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New Reproductive And Genetic Technologies In Canada: Towards A Policy That Manages Technology And Reproductive Rights

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A Thesis

In

The Department

Of

Political Science

Presented in Partial Fulfillment of the Requirements
for the Degree of Master of Arts
Concordia University
Montréal, Québec, Canada

September 1997

ABSTRACT

New Reproductive And Genetic Technologies In Canada:
Towards A Policy That Manages Technology And Reproductive Rights
Donna L. Moore

New reproductive and genetic technologies in Canada, the void of regulation and policy, and the federal government's policy making attempts, to date, are the focus of this paper. The unencumbered growth of new reproductive and genetic technologies (NRGTs) are influenced by a technological imperative and our society's increasing reliance on the notion of reproductive rights. The unfettered use of the NRGTs may proffer a dystopian and eugenic future to society and to those affected, personally and financially, by the use of the technologies. Various stakeholders, including feminist organizations, the medical and scientific communities, and social policy advocates have been concerned with the lack of policy in the field, for well over ten years. To address the issue of NRGTs, the Canadian government established a Royal Commission (which reported in 1993), and has begun to institute a three part policy process that includes a voluntary moratorium on some of the morally and ethically controversial practices, the proposed prohibitive measures of Bill C-47, and a proposed regulatory framework. Throughout the policy development process the Canadian public and stakeholders, including those who have an interest in the future use of these technologies, have been consulted. Ten years into process, a synthesis of common views amongst previously divergent stakeholder groups now seems to be emerging. This paper reviews, analyses and examines the major issues of technological determinism and reproductive rights pertinent to the issue, in an effort to determine their effect on the development of the federal policy regarding new reproductive and genetic technologies.

ACKNOWLEDGMENTS

During my time in the Public Policy and Public Administration graduate programme I was fortunate to follow courses with a variety of principled and capable professors. I owe my interest in the subject of reproductive technologies to Prof. Arthur Kroker's seminar course on Technology and Ethics and Prof. Daniel Salée's course on Rights and Public Policy. Their courses allowed me to begin my study of reproductive technologies that has lead to this thesis. The completion of this thesis has been an arduous task that would not have been realized without the support of many individuals. I would like to thank Dr. Reeta C. Tremblay for her encouragement, support and patience throughout the past four years. Without the assistance and support of Michelle (Teri) Grunert I would still be at my computer editing the text. My colleagues at The CRB Foundation have been more understanding and encouraging than I could ever have imagined. Without their understanding this work would not be finished. There are many other who voiced their encouragement and confidence in my abilities these past few months, colleagues, neighbours and both new and long-time friends (a.k.a. my family of choice) - "I appreciate your support!" I would like to thank Andrew D. McCrae for his encouragement, patience and confidence in my abilities. My parents and brothers have always been behind me wherever my life has lead. Throughout this work I could hear my parents' voices, "You can do anything you want to as long as you put your mind to it." This work is dedicated to the memory of my sister, Laura Lynn Moore.

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Chapter 1 - Introduction

The development and use of new reproductive and genetic technologies (NRGTs) is one of the more controversial issues in social policy today. NRGTs have serious medical, legal, social and ethical ramifications, each on its own worthy of study. Since these technologies came into the public realm, with the birth of the first test tube baby in England in 1978, the field of human reproductive technology in Canada has been constrained only by the pace of scientific innovation and the financial market forces that drive it. Despite the controversial nature of NRGTs and the rapid unfettered pace of their development, in Canada there is no formal legislation to regulate their development and use.

Reproductive technologies and all that they entail are controversial by their nature, as they have the ability to alter what we consider normal childbearing practices and the genetic makeup of society. They are also controversial because of differing perceptions and contexts, i.e. there are differing underlying assumptions which influence the issues inherent in reproductive technologies. These issues involve the notions of: a technological imperative that drives the development and implementation of the technologies; the issue of reproductive rights; and the state's response to the influence of the notions of technological determinism and reproductive rights as evident in their approach to developing public policy regarding NRGTs .

