentially treated as inseparable aspects of the same plan, with the logic of this argument as follows: first, because IVF is so expensive, patients will want as many embryos transferred as possible to ensure success; this increases the likelihood of multiple births. Second, multiple births, because of complications that arise and the likelihood of premature birth, are an expensive drain on the public health care system, which ought to be limited. Third, the best way to do this is through public funding of IVF. If patients do not actually pay for IVF, there will be fewer incentives to transfer multiple embryos. Quebec's policy, as proposed, would therefore kill two birds with one stone, as the savings from fewer multiple births could pay for the IVF coverage. For both ethical reasons (fewer multiple births) and financial ones (stemming from fewer multiple births), IVF should be funded by the state. The fact that Quebec's multiple pregnancy rate immediately dropped from 25.6% to 3.7% for the three months after the program's

initiation – spurred on by a rise in elective single embryo transfer from 1.6% to 50% – was touted by many as proof of increased savings (Bissonnette et al. 2011).

In my own interviews, fertility physicians touted Quebec's regime – which Nelson summarizes as "[s]tate-funded or subsidised treatment linked to [single embryo transfer]" (2013b: 287) – as sound financial strategy and good public policy (Interview 2011b, 2012a). A different perspective is possible, however. As Nelson notes, "the profession is in essence asking the government to pay to solve a problem that the profession is responsible for creating" (2013b: 288). If medical organizations were truly convinced that anything other than single embryo transfer were unethical, they would create internal regulations mandating strict single embryo transfer – and, as the next section demonstrates, they are well on their way to doing so. And if the province of Quebec were truly concerned that rogue physicians would continue multiple embryo transfer in spite of clinical guidelines, then the government could mandate single embryo transfer regardless of whether it also included public funding – or, as Nelson puts it, "[t]here is no need to fund IVF to encourage SET; instead we could simply mandate SET" (2013b: 288; see also Picard 2011). When it comes to funding IVF and mandating clinical rules for IVF, governments can easily do either, neither, or both. Moreover, the financial prudence of the scheme has recently been thrown into question, with reports that costs have been "skyrocketing" beyond original projections (Cattapan 2013; Séguin 2013). Nevertheless, the argument connecting funding to reduced multiple births was championed by physician organizations – for whom the policy will undoubtedly increase the supply of patients – and adopted in Quebec. Overall, Quebec has an extensive assisted conception policy, which includes IVF coverage and clinical guidelines for physicians.

Combined with its rules for surrogacy and parentage (discussed in Chapter 6), this makes its ART policy the most comprehensive in the country. Other provinces have yet to follow suit.

Policymaking through Self-Regulation: National Medical Associations

Quebec demonstrates the extent to which provinces can effectively regulate assisted conception policy, and early results suggest that such regulations can affect physician behaviour. With minimal regulation of assisted conception outside the province of Quebec, it is tempting to argue that these important practices are effectively unregulated in the rest of Canada. However, as this section demonstrates, such an argument understates the role of medical organizations, which have been under-emphasized in the Canadian literature. In what follows, I will argue that one of the explanations for the lack of provincial activity is that provincial medical organizations and national specialist organizations have created enough internal regulation that they have removed an incentive for provinces to act.

It is no secret that professional medical organizations are often delegated responsibility for ART policymaking because of their authority over clinical practice. Compared with other fields, government involvement in medicine tends to be more limited because private medical organizations are among those self-regulating bodies that tend to "dominate monitoring and compliance-seeking" (Porter and Ronit 2006: 67). Yet the study of private actors with respect to ART self-regulation has ranged from slow to nonexistent. Christine Rothmayr Allison's (2009: 421) call for ART scholars to examine "self-regulatory mechanisms established by medical professionals" notwithstanding, the

extent to which non-statutory guidelines actually bind medical professionals is yet to be adequately answered, particularly in Canada. More recently, Engeli and Rothmayr Allison (2013) have begun to analyze the role of ART self-regulation in a comparative context; their study of self-regulation in France, Germany, and Great Britain is the first analysis of this sort. Their preliminary findings suggest that "the state has progressively played a more pivotal role in the field over time" (2). Below, I propose to add the Canadian case study to tell us more about the comparative influence of self-regulatory medical organizations and their capacity to make policy.

Professional self-regulation has also been called private regulation, voluntary regulation, first-party regulation, statutory self-regulation and self-governance (Engeli and Rothmayr Allison 2013: 6; see also Garoupa 2011; Gunningham and Rees 1997; Levi-Faur 2011; Porter and Ronit 2006; Priest 1998; Weimer 2006). Under professional self-regulation, both entry and performance are regulated by the profession, which creates a "relatively large degree of autonomy delegated to the [self-regulatory organization] to regulate its individual members" (Priest 1998: 251-252; Garoupa 2011: 457). Professional self-regulatory organizations (SROs) – in the case of Canada, provincial colleges of physicians and surgeons – are delegated, through legislation, a range of powers over rulemaking, monitoring, enforcement, and sanctions. There is also a "licensure" regime for physicians, whereby the SRO determines strict admission requirements, competency exams, and educational qualifications required for membership (Epps 2011; Priest 1998: 240-242).

As Epps (2007) notes, provinces typically take one of two approaches to health care delegation. "Umbrella" legislation, such as Ontario's *Regulated Health Professions*

Act, is a single piece of legislation that "provides a regulatory framework for all self-governing health professions at the same time, and then enumerates professions to which these are applicable" (83). By contrast, in the "traditional" approach, each health profession is regulated through a separate piece of legislation; Saskatchewan, for example, has over 20 statutes regulating the different health professions, including the *Medical Practitioners Act* for physicians (85). In either case, such statutory self-regulation means medical colleges are the primary policymakers for clinical practice in every Canadian province; they issue licenses to allow physicians to practice medicine, maintain and monitor standards of practice, produce ethical and clinical guidelines, and conduct disciplinary hearings for professional misconduct.

The SROs' self-regulatory authority for health care more generally applies to all aspects of assisted conception policy (and some aspects of screening, enhancement, and manipulation) that fall within provincial jurisdiction. Canadian medical organizations have long preferred self-regulation to government legislation when it comes to ARTs; as Scala (2002: 197, 199) argues, most scientists, medical practitioners, and legal organizations "depicted professional self-regulation as the panacea for any potential misuse of reproductive technologies" during the Baird Commission hearings, and "reaffirmed the role of professional authority in devising and enforcing" any resulting guidelines. Throughout the legislative process leading up to the *AHR Act*, some physicians still opposed the legislation: Dr. Calvin Green claimed the position of the Canadian Fertility and Andrology Society was that the bill "does more harm than good… it compromises the care of our patients, and our patients tell us they do not want it," while Dr. Clifford Librach claimed the legislation was "seriously flawed and will have

devastating consequences for the infertile population" (Canada 2004a). By contrast, others in the fertility industry had come around. Dr. Michael Rudnicki said the legislation was "timely and prudent, and brings a necessary level of oversight and regulation" (Canada 2004a). While admitting he had some reservations about the criminal prohibitions (as most physicians, researchers, and lawyers did), Dr. Ronald Worton claimed agreed "there is a need for legislation, a need for regulation, and a need for a regulatory body to oversee it" (Canada 2004a). And Dr. Roger Godsen from CFAS claimed, "I think I can say on behalf of my colleagues throughout Canada that we do welcome legislation in this area" (Canada 2004a).

As Françoise Baylis notes, however, the introduction of the *AHR Act* – and the subsequent delay of Health Canada regulations due to the pending Supreme Court case – "did not change the status quo with respect to clinical practice," which "continued more or less as before, with the federal government seemingly happy to have fertility clinics provide services" (2012: 512). After the Supreme Court case in 2010 that curtailed the federal government's sweeping powers (which had been legislated but not institutionalized), that status quo remains in every province except Quebec. Professional clinical guidelines continue to set assisted conception policy. Yet these guidelines do not come primarily from provincial medical colleges. Only the College of Physicians and Surgeons of Alberta and the College of Physicians and Surgeons of Saskatchewan have created guidelines for ARTs, in 2011 and 2012 respectively. The documents outline qualifications for medical directors, physicians performing IVF, and support staff. They also stipulate screening tests for patients, mandate written rules for surgical and non-

surgical procedures, and describe the details regarding patient records (including consent forms and the number of gametes and embryos retrieved).

At only 5-6 pages long, however, the Alberta and Saskatchewan guidelines are far from comprehensive; they "lack any description of process and values" and do not even reference the *AHR Act* (Guichon, Mitchell, and Doig 2013: 327, 330). When it comes to clinical practice, the authority for ART policymaking by medical professionals remains much as it was prior to the *AHR Act*, when Montpetit noted that provincial colleges would typically "refer physicians to specialist organizations" (2004: 68). Indeed, one Alberta physician noted that the College of Physicians and Surgeons of Alberta recently "got out of the policy business," preferring to rely on national clinical care guidelines for assisted conception (Interview 2012a). These guidelines are produced by the Society of Obstetricians and Gynaecologists of Canada (SOGC) and the Canadian Fertility and Andrology Society (CFAS), either jointly or independently. Relying on such organizations does not entirely mean professional abdication, however. SOGC and CFAS each have an entire section of guidelines related to assisted conception, including advanced reproductive age and fertility, elective single embryo transfer following IVF, diagnosis and management of ovarian hyperstimulation syndrome, sperm donation and sperm sorting, surrogacy arrangements, egg donation, the use of frozen embryos, ICSI, social screening for assisted reproductive technologies, and medical and genetic screening of egg, sperm, and embryo donors. They also have several guidelines on prenatal screening (including PGD) and embryonic research (Society of Obstetricians and Gynaecologists of Canada 2013; see also Nelson 2013b: 260). These myriad national specialist guidelines for ARTs date back to the late 1990s, when SOGC and CFAS

produced a joint ART policy statement, which outlined clinical guidelines for sperm sorting, egg donation, ICSI, preimplantation genetic diagnosis (PGD), donor screening, embryonic research, and surrogacy (Canadian Fertility and Andrology Society and Society of Obstetricians and Gynaecologists of Canada 1999).