This paper will examine the issues affecting the debate surrounding NRGTs, provide a chronology of the attempts to develop public policy regarding them in Canada; and

speculate as to what effect these issues have had on the development of public policy to regulate NRGTs. There are many conflicting viewpoints on reproductive technologies. These conflicting viewpoints exist in and amongst feminist theorists, the medical and scientific communities, society, the church and the policy makers. This profusion of viewpoints amongst stakeholders has all but created a policy stalemate. There has been an inability by decision makers to ensure public policy regarding reproductive technologies is developed and implemented.

Reproductive Technologies, New Reproductive (and Genetic) Technologies

The advent and rapid development of reproductive technologies in the last thirty years have had and continue to have serious implications for women's reproductive health. The technologies have a wide spread influence on how and what we regard to be normal reproductive processes. Yet these technologies are subject to little or no regulation or legislative fiat in Canada. Increasing use of these reproductive technologies is resulting in mounting medical interventions into women's reproductive functions and a fragmentation of the natural reproductive process. Women have less control over their bodies as clinicians and doctors choose which NRGTs are appropriate for their patients. Use of these, at times intrusive, technologies puts control of women's bodies into the hands of physicians.

Women have traditionally been assisted in reproduction. Centuries ago women were assisted in reproduction by midwives, herbalists, and medicine women and men. Currently reproductive technology is defined as the full range of biomedical and technical interferences during the process of procreation, whether aimed at producing a child or preventing or terminating a pregnancy.[1]

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[1] Spallone, Patricia, Beyond Conception: The New Politics Of Reproduction (Massachusetts: Bergin and Garvey Publishers Inc., 1989), 15.

Reproductive technologies are often distinguished on the basis of their function in relation to life:

- fertility control (contraception, abortion);
- prenatal technologies (amniocentesis, ultrasound, sex selection and genetic testing);
- management of labour and childbirth (fetal monitoring, labour inducing drugs and cesarean sections); and,
- conceptive technologies (*in vitro* fertilization (IVF), artificial insemination by donor (AID), surrogacy, and Gamete Inter Fallopian Transfer (GIFT).[2]

The new reproductive and genetic technologies (NRGTs) fall within the prenatal technologies and conceptive technologies. Usually, they refer to the more recent development of artificial reproduction techniques (ARTs) and assume a need for laboratory manipulation of genetic materials. By definition then IVF and genetic technologies, e.g., GIFT and more recent genetic manipulation techniques, are new reproductive technologies (NRTs). Genetic technologies are the technologies that reformulate the genetic makeup of zygotes and embryos. Genetic engineering involves the substitution of or removal of genetic material into a man's or woman's genetic material in order to determine physical characteristics of that person's offspring. Genetic technologies manipulate genetic materials and therefore require the artificial reproductive techniques of AID, IVF and GIFT. Taken as a whole, the techniques that comprise the full range of NRGTs have created an environment in which women's reproductive experiences and choices are increasingly determined by medical experts and where intrusive, non-fail-safe, and expensive medical treatments are becoming accepted as an ordinary (and often compulsory) part of the childbearing process.[3]

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[2] Canadian Research Institute on the Advancement of Women, Working Group on Reproductive Technologies eds. Reproductive Technologies and Women: A Research Tool (Ottawa: CRIAW, October 1989), 3.

[3] Ibid.

Throughout history the power of reproduction has been the core of women's experience. No matter how devalued, controlled, feared or exploited, women remain indispensable to the perpetuation of the human race as only women have the ability to make people. All human beings are necessarily, at birth (at least at the present stage of technological development), the product of female capacities and female labour. As Eileen Manion states in "A Ms-Managed Womb," "motherhood is...women's greatest hope and greatest anxiety; it is pathogenic, pathological, but it is the ultimate romance. Nothing is more confusing."[4] However, with the recent technological interventions in reproduction, a broad range of views about reproductive technologies exist within different constituencies, such as the general public, medical profession, feminist theorists and ideologies in the state leadership. Feminist viewpoints alone encompass a large diversity in approaches to NRGTs; some viewpoints echo, in content, the opinions of various 'mainstream' philosophies held by medical, religious and political institutions.

Limitations / Caveats

While this study examines the major issues affecting the development of the policy process in regards to reproductive technologies, the major focus, however, is on the impact of the full range of reproductive techniques on Canadian society and its policy process. Though it may appear that limiting the analysis to one specific, reproductive or genetic, technique or a case study may make this study less cumbersome; the apparent disadvantage is that a narrower focus may generate little or no critical analysis. Moreover, while the public agenda may focus on one particular technique at a time, others techniques are simultaneously being developed and implemented with little review. Much of the analyses of the techniques have been completed without regard to the effect of the full range of reproductive technologies on women's reproductive experiences and health and society as a

4 Manion, Eileen. "A Ms-Managed Womb" in Body Invaders: Panic Sex in America, Arthur and Marilouise Kroker eds. (Montreal: New World Perspectives, 1990), 186.

whole. Dealing with the techniques one at a time in an "objective" fashion, by nature, removes the context of the impact the complete range of technologies. Therefore, it seems appropriate not to separate the techniques but to assess the impact of the full range of new reproductive technologies. They have the ability to alter what we consider to be "normal" childbearing practices and to complicate the government's efforts to develop policy to regulate their development and use.

New reproductive and genetic technologies, and all the techniques that they entail are controversial by their nature. The underlying issues that affect them include the notions of: a technological imperative that drives the development and implementation of the techniques; the issue of reproductive rights; the states response or lack thereof to the application of NRGTs; and the effects the issues of a technological imperative and reproductive rights have on the NRGTs policy development process.

A Technological Imperative

The scope and pace of technological change is a predominant influence in society today. New problems and issues arise with each new technological development, while as a society we have yet to apprehend and adequately address the issues raised by previous technological developments. Often we adopt technologies to solve problems that may have developed as a result of the previous round of technological innovations. Does the continuous flow of technological innovation that is a part of today's society make demands upon us that cannot be resisted? Do we accept and even embrace technological innovations because they are available without any critical analysis of their implications?

An example of the technological imperative in action is the Human Genome Project that is mapping human genes. An understanding of the human genome could catapult

biomedicine to an entirely new orbit.[5] The potential benefits are plain to see. Even if they were not, sheer curiosity has made the project hard to resist. "How could we not do it? We used to think our fate was in the stars" observes James Watson, who, with Francis Crick, figured out the structure of DNA in 1953. "Now we know, in large measure, our fate is in our genes."[6]

The research and development of reproductive technologies, that are driven by a technological imperative and market forces, are performed by the medical and scientific communities which continue to be dominated by technological, patriarchal and capitalist concerns. Research in the area of human reproduction is funded by governments, private agencies and pharmaceutical companies that commercially produce, merchandise and sell the products.[7] Much of the work done in this field is also driven by curiosity and the implied need to unlock and thus have control over Nature's secrets. If research into reproductive technologies is funded by pharmaceutical companies, then how can the scientist and medical experts who develop the technologies, and are funded themselves, be unbiased in their research? Moreover, who is responsible for analyzing the technologies and assessing what implications they may have on society? Indeed, the direct involvement of pharmaceutical companies in research into the technologies has resulted in increased commercialization of these technologies. Thus, it is possible for one to conclude that the development of new reproductive technologies is not based on actual need but on the market mentality of the pharmaceutical companies involved in the industry.

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5 Mabie, Margot, Bioethics and the New Medical Technology, (Toronto: Maxwell Macmillan Canada, 1993), 24.
6 as cited in Mabie, Margot, 1993, 16.
7 Steinbacher, Roberta, "Sex Preselection: From Here to Fraternity" in Beyond Domination: New Perspectives on Women and Philosophy, Carol C. Gould, ed. (New Jersey: Rowman and Allanheld, 1984), 277.

Both historically and politically, women's power of reproduction has fallen under the control, largely through sublimated legitimization, of patriarchal religious, legal, medical and commercial institutions.[8] In church doctrine, women's reproductive power is neglected, prescribed, mystified and made sinful. In Canada and the US women have legal rights, yet these rights are suspended when a woman is pregnant and becomes subject to laws that protect the foetus. In the US most states have laws that extend wrongful death statutes to the foetus. For example, in the state of Louisiana, fertilized eggs are legally defined as fully formed humans.[9] In addition, the traditionally hierarchical doctor-patient, or scientist-subject, relationships controls and inhibits many women as they are reluctant to question or disappoint their doctors.[10] The cumulative effect is that the living woman's body acts as host site for the actualization of the technological imperative.