These guidelines – which cover all health professionals involved with ART – are comprehensive, specific, and frequently updated. Moreover, fertility clinics have become increasingly (though by no means fully) transparent; Canadian ART clinics offering IVF, intracytoplasmic sperm injection (ICSI), and frozen embryo transfer (FET) voluntarily contribute detailed information on children born through ART to the Canadian Assisted Reproductive Technologies Register (CARTR), with 31 of 32 centres voluntarily submitting data in 2012 (Canadian Fertility and Andrology Society 2013a).[43] Success rates for all Canadian fertility clinics are published on the CFAS website, and in academic journals such as the *Journal of Obstetrics and Gynaecology Canada*. Fertility clinics and laboratories are also subject to inspection by provincial medical colleges, in addition to Health Canada.

The existence of clinical guidelines and the CARTR register has not assuaged critics of ART self-regulation in Canada because such reporting remains entirely voluntary, is not subject to government oversight, and the register does not identify individual clinics. In general, critics of professional self-regulation stress that there is a conflict between the public interest and professional self-interest, and that self-regulation in the health care field more generally may merely be a strategy of "placating stakeholders without substantively altering behavior" (Arnold and Oakley 2013: 506).

[43] In 2009 and 2010, there was actually a 100% reporting rate among all 28 clinics at the time. Because 32 clinics are now on the register, it is likely that the clinic that did not report data in 2012 is new to the register.

Medical colleges may be reluctant to sanction or discipline their own members, which could lead to decreased compliance with guidelines (see Epps 2011: 92-94; Garoupa 2011: 464; Ogus 1995: 99). Because professional medical organizations are both rule-makers and rule-enforcers, the public choice literature and "capture" theory of professional self-regulation suggest that part of their *raison d'être* is to confer supra-competitive profits on the industry itself, "decrease the supply of professionals below social optimum, increase the prices charged by professionals, and increase existing professionals' incomes beyond marginal productivity" (Garoupa 2011: 456; see also Kleiner and Kudrle 2000; Rowley, Tollinson, and Tullock 1988; Stigler 1971). In the Canadian context, Erin Nelson notes an obvious conflict between the medical professions' obligation "to protect their patients' confidences" and "the need to regulate the use of these technologies in the interests of patients and the wider public" (2013b: 264-165).

Perhaps most importantly for ART policy, critics stress how self-regulating physicians could be inclined towards under-regulation, as the motivation for profits in the fertility industry outweighs ethical concerns in the absence criminal sanctions. American scholar Aaron D. Levine, for example, has compiled evidence that donor agencies and wealthy recipients often ignore the American Society for Reproductive Medicine (ASRM) guidelines regarding compensation for egg donors, in part because "violating the ethical guidelines has few serious consequences" (2010: 49). The same is true for egg cryopreservation in the USA: while the ASRM removed the "experimental" tag for the practice, it cautioned against its use by healthy women and emphasized that all women have full information before undergoing the procedure. However, Alisa von Hagel's

survey of clinics offering the service found that 45% offer "extremely limited to no information about this service" while emphasizing "the potential benefits of cryopreservation without any indication of the uncertainty surrounding this practice" (2013: 9-10). Without comprehensive regulation, Nelson claims the fact that "a variety of highly specialized professions are involved in the delivery of reproductive healthcare… will only intensify the current incoherent and fragmentary approach to regulation of reproduction" in the United States, echoing concerns by Canadian scholars (2013b: 265; see Downie and Baylis 2013). Similarly, Guichon, Mitchell, and Doig stress that "[p]hysician colleges ought not to be placed in the position of being the only regulators of assisted human reproduction" because of "inherent conflicts of interest between the physician as caregiver and physician as manager of an economic enterprise" (2013: 335-336). Indeed, Health Canada's 1996 report that many physicians were not following the voluntary moratorium on certain practices demonstrates that public policy cannot simply rely on professional goodwill (see Chapter 4).

Proponents of self-regulation, by contrast, stress that it tends to create a more flexible, adaptable, and financially efficient governance structure compared with outright state regulation, as administrative costs often are internalized by SROs (Ogus 1995: 97-98; Vrielink, van Montfort, and Bokhorst 2011: 490). More importantly for ART policy, some claim self-regulation can actually *increase* compliance compared with state regulation, as a psychological "buy in" develops to build a professional "ethic" (Bardach and Kagan 1982; Priest 1998: 270-71). As Gunningham and Rees note, when a self-regulated profession develops an "industrial morality" – part of which includes an expectation of obedience – non-statutory guidelines can be "remarkably effective in

guiding and controlling industry conduct" (1997: 380), even when they lack the sanctioning power associated with criminal law. Moreover, some proponents of self-regulation are often in favour precisely *because* the policies produced are more likely to be permissive. As Rogerio A. Lobo of the ASRM wrote in 2011, comparative government regulations often include "prohibiting in vitro fertilization, allowing its use only for married couples, prohibiting treatments for single or gay patients, and denying a woman compensation for the effort, pain and inconvenience associated with being an oocyte donor" (2011: 652). Whether because of the desire for profits, the Hippocratic oath, or some combination of the two, it is difficult to disagree that when barriers to assisted conception exist, those barriers tend to be produced by governments, not professional organizations.[44]

It is certainly true that in terms of punitive sanctions and enforceability, the criminal law can be very effective. Fertility specialists are highly unlikely to go underground or openly perform activities that would put them in jail. In Canada, recent evidence suggests that non-criminal government regulations, as in Quebec, can have an important impact on clinical practice. As Bissonnette et al. (2011) note, the introduction of Quebec's guidelines tying single embryo transfer to IVF funding coverage resulted in a rapid decrease in Quebec's multiple pregnancy rate, from 25.6% in 2009 (the year prior to the program's initiation) to 3.7% in the first three months. By contrast, penalties associated with self-regulation are less severe and less enforceable than the blunt force of

[44] While rare, it is not unheard of that medical organizations will come out in favour of more strict legislation. In 2001, the Slovenian government introduced an amendment to liberalize ART policy by making single women eligible for ART services. The National Organization of Physicians opposed the law. The law was passed, but was subject to a referendum afterwards. Again, the National Organization of Physicians – along with the Professional College for Gynecology and several religious organizations – opposed the law, which was eventually struck down by popular vote (Rothmayr Allison and Varone 2009: 442-443). In Canada, by contrast, religious organizations have not seen eye-to-eye with medical organizations, which have almost uniformly favoured permissive policy.

criminal law, increasing the potential for non-compliance. In Canada, details of internal monitoring, with the exception of the CARTR register, are considerably opaque. Meanwhile, sanctions – though not unheard of, as shown when the College of Physicians and Surgeons of Ontario suspended a fertility doctor was in early 2013 for artificially inseminating four women with the wrong sperm (Haque 2013) – are rare and often weak.

On the other hand, there is certainly evidence that, while not as rapid as outright government regulation when tied to the carrot of state funding, such professional "buy in" exists regarding assisted conception when it comes to CFAS and SOGC guidelines in Canada and comparatively (see Cook et al. 2011: 164). For example, one American study attributed a dramatic decrease in multiple pregnancies through IVF to the introduction of the ASRM's voluntary guidelines, while Australia's non-statutory ethical guidelines have been accepted by the Reproductive Technology Accreditation Committee (RTAC) to govern fertility clinics (National Health and Medical Research Council 2007; Stern et al. 2007; Williams 2011). Guidelines from the Fertility Society of Australia have led to the highest proportion of singleton deliveries ever reported in Australia (Cook et al. 2011: 165). Meanwhile, the high rate of reporting for the CARTR register noted above indicates some buy-in is occurring in Canada as well. The same can be said for embryo transfer. To take one example, the CFAS/SOGC guidelines for embryo transfer following IVF state that single embryo transfer should be the norm for women aged 37 and under, although two embryos can be transferred for women with poor prognosis. This can rise to four embryos transferred for women over the age of 42 depending on the stage of the embryo and the patient prognosis (Min and Sylvestre 2013). The most recent data show that multiple pregnancies arising from IVF have dropped remarkably, from 32% in 2009 to

18.4% in 2012. Interestingly, Canadian fertility physician Al Yuzpe also gave some credit to the now-defunct AHRC for beginning the drive to reduce multiple pregnancies (Canadian Fertility and Andrology Society 2013b). It is, of course, difficult to impute cause and effect concerning statistical trends, particularly when improvements in terms of clinical outcomes and transparency could be related to liability concerns or technological improvements. What this does speak to is the need for further qualitative and quantitative study – both within Canada and comparatively – of the extent to which physicians feel compelled to abide by non-statutory guidelines in the absence of strict sanctions. Overall, the fact that ART clinics are buying in to such reporting – and the fact that multiple pregnancies have been reduced – suggests that an "industrial morality" concerning ARTs in Canada may be developing (Gunningham and Rees 1997).

Indeed, the current self-regulatory framework might explain the limited institutionalization at the federal and provincial government level concerning assisted conception policy. The growth of Canadian national specialist guidelines since the 1990s seems to confirm Varone, Rothmayr, and Montpetit's prediction that policy communities – researchers and medical professionals in the ART context – are "likely to develop self-regulation as a strategy of influencing and possibly preventing future state intervention," in particular by defining "quality standards and codes of ethics" (2007: 11).

Further empirical work is required to determine the extent to which Canadian fertility clinics have bought in to these guidelines. If nothing else, this preliminary description of self-regulating professional medical organizations, and the extent to which they have devolved policymaking to national specialist organizations, demonstrates that

such organizations need to be taken seriously as policymakers in both the Canadian and comparative literature. As the next section describes, so too should the judiciary.