Other issues raised by the notion of a technological imperative are:

- The increasing medicalization of childbirth into a crisis event that requires medical intervention;
- The language used in the medical/scientific/pharmaceutical context disassociates women from their bodies, (akin to the language used in reporting wars which removes the personal and emotional), and the mind/body split engendered by NRGTs; and
- Un/informed consent - informed choice debate, i.e., is it possible to have informed consent or is it too late? Are we socialized to implicitly believe in the medical

[8] Ibid., 276.
[9] Faludi, Susan, Backlash, The Undeclared War Against American Women. (New York: Doubleday, 1991), 423.

profession and do women consent to or choose NRGTs in response to a pronatalist society in which women can only be fulfilled as individuals once they have become mothers?

It can also be suggested that the technological imperative driving the medical/scientific community in research of and in the production of drugs is influencing people to believe that they have a right to reproduce in the strong sense i.e. that they are entitled to a child. The combination of the technological imperative and a perceived need results in increased dependence on medicalized procedures during reproduction resulting in increased economic costs to society and increased health costs to women.

Reproductive Rights

The biological role of women in reproduction implicitly infers a variety of reproductive rights and freedoms. However, women's reproductive rights and freedoms is an important issue that is often ignored by legal and judicial structures and processes. Women's rights have traditionally had the connotation of equality rights. In essence, the reproductive function of women has been blatantly ignored by the legal and judicial systems when its comes to the determination of women's rights. The power of reproduction is at the core of women's experience. One cannot help but question what implications the dismissal of this reproductive function, as a determinant of rights, has had on the emotional, physical and psychological health of women. The only framework most often used in discussion of women's reproductive rights has been, up until now, the right to choose within the context of abortion debates. However, the abortion rights framework is too simplistic to be imposed

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[10] Spallone, 30.

upon an issue as complex as that of reproductive technologies. The right to choose maxim also may inhibit an adequate legal response to NRGTs as full responsibility for choices made is placed solely on the woman/client, even though physicians choose which technology to offer (recommend) to which patient. In light of these complexities, many stakeholders in the debate over reproductive technologies are turning to a rights-based discourse to support their views. Christine Overall in Reflections on Reproductive Rights in Canada argues that women have both the right not to reproduce and the right to reproduce. At times the right of a woman to reproduce in the strong sense may infringe upon the right not to reproduce of another woman.

The right not to reproduce is defined as the right not to be compelled to beget or bear children against one's will and the right not to have to engage in forced reproductive labour. In a weak/liberty sense, this is the right not to be compelled to donate gametes or embryos against one's will. In the strong/welfare sense, it is the right of access to services like abortion and contraception which enable women to avoid procreation. This notion of the right not to reproduce has developed in Canada and US during the last 25 years.

For Overall, the right to reproduce in the weak/liberty sense is the right not to be interfered with in reproduction or prevented from reproducing (this is at times compromised by state restrictions on where, when and how women give birth, including cesarean sections). In the strong/welfare sense, the right to reproduce is the entitlement to receive all necessary assistance to reproduce, the right of access to any and all available forms of reproductive products, services, labour and the full range of procreative techniques.

Recognizing this right to reproduce shifts the burden of proof to those who have doubts about the technologies and suggests we each are owed a genetically linked child. The recognition of the right in the strong sense for women may violate the right not to reproduce of other women i.e. those undergoing IVF treatment, and those who due to financial need may be forced to sell eggs and embryos for research and implantation.

Overall believes the potential motivation for surrogacy contracts should be reduced by making them unenforceable and making contract motherhood agencies criminal. She can not support IVF (which provides a 0-20 % chance of a live birth) nor endorse limiting or banning it (limited access is a barrier to all but the affluent as each IVF attempt can cost between $3,500 and $5,000).

Overall believes women should make genuinely informed choices. This means a full knowledge of the short and long term effects, possible benefits, chances of success and failure, alternate approaches and treatments and of the pronatalist social pressures to procreate. Over the long term, Overall suggests we should consider whether infertility treatment can be incorporated into woman-centred and woman controlled reproductive health centres. Her goals are to preserve and enhance access to reproductive services and techniques that benefit women while preventing further encroachments and access to women's bodies by the state and the medical establishment.

Significance

The development and implementation of the full range of NRGTs in Canada continue to exist in a regulatory and policy void. Despite a government effort to develop policy that to date has included: a Royal Commission report (in 1993), a voluntary moratorium on nine

practices (announced in 1995), and a bill prohibiting certain pratices that was tabled in 1996 and died on the Order Paper in early 1997. NRGTs have the power and ability to produce potential long term effects to our genetic makeup and functioning that we are unaware of and may potentially change our basic biological structure. They raise serious moral, ethical and legal issues as well as having the ability to redefine what our society looks like and what we consider to be a normal human reproductive process.

The debate surrounding NRGTs continues after over eight years of public debate. A synthesis of stakeholders' viewpoints on some issues (criminalization, reproductive rights and the proposed regulatory framework) is beginning to develop. As at this time, there is no longer proposed legislation before parliament many stakeholders consider the government has been granted the opportunity to alter the policy development process and start anew. Canada is at least fifteen years behind other developed countries (England and France) in establishing policy and regulation governing NRGTs The government's challenge is to proceed with action based on common ground that had been identified through extensive soundings of Canadian and international expertise and viewpoint. To attain this goal rational discussion and careful formulation of policy and legislative options involving stakeholders is needed.

Chapter 2- Definitions of NRGTs, Related Concepts and Literature Review

Definitions of NRGTs

In order to establish the context within which the debate surrounding new reproductive technologies takes place, it is important to determine the history of the technologies, how the debate is characterized and define key notions that are raised within the debate. This chapter will trace the history and characteristics of NRGTs, define the key concepts of infertility, pronatalism, informed choice, bioethics and provide an overview of the plethora of views that exist in regards NRGTs.

The conceptive technologies (*in vitro* fertilization (IVF), artificial insemination by donor (AID), surrogacy, and Gamete Inter Fallopian Transfer (GIFT)) are all non-coital forms of reproduction. They also include some of the most controversial techniques of the new reproductive technologies. Artificial insemination by donor (AID) is not a 'new' reproductive technology. This technique has been practiced since the late 1890s. In 1884 the first artificial insemination, was done without the knowledge or consent of the woman involved.

Artificial insemination by donors (AID) and surrogate parenting, neither of which contribute significantly to our scientific knowledge about reproduction, have become the most problematic legally and contentious socially. Not because they involve non-coital procreation, but because they involve third parties and, in some instances, a payment of

money to an outside person.[11] Surrogacy has become a symbol of the dehumanization of modern life, the commodification of children and the exploitation of women.

Non-coital reproduction and surrogate parenting raise complex issues about the definition of the family and parenting for which we have incomplete knowledge and inadequate frameworks (which are themselves changing).[12]

In vitro fertilization (IVF), literally in glass fertilization, entails the removal of ripe eggs from a woman's ovaries. This is done by hyper-stimulating the ovaries with powerful fertility drugs, and regulating menstrual cycles with hormones. Ripe eggs are removed by a surgical procedure requiring laparoscopy. The eggs and sperm are mixed in a petri dish with a growth medium, 2-3 days later if fertilization has occurred, a number of pre-embryos are placed in a catheter which is inserted through the cervix into the uterus. After two weeks time it is possible to tell if pregnancy has occurred. If pregnancy results, treatment continues, possible more hormones, ultrasound scanning, amniocentesis and usually cesarean section birth.[13]

"Surrogacy" or preconception arrangements are agreements made before conception in which a child is to be produced for transfer from the woman who gives birth to another person or persons. The woman who gives birth may or may not receive some form of compensation, usually a monetary payment. There are two types of surrogacy. 1) Genetic surrogacy in which a woman is artificially inseminated, carries the pregnancy to term, and hands the baby over to the father (and his wife or partner, if he is married) for adoption. The

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11 McCormack, Thelma, "Public Policies and Reproductive Technology: A Feminist Critique" Canadian Public Policy- analyse de Politique, XIV 4, (1988) 362.