The Judicialization of Assisted Conception Policy

As described in earlier chapters, Canada's ART policy has been shaped by judicial decision-making, both from the Supreme Court at the national level and from several provincial court decisions related to parentage and surrogacy. Yet the judiciary also had a preliminary and almost crucial influence on one aspect of assisted conception policy: donor anonymity. Donor identification typically falls into the class of assisted conception rules that target the behaviour of donors, patients, and children born through assisted conception. Along with screening requirements for patients, the most important consideration for donors is whether their identifying information must be released – and to what extent it will be released – to donor-conceived offspring. Without legislation, the default rules for patient-doctor confidentiality typically apply, which tend to favour donor anonymity; if a sperm donor[45] does not wish his identifying information to be released to his offspring, then it will not be released unless legislation dictates otherwise. Currently, every province in Canada operates under conditions that permit donor anonymity, and doctors will usually destroy patient records for sperm donors after 5-6 years.

One person who sought to end donor anonymity was Olivia Pratten. Born in 1982, Pratten was conceived via artificial insemination at a Vancouver fertility clinic. In the absence of government legislation, internal rules from the College of Physicians and Surgeons of British Columbia (CPSBC) meant Pratten was unable to receive identifying

[45] Anonymous gamete donation occurs with both sperm and eggs. However, because of the expense, time, invasiveness, and health risks associated with egg donation, sperm donation is far more common.

information about the sperm donor, her biological father. She and others had lobbied for federal legislation to ban anonymity and mandate identifying donor information which offspring could locate after a certain time, and initially it seemed as if her efforts would be successful. Although the 2001 draft legislation presented to the federal Standing Committee on Health (Brown Committee) originally contained a provision to maintain donor anonymity, Pratten appeared before the committee to convince legislators otherwise, claiming "there is no ethical, moral, or legal justification for allowing an anonymous sperm system to operate, or any other gamete donation system" (Canada 2001a). Barry Stevens, another donor offspring and member of the Alliance of People Produced by Assisted Reproductive Technology (APPART), articulated the threefold opposition to donor anonymity: "It deprives us of essential medical information; it promotes a culture of deception and secrecy; and it leaves a gap in the formation of a person's identity" (Canada 2001a).

The committee was receptive to Pratten and Stevens' claims. Liberal Committee Chairperson Bonnie Brown reflected that "[w]e pretty well all agreed we're against this anonymity thing… [t]he whole committee, as a matter of fact, I think is unanimous." Canadian Alliance MP James Lunney noted that "some of us weren't too impressed" by the arguments for maintaining anonymity, and subsequently became "quite interested in making sure the needs of the children are adequately protected" (Canada 2001a). In the end, the Committee's Final Report argued that federal legislation should remove donor anonymity. The majority report said "where there is a conflict between the privacy rights of a donor and the rights of a resulting child to know its heritage, the rights of the child should prevail… [w]e want to end the current system of anonymous donation" (Canada

2001b: 21). The Canadian Alliance,[46] New Democratic Party, and Bloc Québécois all echoed the sentiment, although the Progressive Conservative dissenting statement had "extremely strong reservations about doing away with anonymity" (93).

However, this near-unanimous recommendation did not make its way into subsequent legislation, which maintained anonymity but allowed the disclosure of certain health-related information. Section 18(3) of the *AHR Act* permitted Assisted Human Reproduction Canada "on request," to "disclose health reporting information relating to a donor" to offspring," but added that "the identity of the donor – or information that can reasonably be expected to be used in the identification of the donor – shall not be disclosed without the donor's written consent" (Canada 2004b). The disconnect between the Committee recommendations and the legislation was explained by Ian Shugart, the Assistant Deputy Minister for Health, who claimed "the conditions conducive to the mandatory release of donor identification are not yet in place in Canada," and that removing anonymity "gets very much into the domain of the federal-provincial environment," particularly regarding family law. Or, as the federal government lawyer Glenn Rivard noted during C-56 hearings, regulating donor anonymity was "really not an authority that the federal government has" (Canada 2002b). Essentially, the government argued that rules regarding the anonymity or identification of donors was provincial jurisdiction. In light of the Supreme Court decision in 2010, they were correct about the constitutionality of this aspect of the legislation.

[46] The Canadian Alliance dissenting report claimed the majority report was not emphatic enough in its rejection of anonymity; it called for "a clear statement to the effect that where the privacy rights of the donors of human reproductive materials conflict with the rights of children to know their genetic and social heritage, that the rights of the children shall prevail" (Canada 2001b: 81).

Although the *AHR Act* provided for the establishment of a Personal Health Information Registry to create a national database for information pertaining to donors, patients, and donor-conceived offspring, this federal registry was never created. Following the Supreme Court Reference, such registries, if they are to exist, must now be created and maintained by the provinces. Pratten, who claimed permitting the release of non-identifying medical information would be "like making a gourmet meal, then putting it in front of me, and then telling me I cannot eat," was not content with non-identifying registry (Canada 2001a). Having failed to convince the government, she turned to the courts, using the *Canadian Charter of Rights and Freedoms* to demand permanent preservation of patient records in the case of sperm donation.

Initially, Pratten launched her judicial challenge against both the Province of British Columbia and the College of Physicians and Surgeons in British Columbia (CPSBC), whose rules regarding donor anonymity and destruction of records were the default policy in the absence of legislation. In 2010, an agreement was reached between Pratten and the CPSBC, stating that the College would amend its bylaws in the case of a Pratten victory. Consequently, Pratten's action against the College was dismissed, and her case focused solely on the government (*Pratten v. British Columbia* 2011: para. 22). In May 2011, it seemed her hard work had paid off. Justice Elaine Adair of the Supreme Court of British Columbia struck down much of British Columbia's *Adoption Act* and *Adoption Regulation*, claiming that the provincial government's adoption policy unfairly discriminated against children born through assisted conception. Justice Adair gave the province fifteen months to rewrite the legislation to grant equal information access to donor-conceived offspring. Just as importantly, Justice Adair granted a permanent

injunction “prohibiting the destruction, disposal, redaction or transfer” of gamete donor records from British Columbia (para. 335).

Pratten’s *Charter* challenge was twofold, based on a successful equality (section 15) challenge and an unsuccessful life, liberty, and security of the person (section 7) challenge. The section 15 arguments were essentially comparative, juxtaposing the privileges offered to donor-conceived offspring with adopted children. In British Columbia, the social and medical history of biological parents is preserved for adopted children in case of medical necessity; after those children reach the age of 19, they can access the records personally. Adopted children also have the right to locate their biological parents, provided those parents offer their consent. By contrast, donor-conceived offspring receive no such information. Under British Columbia’s *Health Professions Act* (formerly the *Medical Practitioners Act*), the College of Physicians and Surgeons in British Columbia (CPSBC) requires that private physicians retain patient records for six years, after which they may be destroyed. Dr. Gerald Korn, the doctor who helped conceive Olivia Pratten, claims records of Pratten’s biological father were destroyed in accordance with these regulations (2011: para. 152).

Pratten used the equality provision in the *Charter* to argue that British Columbia’s adoption regime was underinclusive, insofar as it involved “differential treatment” and “impose[d] a disadvantage” on donor offspring (para. 19). Justice Adair accepted Pratten’s argument, claiming “the distinction made between adoptees and donor offspring creates a disadvantage to donor offspring by perpetuating stereotypes,” which ranged from the fact that donor offspring lack the “needs” of adopted children with respect to knowledge of their origins (because they already know one biological parent) to a “more

sinister stereotype… that donor offspring are, in a sense, manufactured, and either they lack normal human needs, or if they have needs, it is acceptable to ignore them" (para. 251). Having accepted Pratten's first argument, Justice Adair rejected her second constitutional argument, which was that the Charter's section 7 guarantee of "life, liberty and security of the person" gave Olivia Pratten a "constitutional right to know where she comes from" (para. 273). "The potential implications of a free-standing constitutional right to know one's biological origins," Adair wrote, "are uncertain and may be enormous" (para. 290).

Although the records concerning Pratten's own biological father had long since been destroyed, the result of the case was a victory for donor-conceived offspring in British Columbia. However, this victory was short-lived. In 2012, the Court of Appeal for British Columbia overturned the decision. The Court found the government's adoption legislation and regulation was saved by section 15(2), as it qualified as an ameliorative program that targeted a disadvantaged group (*Pratten v. British Columbia* 2012, paras. 34-43). Essentially, section 15(2) permits affirmative-action-type policies that are aimed at reducing the burdens of a historically disadvantaged group, even if that program discriminates against others. Because British Columbia's permissive adoption regime was designed to aid adopted children (who themselves had faced historical disadvantage), Justice Frankel found it qualified "as an ameliorative program within the meaning of s. 15(2)" and was thus constitutional (para. 37). He was also "not persuaded that the right 'to know one's past' is of such fundamental importance that it is entitled to free-standing constitutional recognition" (para. 62), thus rejecting Olivia Pratten's section 7 argument as well. Pratten appealed this ruling to the Supreme Court of Canada, which in May 2013

denied her leave to appeal. For now, donor anonymity remains the default framework in every Canadian province.

While the *Pratten* case had the potential to bring about substantial policy change by forcing the creation of patient donor databases, there are additional minor examples of the capability of the judiciary to affect assisted conception policy. In 1999, the Nova Scotia Court of Appeal rejected an argument that Nova Scotia's failure to cover IVF and ICSI was an unconstitutional violation of the *Canadian Charter of Rights and Freedoms*. The case had been successful in the lower courts, and could conceivably arise in other provinces, particularly if infertility becomes more widespread. Moreover, there will likely be disputes surrounding the "ownership" of human gametes and embryos as well. In 2012, the Supreme Court of British Columbia ruled that sperm obtained by a lesbian couple from an anonymous donor was to be split evenly in a custody case, holding that the sperm was "property" and that additional consent regulations did not need to be addressed (*J.C.M. v. A.N.A.* 2012; see also Gruben and Campbell 2013). As debates continue surrounding the limits of health insurance coverage, the use of human reproductive material, and the role of donors in the process of assisted conception, the judiciary will remain front and centre.