[12] McCormack, 366.

woman who gives birth to the child in the baby's genetic mother. 2) Gestational surrogacy in which a woman undergoes IVF to receive an embryo made up of another woman's egg. She is not the genetic mother of the child. The couple who arranged for the surrogacy then adopt the baby. Usually at least one of the sperm and/or the egg are the genetic material of the adopting couple.

Infertility

New reproductive technologies have emerged from the normative and ideological structures that tend to equate womanhood with motherhood and which actively encourage childbearing.[14] Since their first applications in North America in the 1980s there has been an increasing demand for NRGTs. One explanation for the demand is in an increase in infertility, another explanation, more consistent with the data on infertility in developed countries, is the precipitous drop in the number of babies available for adoption. The improved forms of readily available contraception and practice, the desire of teenage mothers (married or unmarried) to keep their babies and the legalization of abortion act together to account for the decreased number of babies available for adoption.[15]

Technologies have developed to the extent that those who are infertile may be able to have their own genetic offspring. Infertility is now labelled a 'disease' by the medical establishment and is a condition with social stigma associated with it even though there is little understanding of the plethora of physical, physiological and psychological factors that

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[13] Spallone, 12.

[14] Williams, Linda S. "But What Will They Mean for Women? Feminist Concerns About the New Reproductive Technologies," Feminist Perspectives Feministes, No 6. (Ottawa: Canadian Research Institute on the Advancement of Women, 1986), 12.

[15] McCormack, 361.

can influence it. The definition of infertility varies from country to country. In Canada, a couple is defined as infertile after trying to conceive for one year, whereas France finds a four year delay within normal limits for conceiving.[16] The Canadian definition of infertility along with the current reproductive technologies, supportive of this definition, encourages potentially healthy couples to see themselves as patients in need of treatment and technological intervention. Yet there is no mention in this definition as to how often intercourse takes place or whether it occurs when the woman is ovulating. Idiopathic infertility (where the cause is unknown) often results more from impatience to procreate than an inability to do so, which is why 25 to 60 percent of couples who attend fertility clinics will conceive through means completely unrelated to the treatment.[17]

In the United States, where one in six couples is labeled infertile (also a one year definition), little regard is given to the plethora of causes of infertility, some of which are linked to workplace and environmental hazards. Research funds, while not directed towards discovering the causes of infertility, are spent on discovering efficient methods of interventions to help the infertile. Indeed, some cases of infertility experienced by women might be traced to other reproductive technologies, D.E.S. (Diethylstilbestrol) and the Dalkon Shield IUD (intra-uterine device). Ironically, medical technology ironically offers to restore at a price what it had previously taken away.[18]

A case in point is the rising rate of infertility in Russia due to the use of multiple abortions as a common form of birth control. To counter the tide of infertility, there are now

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[16] CRIAW, 1989, 6.
[17] Ibid., 20.
[18] Manion, 192.

twelve fertility clinics in a country of 150 million.[19] Infertility in Russia is often caused by pelvic inflammation or scarring resulting from abortions. Abortions is still one of the most common methods of birth control in Russia, some women have had as many as nine.[20]

There are no reliable statistics on infertility in Russia, but the birth rate has decreased by 44% between 1983 and 1993.[21] This outcrop of infertility is highly prevalent among the less well off women, unable to afford treatment. Their problems are compounded even further in light of the unavailability of proper health services. The inaccessibility of safe forms of contraception which force women to turn to the extreme alternative of abortions is reminiscent of Canada and the USA before the advent of legal contraceptives and safe abortion services. In the case of Russia, then, infertility is plainly not a disease per se but the logical result of both misused and overused technologies.