Conclusion

The purpose of this chapter was to address the subfield of assisted reproductive technology policy most commonly associated with the policy field as a whole: assisted conception. I began by defining assisted conception policy as addressing three overlapping areas: rules to target the behaviour of medical professionals; rules to target

the behaviour of donors, patients, and offspring; and rules regarding patient health-insurance coverage. The federal government's *AHR Act* was designed to cover this subfield in various ways, including licensing, monitoring, and regulation. However, the 2010 Supreme Court of Canada decision gave primary jurisdiction over most non-criminal decisions regarding assisted conception policy to provincial governments. Following minimal provincial government action, many commentators claimed the subfield was effectively unregulated, a "Wild West" without adequate regulatory control. Yet the limited Canadian examples of "Wild West"-type behaviour – certainly compared to many American states and overseas ART havens such as India and Ukraine – led me to believe this was not an entirely accurate representation.

In determining "who regulates" in the subfield of assisted conception, this chapter took a closer look at the assisted-conception-related policy from four policymakers: the federal government, the provinces, medical associations, and the courts. My primary finding is that, for all its failings and its "patchwork" nature, it is simply incorrect to refer to Canadian assisted conception policy as unregulated. The federal government's role was certainly limited by the Supreme Court decision, but its prohibitions on the sale of gametes, in addition to several regulations, continue to affect assisted conception policy across the country. And while most provinces have not responded to the Supreme Court decision, Quebec's legislation, which addresses all three components of assisted conception policy – rules for professionals, rules for patients, and rules regarding coverage – demonstrates that provinces have the capacity to regulate this subfield. Combined with its parentage and surrogacy legislation, Quebec's current policy

framework demonstrates that comprehensive regulation of ART policy need not be done by the federal government.

Outside of Quebec, it is true that provinces have not acted. However, by analyzing the self-regulatory role played by medical organizations, we are given some explanation as to why those governments have yet to act. While provincial colleges have done comparatively little regarding ARTs, they have ceded considerable policymaking authority to national specialist organizations, which have a wide array of policies related to assisted conception. While those policies, mostly done through clinical guidelines, certainly tend to be more permissive than comparable government policies, they nevertheless constitute effective public policy that has the potential to constrain physician behaviour. There are arguments to be made regarding the enforceability and sanctioning power of those policies, but as my brief discussion of the literature on self-regulation demonstrates (Garoupa 2011; Priest 1998; Levi-Faur 2011), they certainly qualify as regulations. I posit that these internal medical regulations go some distance towards providing an institutional explanation for why provinces have been unwilling to legislate in this area.

Finally, building on last chapter's description of surrogacy and parentage policy, I demonstrate how the judiciary has the potential to play a crucial role in assisted conception policy. While the *Pratten* (2011) decision mandating the removal of donor anonymity was eventually overturned on appeal, it nevertheless shows how the *Canadian Charter of Rights and Freedoms* has been used – and may be used in the future – to produce policy change at the provincial level regarding ARTs. ARTs undoubtedly constitute morality policy, insofar as they are "legal sanctions of right and wrong" that

concern “fundamental questions” of primary identity, increasing the likelihood of litigious rights claims (Mooney 2001: 3-4; Snow 2012). While the initial judicialization of ART policy ultimately produced an unsuccessful challenge to British Columbia’s refusal to introduce donor identification laws, there is little doubt that the judicial branch will play an important rule in adjudicating and producing policy for this and other components of assisted conception going forward. Donor-conceived offspring are not the only ones who will be asserting their ART-related rights in the future.

While this and the previous chapter offer plenty of information to suggest that ART policy in Canada is subject to considerable regulation from multiple policymakers, they also confirm a common criticism of Canadian ART policy: that it is undoubtedly a patchwork of myriad regulations. The federal government, provincial governments, provincial medical colleges, national specialist organizations, and courts have each had direct and indirect policy consequences for the three subfields of assisted reproductive technologies most closely related to what most would agree is the overall purpose of the technologies: having children and building families. Insofar as it is difficult to stipulate the myriad actors and policies in these subfields, it is no surprise that political scientists scholars have consistently ignored or downplayed their influence . However, emphasizing such policy outputs can provide a greater degree of clarity for understanding Canada’s ART policy, provide mechanisms to measure policy variation, and build understanding about the comparative regulation of ART.

CHAPTER EIGHT:

MAKING SENSE OF CANADIAN ART POLICY

In describing the trajectory and development of Canadian ART policy, this dissertation has drawn together information on a Royal Commission, parliamentary debates, Supreme Court jurisprudence, professional medical self-regulation, and provincial rules for parentage transfer, to name a few. This concluding chapter is an attempt to bring all this information together to make sense of Canadian ART policy, and to draw conclusions for scholars of Canadian politics, comparative ARTs, and comparative politics more broadly.

A central goal of this dissertation is to explain the causal factors that led to the current state of ART policy in Canada, and as such I began with a summary of the role of the Baird Commission, which constitutes the critical juncture for Canadian policy development. After detailing the reasons behind the federal government's failed attempts at regulating ARTs, I move on to answer a second question: what exactly is Canadian ART policy? In terms of comparative political science, how ought it be classified? Overall, Canada's ART policy remains "intermediate," as Montpetit (2007a) claimed prior the Supreme Court decision. However, for a field as encompassing as ARTs, a one-size-fits-all characterization is almost meaningless, as it obscures important variation between the ART subfields and among provinces. In the early part of this chapter, I undertake a breakdown of the content of ART policy in the six subfields when all policymakers have been taken into account, and find that although there is variation between (and even within) subfields, most can be classified as "intermediate."

While ART policy in Canada is a complicated field to describe, this complication nevertheless provides several important lessons for Canadian political scientists,

comparative ART scholars within political science, and comparativists more generally. Many of these contributions speak to the value of studying political science from an institutional perspective. In Canada specifically, perhaps the biggest lesson is the enduring influence of federal institutional constraints on policymakers, and the extent to which jurisdictional framing strategies can affect policy outputs. For ART scholars specifically, I stress how the six-part typology and the focus on alternative policymakers beyond national governments provide a more accurate picture of a country's overall policy mix. As political scientists move forward with comparative measurement of ART policy, the description of surrogacy and parentage policy in particular provides a lesson concerning the value of disaggregation for measuring the subfields of ART policy.

Finally, the Canadian story of ART policy provides valuable contributions for scholars of historical institutionalism more broadly. In particular, the interaction between policy framing and what Daviter (2011) calls the "organization of politics" requires greater articulation from comparativists. Dominant ideas and frames can clearly influence the development of political institutions, especially during states of policy flux such as the "critical juncture" period of Canada's Baird Commission. However, even when ideas are reproduced in path-dependent ways to shape legislation, the constitutional structures in federal jurisdictions can work to limit institutionalization, as clearly occurred in Canada. In future case studies and small-N comparisons, scholars ought to pay more attention to how existing institutions can limit institutional change, even when faced with attempts to reproduce dominant ideas. The "failure to reproduce" the Baird Commission's recommendations can serve as a lesson for scholars and policymakers in Canada and elsewhere.

The Baird Commission: The "First Mover" of Canadian ART Policy

I have argued throughout that to understand any facet of Canadian ART policy, one must begin with the 1993 Royal Commission On New Reproductive Technologies (the Baird Commission), whose indelible influence cannot be overstated even twenty years after it issued its recommendations. To argue that the Baird Commission influenced the *AHR Act* is hardly controversial; however, it may seem odd to say that its recommendations *continue* to influence Canadian ART policy to this day. The Commission's principal recommendations were legislated but never institutionalized; its worst fear – a patchwork of provincial and medical-professional regulations – best describes the current status quo. Yet I have demonstrated that current policy outcomes stem directly from the Baird Commission's recommendations, particularly its decision to frame certain technologies and activities as both medically beneficial and requiring federal government intervention. True, the Commission did not get the outcome it wanted; however, that does not lessen its influence on that outcome.

My qualitative reading of the Commission hearings, parliamentary debates, and committee hearings preceding the *AHR Act* demonstrates that the way the Baird Commission "framed" assisted reproductive technologies did not fit with the structure of Canadian federalism. The Baird Commission was not mere "policy analysis," as Supreme Court of Canada Chief Justice McLachlin argued in 2010. Instead, it constitutes *the* critical juncture for Canadian ART policy for a number of inter-related reasons: it was given an extremely wide latitude for action; its perceived expertise granted it considerable authority; and the field of ARTs was most certainly a legislative (and largely medical) policy vacuum, with little in the way of concrete rules in 1993. The

Baird Commission's work, consistent with the literature on critical junctures, occurred during a "relatively short" time period with "a substantially heightened probability that agents' choices [would] affect the outcome of interest" (Capoccia and Keleman 2007: 38).

And the Commission's subsequent influence was undeniable. Policy experts and members from every party referenced it approvingly and with great frequency throughout the parliamentary process. Its chief recommendations were reproduced in four legislative iterations, and eventually passed into law in the form of the *AHR Act* in 2004. Equally as important as the consistency between the content of the Baird Commission's recommendations and the resulting legislation was the way in which policymakers framed this novel policy field. While distinguishing between medically-beneficial technologies and activities (which would be subject to licensing and regulation) and morally-harmful technologies and activities (which would be subject to criminal prohibition), the Commission insisted that both ought to be administered by the federal government. In other words, while there may have been a "division of labour" between regulation and criminal prohibition, all the work was to be done by the same labourer: the federal government. That government, perhaps not surprisingly, embraced the Commission's perspective, and persistently maintained it in path-dependent ways.

This framing strategy, more than the actual content of the legislation, explains much about the state of Canadian ART policy today. In particular, framing the regulation of medically-beneficial ARTs as of sufficient "national concern" to justify federal jurisdiction had always been constitutionally risky and became ever more so throughout the federal government's legislative process, as the Supreme Court of Canada itself

shifted away from "national concern" as a significant support for federal legislation that impinged on provincial jurisdiction. This meant that Ottawa faced the much more difficult challenge of justifying the regulation of medically-beneficial ARTs as legitimate criminal law. In short, the persistent, path-dependent framing strategy established by the Baird Commission and maintained by Ottawa put the *AHR Act* on a collision course with Supreme Court jurisprudence.

When the institutional clash finally occurred, the Supreme Court of Canada (in 2010) struck down nearly every regulatory aspect of the federal *AHR Act*, essentially leaving only the criminal prohibitions in place. Ironically, a majority of Supreme Court justices agreed that the legislation contained a division of labour between beneficial and harmful activities, but insisted that the same labourer could not do both jobs. In their view, the regulation of medically beneficial activities could not plausibly be characterized as criminal law and thus fell within the health-care jurisdiction of the provinces. The Baird Commission's initial constitutional gamble, reinforced throughout the years by a federal Liberal Party fond of national programs, had failed. While the Commission's recommendations themselves had been successfully reproduced via legislation, the structure of Canadian federalism meant they were never fully institutionalized. A "patchwork" of provincial and medical-regulatory policies – the Commission's worst fear – would come to constitute Canada's ART policy framework going forward.

ART Policy in Canada: The Six Subfields

Following the Supreme Court decision, Canadian commentators and policy experts have decried the current policy status quo. The most common criticisms are twofold: first,

Canadian ART policy is "unregulated"; second, it represents a "patchwork." Chapters 6 and 7 of this dissertation address these concerns, showing that they are only partially justified. This becomes evident when one pays closer attention to the different components, or subdivisions, of ART policy than previous studies have done. I argue that greater analytical clarity is achieved by dividing ART policy into six distinct subfields, each of which is separately defined and can be measured individually: 1) assisted conception, 2) surrogacy, 3) embryonic research, 4) reproductive human cloning, 5) screening, enhancement, and manipulation, and 6) parentage. Using these subfields to analyze the state of current ART policy in Canada – i.e., after the 2010 Supreme Court decision – shows that while it is indeed a "patchwork," it is a mistake to refer to it as unregulated.

Assisted Conception Policy: Intermediate, with a Quebec-Shaped Asterisk

Of the six subfields, assisted conception policy – the subfield most commonly associated with ARTs as a whole – is the most encompassing, the most difficult to define, and involves the greatest number of policymakers in Canada. In the absence of outright government regulations outside of Quebec, much depends on professional medical guidelines, which certainly do not carry as much weight as criminal prohibitions or even government regulations.

As mentioned in Chapter 7, assisted conception contains three overlapping areas: rules targeting medical professionals (licensing, inspection the use and transfer of human reproductive material, and clinical practice); rules targeting donors and patients (donation and screening requirements); and rules for patient coverage. These rules exist on a

continuum from restrictive to permissive, with restrictive regimes characterized by high levels of physician autonomy and patient access (see Bleiklie, Goggin, and Rothmayr 2004; Engeli 2009: 60). Using this rubric, Canada's post-2010 assisted conception policy is certainly not as "unregulated" as reactions to the Supreme Court decision suggested. Outside of Quebec, Canada's assisted-conception regime should be classified as intermediate on the permissiveness continuum, in large part due to federal prohibitions on compensation for gametes and embryos. Medical professionals are subject to light governmental policies such as Health Canada inspections, in-house licensing requirements, and rules regarding the importation and freezing of human gametes. While Chapter 7 details the many clinical guidelines produced by national specialist organizations, these guidelines lack the force of the criminal law and fall on the permissive side of the spectrum in any case. Patients are not restricted from accessing assisted conception based on particular characteristics – indeed, section 2(e) of the *AHR Act* states that "persons who seek to undergo assisted reproduction procedures must not be discriminated against, including on the basis of their sexual orientation or marital status." However, outside of Quebec, there is no financial coverage for costly assisted conception procedures such as IVF. Finally, with respect to donors, policy is also intermediate; patients currently retain the option of donor anonymity in every province, but the *AHR Act* prohibits compensation for gametes.

Within Quebec, assisted conception policy is more permissive, but is still subject to the federal prohibitions. While Quebec legislation grants licensing powers to the Minister and mandates the collection of patient information, both inspection and data gathering are still largely completed by the Collège des médecins du Québec (CMQ).

Quebec legislation has no rules for gamete donors, and the CMQ maintains donor anonymity. Indeed, the two practical differences between assisted conception policy in Quebec and in the rest of the country are rules concerning coverage for IVF (far more permissive in Quebec than the rest of the country) and single embryo transfer (which is slightly more restrictive than the SOGC/CFAS guidelines that govern the rest of the country). Overall, it is fair to say that Quebec is more permissive than the rest of the country. The only "hard instruments" (Engeli 2009: 60) that apply to assisted conception policy in Quebec are the federal ban on gamete compensation and the provincial regulation regarding embryo transfer. Comparatively, the funding of IVF makes a strong case that assisted conception policy in Quebec deserves to be classified as more permissive than in the rest of the country, which I characterize as "intermediate-permissive."

The fear that the ART policy would be "unregulated" after the Supreme Court decision is not entirely borne out in the case of assisted conception policy. Certainly, it is not as strictly regulated as those favouring a restrictive approach would prefer. The federal government has also not been as robust with respect to the enforcement of its prohibition of payment for gamete donation, although the 2013 conviction of Leia Picard for payment of gametes (in addition to facilitating surrogacy-for-hire) suggests this might be changing (see Blackwell 2013b). And the lack of provincial government policy outside of Quebec means most policy lacks the penalizing power associated with government regulation. However, national specialist organizations have certainly introduced a thin regulatory structure that affects the behaviour of physicians and organizations, with (admittedly permissive) guidelines being updated consistently. Those

favouring provincial legislation will rightly claim that the provinces could certainly be *more* regulated, but existing federal prohibitions and medical guidelines means it is a mistake to call this policy area *un*regulated.

While the criticism that assisted conception is "unregulated" outside of Quebec requires qualification, the claim that it is a "patchwork" is certainly borne out by the facts. Medical colleges in Alberta and Saskatchewan are the only two that have introduced (very limited) standards for testing and training for assisted conception, while Quebec is the only province to include comprehensive insurance coverage and rules for embryo transfer. Ontario and Manitoba have minor policies related to insurance coverage and tax credits, and every province differs at the margins with respect to the procedures and drugs that are covered by health insurance. And while medical specialist guidelines likely go some distance to achieving uniformity, greater research is required to determine the extent to which these growing rules and guidelines are followed. The varying degree of regulation across provinces renders the "patchwork" accusation especially appropriate in this particular subfield.

Human Cloning, Embryo Research, and Screening, Enhancement, and Manipulation

What about these three policy sub-fields? Do they represented the "unregulated nightmare" feared by critics of the Supreme Court decision? That is how it might look if one looks only at provincial intervention, which is non-existent in these areas. So too, in essence, is medical regulation. While CFAS does have internal guidelines regarding the treatment and use of embryos, these rules are effectively superseded by federal legislation. CFAS and SOGC also have rules is regarding the "screening" component of

screening, enhancement, and manipulation, rules that largely concern preimplantation genetics diagnosis (PGD). However, both because of their source (professional organizations) and their content, these rules only marginally increase overall policy restrictiveness.

The lack or weakness of activities by provinces or self-regulatory organizations in these subfields does not, however, mean that they are unregulated. This because they are covered almost entirely by the federal government. Human cloning policy, which is subject to an unconditional criminal ban in the *AHR Act*, is restrictive. Embryonic research policy is slightly more complicated. As noted in Chapter 2, the key concern here is the extent to which researchers are granted autonomy to conduct their research. On this issue, Canadian policy falls into the "intermediate" category insofar as the Criminal Code bans some but not all embryonic research. However, the scope of the prohibitions lean in the restrictive direction – i.e., in addition to limiting embryonic research to surplus embryos, the *AHR Act* prohibits the creation of animal-human chimeras, hybrids, creating an embryo from part of an embryo or fetus, and non-reproductive human cloning. These prohibitions have been subject to considerable criticism from several academic commentators, who claim they inhibit scientific research (Caulfield 2004; Caulfield and Bubela 2007; Morris 2007; Rasmussen 2004). Nevertheless, because Canadian law permits some embryonic research – and lays out rules pertaining to federal funding of such research under the 2010 Canadian Institutes for Health Research *Guidelines for Human Pluripotent Stem Cell Research* – I still classify its embryonic research policy as intermediate, albeit with a restrictive bent. Neither the human cloning nor the embryonic

research subfields are unregulated. Moreover, because federal law governs these fields, the term "patchwork" clearly does not apply here.

The same is true for the subfield of screening, manipulation, and enhancement, where the national criminal law is again of "intermediate" permissiveness, albeit with a restrictive bent. Most bans relate to enhancement and manipulation: in terms of enhancement, the *AHR Act* bans germ-line engineering, a form of genetic manipulation that creates permanent genetic enhancements. In terms of manipulation, it bans ectogenesis, the use of human reproductive material into a non-human life form for the purposes of reproduction, and the creation of chimeras and animal-human hybrids. In terms of screening, both prenatal screening and PGD are permitted in Canada, with rules effectively governed (like assisted conception) by CFAS and SOGC regulations. However, the *AHR Act* does contain one screening-related prohibition: the ban on non-medical sex selection after PGD. Thus, while screening is for the most part regulated loosely by CFAS and SOGC regulations, as a whole the category of screening, enhancement, and manipulation is on the restrictive side of intermediate, stemming almost entirely from bans in the *AHR Act*. In this subfield, neither "unregulated" nor "patchwork" is an apt description.

Surrogacy and Parentage Policy: One Size Does Not Fit All

As Chapter 6 shows, the "patchwork" thesis is more fairly applied to the subfields of surrogacy and parentage. In these subfields, policy permissiveness is defined in terms of the absence of legal barriers for intended parents, and there is considerable variation among the provinces in the parts of these subfields they control. However, because the

provinces have been bringing in considerable legislation in recent years, the term "unregulated" is as unjustified here as in the other subfields.

While the federal government has banned compensation in the *AHR Act*, the validity and enforceability of surrogacy arrangements are regulated by the provinces, with varying degrees of restrictiveness. Surrogacy is not subject to a criminal ban in Canada, but the federal ban on compensation means it would certainly be incorrect to describe Canadian surrogacy policy as permissive. Indeed, in the five provinces that have not legislated with respect to surrogacy arrangements, Canada tilts towards the restrictive end of the spectrum. There continue to exist considerable legal barriers – quite unclear outside of Quebec, British Columbia, and Alberta – through which prospective parents must navigate in order to undergo a surrogacy arrangement.

Chapter 6 also demonstrated, via a new metric for measurement, that parentage is subject to considerable variation among provinces – all of which, whether through legislative or judicial action (or a combination of both) have introduced policy over the last decade. Even more than surrogacy policy, it is impossible to refer to parentage policy in Canada as permissive, intermediate, or restrictive *as a whole*. It would be accurate to say it is quite restrictive in New Brunswick, Prince Edward Island, and Manitoba, and that it is permissive in British Columbia, Newfoundland and Labrador, and even Alberta (which, although it has a score of 9, has probably the clearest legislative rules in the country). Like surrogacy and assisted conception policy in Canada, parentage truly represents a patchwork, but one that is subject to increasing policy action and, as a result, increasing permissiveness.

Summarizing Canada's ART Policy

Two consistent lines of argumentation concerning Canada's post-2010 ART policy are that Canada is both "unregulated" and a "patchwork" of policy variation. The above analysis soundly refutes the first argument and just as soundly confirms the second. In each subfield, Canada has myriad regulations and prohibitions. More interestingly, in no subfield would I call Canada's regime "permissive," as Table 8.1 makes clear.

Table 8.1
ART Policy in Canada (post-2010)

	Federal Prohibitions	Federal Regulations	Provincial Regulations	Medical Regulations	Overall Score
Assisted Conception	x	x	Quebec	x	Intermediate (Quebec Intermediate-Permissive)
Surrogacy	x		x		Intermediate-Restrictive
Embryonic Research	x	x			Intermediate-Restrictive
Human Cloning	x				Restrictive
Screening, Enhancement, Manipulation	x	x		x	Intermediate-Restrictive
Parentage			x		Varies

In every single subfield except parentage, federal prohibitions exist. Provincial governments are active in surrogacy and parentage (although not as active as they could be). Medical organizations – particularly national specialist organizations – have a number of internal (if not especially enforceable) regulations regarding assisted conception, and a few related to screening. Moreover, the existence of multiple policymakers – not to mention variation across ten provinces – makes a "one-size-fits-all" definition of ARTs especially difficult to determine for Canada and likely for other federations. This further strengthens the case that simply defining ART policy as "permissive," "intermediate," or "restrictive" misses important details of a given

country's ART framework. Even when analyzing the subfields themselves, a simple classification does not give the detail of a qualitative reading of, for example, Quebec's assisted conception regulations or Alberta's parentage regime. For better or worse, Canadian ART policy is undoubtedly a patchwork, and understanding the overall design requires a close inspection of the different shapes that constitute the fabric of that patchwork. My qualitative reading of Canadian ART policy only strengthens the argument for further qualitative comparative work.

Implications for Canadian Political Scientists

Insofar as the Canadian patchwork is hardly what the Baird Commission and subsequent policymakers intended, this ART policy "failure" is instructive for Canadian political scientists in several ways. In particular, they provide important lessons about the need to pay attention to federalism, the judiciary, and private medical organizations.

The Federal Elephant in the Room

First and foremost, this study demonstrates the enduring influence of federal institutions in Canadian politics. Consider the following train of events: A federally-appointed Royal Commission's ideational framing strategies lead to federal legislation but limited institutionalization. A federal court strikes this legislation down, in the process granting provincial governments authority over several aspects of the field. Provincial government inaction means that rules produced by provincial medical organizations effectively govern other aspects. However, these rules stem from national specialist organizations, which creates the ironic consequence of uniformity after a remarkably decentralized

string of events. Subsequent provincial court rulings in British Columbia re-order responsibilities, mandating provincial government intervention in an area historically administered by provincial medical associations – but only in that province. A provincial court strikes this decision down, returning to the status quo. Quite simply, one cannot explain the Canadian ART policy experience without taking account of federalism at every instance. And yet that is precisely what federal policymakers did from the beginning, and what the literature to date has generally replicated.

In Chapter 1, I described Canadian ART policy as a "tragedy" that can be traced back to its first act: the Baird Commission. I mean tragedy in the literary sense of the term. In contrast to everyday understanding of tragedy,[47] which describes "situations where pain and suffering are mainly inexplicable," tragedy in the literary sense is "written by authors who seek to make the trials of life intelligible and instructive" (Ricci 1984: 20-21). As Ricci notes,

> Tragedy is an affair of men and women choosing between ideals such as civic duty and family obligation, which are severely dear to them, when no one alternative is patently superior to rest, and where failure to compromise, if compromise is possible at all, leads to downfall and destruction. (22)

I do not claim the stakes in Canadian ART policy are as high as life and death, although some certainly would. Rather, I use Ricci's apt description to elucidate how the Baird Commission's initial choice between two ideals, and its failure to compromise, led to a tragic outcome. Here, the competing ideals were Canada's constitutional framework and the desire for national uniformity. No federal policymaker suggested Canada ought to

[47] Elsewhere, Baylis and Downie (2013) have described the life and death of Assisted Human Reproduction Canada as a "tragedy," although it is clear that they are referring to tragedy in its colloquial sense – as an unfortunate turn of events and squandered opportunities – rather than the literary sense used here.

rewrite the constitutional division of powers; the commitment to Canada's constitutional order was never questioned. However, much of this was actually lip service. The federal government suggested it would consult with the provinces, but never did. It included equivalency agreements to placate the provinces, but these agreements were essentially dependent on federal discretion. It ignored opposition party concerns about constitutionality. While the federal government ostensibly wanted to avoid intruding on provincial jurisdiction, its commitment to a national program outweighed all other concerns. This was most prominent at the Baird Commission, which did not adequately articulate the constitutional doctrine that would justify federal intervention. This narrative was sustained throughout by a federal government convinced – and at times galvanized by constitutional lawyers, almost all of whom argued the legislation was constitutional – that the need for a national framework outweighed constitutional concerns. And, as we now know, the federal government lost its gamble.

The ART policy experience should also serve as a cautionary tale for those who favour a national strategy to any and every emerging policy issue. The call for national standards is a hallmark of Canadian politics, whether in the field of housing, health care, post-secondary education, or assisted reproductive technologies. Yet ART policy demonstrates that the constitutional division of powers can inhibit overzealous federal governments from overstepping their bounds, and that the Supreme Court is not afraid to enforce federal encroachments on provincial jurisdiction. The Baird Commission, the federal government, and most legal scholars dangerously underplayed the extent to which the Supreme Court would find federal ART legislation unconstitutional, and the result was, by the standards of almost everyone involved, a sub-optimal outcome.

This experience should also stress the importance of framing strategies. Had the *AHR Act* been portrayed throughout the legislative process using the moral frame – as a piece of legislation that, in its entirety, was dedicated to limiting harmful behaviour – the courts would have had a much harder time striking down the impugned provisions. Yet, in the end, the federal government relied on ambivalent framing because the legislation truly did have two purposes, and the federal government could not fathom that its role was limited only to eliminating harmful behaviour. Future policymakers cannot and should not underplay the importance of constitutional law and Supreme Court jurisprudence, as the Baird Commission and subsequent federal policymakers undoubtedly did. As Thomas Posyniak notes, "such comprehensive legislative responses to new social phenomena, apart from exceptional and exigent circumstances, should remain reflective of our constitutional history and our incrementally developed and judicially influenced regime of divided legislative powers" (2011: 3). More careful attention to quite what constitutes "exceptional and exigent circumstances," particularly according to judicial doctrine, is required.

The Canadian ART policy experience also demonstrates the extent to which federal institutions can, intentionally or unintentionally, delay policymaking. In 2004, prior to the passage of the *AHR Act*, Montpetit wrote that Canada's federal structure had "worked to prevent policy-makers from making decisions on ART," as the constitutional division of powers "discouraged the regulatory option in the short term, channeling policy-making efforts into criminal prohibitions" (81). Although this was true at the time, the imminent passage of the *AHR Act* would condition this argument slightly; it is more accurate to say that the division of powers *delayed* rather than prevented ART

policymaking, particularly given the federal government's ostensible desire to create regulations. This is in keeping with other areas – such as income security and the environment – where federal institutions prevented or delayed policymaking (see Banting 1987; Harrison 1999).

Yet, a decade later, Montpetit's analysis rings true in an entirely different sense: Canadian ART policy provides yet another highlight of the extent to which Canada's intergovernmental cooperation is poorly institutionalized. Both the federal government's failure to consult the provinces before the passage of the *AHR Act* and the lack of provincial collaboration after the 2010 Supreme Court decision have contributed to a patchwork of ART-related regulations and to considerable medical self-regulation. Absent strong federal attempts at true collaboration, there are few existing institutional incentives for provinces to collaborate with one another, as is borne out by Canada's current ART policy, particularly in the subfields of assisted conception, surrogacy, and parentage, where policymaking has been anything but coordinated.

The Judicialization of Assisted Reproductive Technology Policy Canada

It has become a truism to state that, particularly since the introduction of the *Canadian Charter of Rights and Freedoms* in 1982, Canadian courts have become more involved in policymaking. Even in such a relatively new policy area such as ARTs, the judicial presence is striking. The Supreme Court's intervention as federal "referee" in the 2010 case demonstrates both the enduring influence of Canada's constitutional constraints, as noted above, and the willingness of courts to strike down legislation. The British Columbia Court of Appeal's decision in *Pratten*, although subsequently overturned on

Appeal, demonstrates that the interested parties will continue to use the courts in order to achieve policy change with respect to ARTs.

Moreover, when read together, these two cases are an interesting example of policy results stemming from the intersection of federalism and Charter cases, particularly in conflicts involving health care and the criminal law. Over the last few decades, the Supreme Court has adopted a socially liberal approach to moral issues in *Charter* cases, including cases regarding gay rights, reproductive autonomy, and drug use (*Dobson (Litigation Guardian of) v. Dobson* 1999; *M. v. H.* 1999; *Canada (Attorney General) v. PHS Community Services Society* 2011). In the *Reference re Assisted Human Reproduction Act*, the division between the majority and dissenting judgments effectively concerned different conceptions of morality – the majority's medicalized framework argued that the AHRA sought to regulate a "good" (the medical-scientific frame), while the dissent claimed the Act was designed to eliminate an "evil" (the moral frame). Quebec was able to convince a majority of justices that the non-criminal components of the *AHR Act* fit under the "medical-scientific" frame and were fundamentally related to health rather than to the criminal law, and this medical-scientific majority view led to an increase in provincial power. Thus, the medical-scientific (and socially liberal) view of morality in the courts has implications for the federal division of powers: while a socially liberal approach to morality in *Charter* cases often invalidates legislation by any level of government, the same approach in *federalism* cases increases provincial power (see Snow 2012).

It is useful to read this in concert with Justice Adair's *obiter* comment in *Pratten*, that "I do not think that practices developed by private service providers, however

excellent or thoughtful or thorough, can be a full answer to the circumstances of donor offspring" (para. 177); she also added that "the circumstances of donor offspring… are too important to leave unregulated" and that "[t]he private sector cannot provide an adequate substitute for government protection and regulation" (para. 210). This reflects what Thomas M. J. Bateman calls "postliberal" constitutionalism, which claims that "human freedom is often advanced, not curtailed, by positive action of the state" and that "[s]tate inaction is tacit approval of the prevailing order" (Bateman 1998: 6). Under postliberal decision-making, judges are more likely to mandate, rather than restrict, government action in order to enhance individual liberty and opportunity. Thus, from these two constitutional rulings, a curious picture emerges. The medical-scientific frame in a federalism case, mixed with a post-liberal approach to liberty in a *Charter* case, produced judicially-mandated provincial action concerning assisted conception. Private-sector inability mandated state action, while federalism mandated that such action be undertaken by *provincial* governments. As Justice Adair herself said, the Supreme Court ruling made clear that "the primary legislative response needed – and needs – to come from provincial legislatures" (para. 211). The result of this decision would have been to mandate provincial intervention concerning assisted conception. Although the case was overturned a year later, it is highly suggestive that challenges to the lack of provincial ART regulation may be successful in the courts.

Yet Another Policymaker: The Role of Professional Medical Organizations

The role of physicians, especially in Canada, cannot be understated when it comes to ART policymaking. As Erin Nelson (2013b: 265) notes, "[w]hatever one's views about

the necessity of regulation, the reality is that reproductive technologies of all types must be accessed through a gatekeeper of sorts – in some cases, individual physicians, in others, professional organizations or the State itself. Regulation, whether accomplished publicly or privately, is inevitable" (Nelson 2013b: 265).

While this is true, there is a dearth of Canadian political science literature on the role of medical professionals in health care policy. Indeed, a recent article from Guichon, Mitchell, and Doig exploring the policymaking authority of provincial colleges does not mention national specialist guidelines at all, and mentions CFAS and SOGC only in passing (2013: 336). Chapter 7 may only scratch the surface, but it makes the case that greater qualitative exploration of medical organizations is necessary. Such scholarship should include, at the very least: an exploration of the extent to which physicians feel constrained by college sanctions; the extent to which they have created internal norms and a "professional ethic"; how the views of private service providers such as doctors at IVF clinics differ from those working in public hospitals; physicians' views on provincial and federal governments' ability to become involved in health care policymaking, especially with respect to clinical practice;[48] the role of provincial college policy-specific guidelines, such as have been introduced in Saskatchewan and Alberta recently for ARTs; the extent to which physicians feel compelled to follow national guidelines from organizations such as CFAS and SOGC; the fear (if any) of punishment for not following such sanctions; and the correlation of physicians beliefs and attitudes with longitudinal

[48] I asked one fertility physician, whom I interviewed anonymously, about what would happen if his/her province introduced regulations for clinical care (such as limiting embryo transfer) without introducing simultaneous health-insurance coverage. This physician erroneously answered, "I don't think [the province] can do that," at least when it came to private IVF clinics. This statement says as much about the extent to which provinces have stayed out of clinical policymaking as much as it does physician attitudes, as this particular physician thought governments simply could not tell doctors how they must practice (Interview 2012).

data to measure the effectiveness of internal and external regulation. Well beyond ARTs, we have a limited understanding of how medical practice actually works in Canada. Considering the enormous influence of physicians as healers, policymakers, and gatekeepers, greater understanding is required.

The typical response to medical self-regulation within Canadian political science, and indeed other fields studying ARTs, has been to assume that medical self-regulation effectively means no regulation. As noted in previous chapters, before and after the *AHR Act* passed, Canada on the surface very much resembled the "Wild West" of assisted reproduction, where doctors could take risks and disregard patients' best interests with little fear of sanction. Yet there is evidence that this view requires reconsideration. Canada certainly has a burgeoning for-profit fertility industry. As would be expected in a country without outright government regulation, until 2010 it had one of the highest ART-related multiple birthrates in the Western world (Cook et al. 2011). However, that rate has been dropping rapidly, from 32% in 2009 to 18.4% in 2013 (Canadian Fertility and Andrology Society 2013b). Moreover, Canada has no equivalent to America's "octomom," where a California woman had octuplets after an overzealous doctor had transferred 12 embryos; nor has Canada experienced a Rajo Devi Lohan, the Indian woman who had a child at age 70 through IVF (Daily Mail 2013; Dobuzinskis 2011). Indeed, when a 60-year-old woman who had IVF in India gave birth to twins in Calgary, there was a general medical consensus that the initial treatment would never have occurred in Canada (CBC News 2009). In a completely unregulated system, one might have expected that the introduction of a piece of federal legislation deemed one of the most comprehensive in the world would have had a noticeable effect on the industry, or

that its winding down would have opened the floodgates to all sorts of fertility-related experimentation. Yet in practice, the *AHR Act* changed little. I submit that this speaks, at least in part, to the considerable degree of self-regulation that had taken place in Canada.

This dissertation is not a defense of medical self-regulation as a panacea; it merely contains a preliminary articulation of its merits and limitations in the Canadian context. My more modest argument is that the existence of medical guidelines should lead us to reconsider claims that ART is an "unregulated nightmare" that reflects the "Wild West." ART policy in Canada is not perfect, nor can self-regulatory bodies do everything. There are clearly subfields of ART policy, such as parentage and reproductive human cloning, which cannot be adequately guided by medical organizations. However, as Canada and other countries move forward with new ART policies, scholars must pay greater attention to the scope and content of medical organizations' internal guidelines to gain a more complete understanding of this emerging field.

Two points in particular highlight the increased need for a focus on medical self-regulation in the Canadian context. The first relates to ART specifically, and the utility of the six-part typology developed here. I have argued that a renewed emphasis on both federalism and medical self-regulation can, in combination with this new typology, enable scholars to identify where a given subfield of ART policy is regulated – and perhaps where it ought to be regulated. In Canada, assisted conception takes place in public hospitals and private fertility clinics, jurisdiction for which falls primarily at the provincial level. Since these types of health services are typically delegated to provincial medical colleges, those colleges, along with national specialist organization composed of

members of those colleges, may be the best place to create and implement certain components of assisted conception policy – keeping in mind, of course, the potential problems with self-regulation identified above. Strictly speaking, CFAS and SOGC have direct guidelines that govern in only two subfields: *assisted conception* and *screening, enhancement, and manipulation* – and for the latter, those guidelines are exclusively related to screening. However, in the absence of provincial and federal legislation, medical organizations can also develop indirect, and perhaps unintentional, policymaking authority. Consider the subfield of embryonic research: the *AHR Act* limits embryonic research to "surplus" embryos created during assisted conception, but medical guidelines determine the number of embryos created during assisted conception and, by implication, the number of embryos left over for research purposes. For scholars interested in the scope of medical self-regulation and governments interested in reform, a closer look at such "policy creep" is especially relevant.

A second point about medical self-regulation requires explication: the role of federalism in, paradoxically, creating some level of national policy uniformity. Assisted conception policy, as with much other policy related to clinical practice in Canada, is quite decentralized in theory. Provincial governments have authority, but they have delegated this policy authority to medical colleges through statutory self-regulation (see Chapter 7). Because provincial colleges have increasingly "got out of the policy business" (Interview 2012a), guidelines are effectively set by national specialist organizations – in the case of assisted conception policy, the Canadian Fertility and Andrology Society and the Society of Obstetricians and Gynaecologists of Canada. As Dr. Richard MacLachlan noted during Brown Committee hearings, rather than being

"balkanized," national specialist organizations can have a paradoxically unifying effect on Canada's seemingly decentralized ART policy: "a large part of the world we operate in is meeting national standards… when my hospital or my facility is accredited by the Canadian Council on Health Services Accreditation, a single standard is used nationally" (Canada 2001a). Given the specialist organizations' national scope, these rules, if followed, could buck the trend of decentralization. Greater qualitative evidence is required, but it demonstrates a feedback loop of policy uniformity through decentralized means that is, to my mind, completely understudied in Canada.

Implications for Comparative ART Scholars

The three main areas of further study identified above for Canadian scholars – federalism and decentralization, judicialization, and the role of medical professionals – are of just as much interest for comparative ART scholars. Yet a few points require elaboration for those engaging in the comparative study of ART.

One of my central arguments has been that comparative scholars of ART policy have inadequately defined their scope of inquiry. There are two reasons for this: first, scholars rarely explicitly delineate what is included and excluded by the term "assisted reproductive technology policy." Second, to a large degree there has been a failure to properly identify the extent to which actors other than the federal government engage in self-regulation in the absence of, or as a complement to, national policy in this area. My Canadian case study demonstrates the utility of the six-part typology for defining ART policy, and of expanding the focus beyond national governments to other policy actors. Clarifying the definition of ART policy and extending the definition of "state actor" to

examine medical organizations with delegated authority can signal the beginning, for Canada and comparatively, of a more expansive research project. Without examining policy produced by provincial governments, medical organizations, and courts, the description of Canadian ART policy would simply be incomplete. I suggest the same is likely true for other jurisdictions, even those with centralized ART policymaking. A disaggregated ART policy definition can help explore policy divergence across regimes with greater clarity.

Within jurisdictional federations such as Australia and the United States, the role of subnational governments requires explication in order to get a proper understanding of comparative ART policy. Likewise, a focus on judicialization is necessary – Canadian surrogacy and (especially) parentage policy cannot be understood without reference to judicial decisions. Even when simply reflecting the common law, scholars need to pay closer attention to the extent to which such decisions impact the various subfields of ART policy. Having said all this, the area most in need of study within the comparative political science ART policy scholarship is self-regulation. There is a paucity of comparative literature on the subject, the one exception being Isabelle Engeli and Christine Rothmayr Allison's unpublished yet excellent paper on medical self-regulation in Great Britain, France, and Germany (Engeli and Rothmayr Allison 2013). In it, the authors find that the type of regulation varies considerably within each polity: whereas the French government has "fully taken over" self-regulation and adopted a "command and control" approach to ARTs, the UK has "mostly delegated regulatory power to an independent body." Germany's "hybrid" approach falls somewhere between the two (2013: 1). Overall, however, they find that "the state has progressively become a primary

player in governing the field of human biotechnology, and its responsibility and steering capacity has strengthened over time" (3).

Their finding raises several important questions concerning ART policy. The first is simply whether the growth of state power in the ART field is true across jurisdictions. Their sample size of three jurisdictions is, as expected for a preliminary study, small. The evidence produced in the preceding two chapters of this dissertation suggests that outside of Quebec their conclusion is not entirely true for Canada. True, compared with 1993, the year of the Baird Commission, there is greater state action than there was in the past, particularly because of federal criminal prohibitions. However, there has been limited institutionalization at the federal level, with some (Downie and Baylis 2013) questioning the federal government's willingness and capacity even to enforce the criminal prohibitions. At the provincial level, meanwhile, there has (outside Quebec) been virtually no strengthening of the state's "responsibility and steering capacity" concerning assisted conception policy over time, even following a Supreme Court decision that opened the door for provinces to act. At least compared to its European brethren, Canada seems to have bucked the statist trend.

As to *why* the Canadian state has not become particularly involved where medical self-regulation exists, there are several potential explanations. One may have to do with the federalized nature of Canada's own self-regulatory framework. The primary decision-making and licensing bodies are provincial organizations, not federal ones. Another may have to do with the fact that, as Rothmayr and Engeli note, "comprehensive and well-respected voluntary self-regulation strengthens the medical community's position as expert and its credibility as reliable partners in the regulatory process" (2013: 11). In

France, division amongst medical expert organizations was a catalyst for increased state intervention. In Canada, by contrast, this division never occurred. As Montpetit (2004) notes, physicians had an "unambiguous preference for self-regulation" of ARTs; they opposed criminal prohibitions and favoured an independent regulatory body provided that it "complement, not duplicate, the work already accomplished through so called self-regulation" (64, 75). While Chapter 4 demonstrates that some physicians claim to have welcomed the *AHR Act*, they uniformly opposed its criminal prohibitions and showed no sign of internal strife regarding the federal government's proposed national regulatory policy. And while Montpetit cautions that "the sheer power of the medical profession … does not constitute a sufficient explanation" (81) for the lack of legislation prior to the *AHR Act*, the profession's homogeneity of beliefs certainly may have helped delay the legislation.

One final point regarding comparative studies of medical self-regulation is worth noting: the Canadian case shows that scholars must recognize the important distinction between policy capacity and policy content. Clearly, provincial medical colleges and national specialist organizations in Canada have the regulatory capacity to create clinical guidelines for certain subfields of ART, particularly assisted conception. They have been doing this for years, if not decades. Yet it is likely that the content of policies offered through medical self-regulation tends to be more permissive than those put forward by governments. This seems to be true in Canada, where Quebec's stricter single embryo transfer policy has resulted in a lower multiple birth rate than the rest of Canada. The distinction between capacity and content should be kept in mind, particularly when ART

scholars effectively argue that self-regulation means no regulation, insofar as self-regulation tends to be more permissive.

Further comparative evidence is required in order to determine the validity of such speculation. The need for this research, however, only underscores the point that future studies of ART policy ought include medical organizations, and to examine precisely the subfields in which they create policy.

Implications for Comparative Political Science

One qualitative case study does not make the case for a general theory, but small-N studies can help the process of theory-building. For comparative scholars more broadly, this dissertation demonstrates the utility of adopting a historical institutional framework when undertaking qualitative analysis. Particularly in fields such as ART policy, where a legislative vacuum and policy initiation can be identified, the literature on critical junctures is useful. I have demonstrated that the Baird Commission fits all the criteria for a critical juncture, and its subsequent influence leaves little doubt that this is true.

Moreover, historical institutionalism provides an especially valuable tool for understanding a sub-optimal policy status quo; as Bateman notes, "[i]nstitutionalist analysis proves helpful in understanding political arrangements even when they do not work well" (2011: 20). Because the embeddedness of initial choices can often lead to unintended consequences over time, historical institutionalism's attention to the importance and fluidity of ideas rejects functionalist accounts by which "institutions take the form they do because powerful actors engaged in rational, strategic behavior are seeking to produce the outcomes observed" (Pierson 2004: 14). As the preceding chapters

attest, such functionalism provides an inadequate account of Canadian ART policy; instead, contradictory frames taken on during the early stages of ART policy development have created a status quo with which almost every stakeholder is dissatisfied.

The dissertation also demonstrates the importance of framing strategies, even when they are not made particularly explicit – although I have adopted the terms "medical-scientific" and "moral" throughout, at no time did a Commissioner come out and say "we are using the medical-scientific frame." Given its potential for influence, it is not shocking that the Baird Commission's medical-scientific/moral "division of labour" was reproduced by the federal government, although the extent to which it was duplicated and sustained for over a decade is quite remarkable. What is most striking is the extent to which it informed a majority of Supreme Court justices. The distinction between harmful and beneficial activities is at the heart of the majority opinion, but the Court's attention to its own jurisprudence meant that the beneficial activities were rendered unconstitutional. That not just the content but the ideational frames used to justify federal legislation remained salient for two decades and through various institutions once again demonstrates the formative power of ideas in politics.

Finally, this dissertation demonstrates that scholars ought to pay more attention to the distinction between ideas and institutions. Specifically, while policy framing created ideational path dependence, it resulted in limited overall institutionalization. Canada's unique situation from 2004-2010 – a robust federal framework in theory, with little actual policymaking done by the federal government – provides an important lesson, one which is informed by the above discussion of self-regulation. Not only was there limited

institutionalization; there is also limited evidence that federal legislation actually affected medical activity. One could argue, as Varone, Rothmayr, and Montpetit (2007) do, that Canada is an example of medical organizations "develop[ing] self-regulation as a strategy of influencing and preventing state intervention" (11). This was certainly not the primary goal the federal government had in mind when creating its legislation, although it may be the one with the most lasting influence. Canada's case study shows that, whatever ideational path dependence exists, the actual transfer from ideas to institutions requires more than simple legislation.

ART Policy and Political Science: Taking a Closer Look

This dissertation began as an attempt to tell the story of Canadian ART policy. By adopting a qualitative historical-institutional approach, it has also produced a model for comparative scholars of ART policy that can be used to measure variation across and within regimes with greater clarity. In particular, the six-part typology can help explain differentiation within and among different countries, creating a more robust comparative framework. Put simply, without exploring these other actors and disaggregating the ART policy subfields, we would have an impoverished view of the overall state of ART policy in Canada.

From the enduring influence of Canadian federalism to the need for precise definition and measurement of emerging policy fields, this study has much to contribute to the study of ART policy. On both theoretical and practical levels, it offers many avenues for greater understanding. At the broadest level, however, it makes the case that qualitative historical analysis can provide considerable analytical weight to explaining

policy outcomes and that small-N studies can contribute to theory building within comparative political science. Channeling Paul Pierson (2004: 47), I firmly believe that the most important first step political scientists can take is to "go back and look," and to do so in as much detail as possible, when seeking to understand political outcomes. It is my hope that this study can play some small part in adding to that overall understanding.

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