Another cause of infertility is the wide use and release of chemicals in our environment, which may be infiltrating foetuses and skewing sexual development in male babies, resulting in a decline in men's sperm count. This decline has been reported in the US, Europe, Asia and Africa.[22] A Danish study reported a 42% decline in men's sperm count world wide in the last 50 years,[23] which parallels world-wide industrialization in the post war era. However, rather than addressing the dangers of environmental pollutants, and thus the potential causes of infertility, reproductive research prefers to choose to create more technologically sophisticated methods of reproduction to 'cure' infertility.

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[19] Stanely, Alessandra, "Sperm Bank Discovers a Good Man Hard to Find" The Ottawa Citizen, July 29, 1995, H9.

[20] Ibid., H9.

[21] Ibid., H9.

[22] Nichols, Mark, "The Sperm Scare" in MacLeans, (Toronto: 1996) Volume 109, No. 14, April 1, 1996, 50.

[23] Ibid., 50.

Socially, infertility is a major obstacle to biological motherhood which has traditionally been sanctified in many cultures. For women with limited opportunities for achievement, childbearing is seen as a form of success; for liberated or independent women it is seen as obligatory.[24] The desire to have a child, whether inherent or induced by societal expectation, is strong in many infertile individuals and couples. This desire is so strong that they, especially the women, are willing to risk their own health and well being in the hopes of having a child. Parenthood and childbearing are so thoroughly socially prescribed that a name has been given to this phenomenon; pronatalism. Pronatalism is "any attitude or policy that is 'pro-birth,' that encourages reproduction, and exalts the role of parenthood."[25] In our patriarchal social matrix, pronatalism makes the conceiving and bearing of children definitional of the true, complete woman.[26] Mary Sue Henifin comments that anthropological evidence exists that the desire to have children that are genetically related is not biologically determined, but rather culturally constructed.[27]

Medicalization of Human Reproduction

Implied in much of the discussion of reproductive technologies is the concern over the medicalization of human reproduction. According to many feminist writers, the medical industry seeks to control reproduction by continuously imposing itself as indispensable to the reproductive process. It does this by intervening in women's natural conception and birthing process, surgically and pharmacologically with complex monitoring devices and with multi-

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[24] Moragn, Kathryn Pauly, "Of Woman Born? How Old Fashioned! - New Reproductive Technologies and Women's Oppression" in Christine Overall ed., The Future of Human Reproduction. (Toronto: The Women's Press, 1989), 71.

[25] Williams, 9.

[26] Morgan, 4-71

[27] Henifin, Mary Sue. "Introduction: Women's Health and the New Reproductive Technolofgies," in Embryos, Ethics and Women's Rights, E.H. Baruch, A.f. D'Adamo and J. Seager eds. (London: Haworth Press, 1988), 6.

stage hospitalization.[28] Reproductive technologies have carried women's fertility further from natural mystical and woman centred reality into the domain of medical expertise and the technological imperative.

Birth has been medicalized as a crisis event. As social pressures on women to seek reproductive technologies have increased, there are concurrent pressures from experts for women to submit to invasive procedures of infertility testing and IVF experimentation.[29] The medicalization of conception increases the dependence of genitors on biomedical institutions, while reinforcing women's insecurity regarding child-bearing.[30] Through reproductive technologies, women are increasingly being submitted to the technological imperative of the medical establishment. Women are encouraged to believe that the technology offered or ordered for them is maximizing or enhancing their choice. However, technology primarily serves to control reproduction (i.e., who gets to propagate and how), to redefine women's reproductive role in primitive reductionistic notions,[35] and reduce women's control over their own bodies.

Women's reproductive power to create and give birth is seen as "dangerously mediocre when compared with the promises attached to the development of an artificial womb."[31] Today, for the first time in history, the power to negate women's indispensability to human reproduction, her perceived reason for being, is within reach of the patriarchy.[32]

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[28] In 1980 the Quebec Order of Pharmacologists declared that sperm is medicine. Steinbacher, 176.
[29] Morgan, 72.
[30] CRIAW, 1989, 15.
[31] Morgan, 68.
[32] Steinbacher, 274.

Commercial interests have increasing control over IVF. When medical teams sell their technology to private commercial interests, public input and the monitoring of the development of reproductive technologies decrease. One striking example of commercial interest in IVF is CP Ventures Ltd., a management investment company in Australia, which named IVF as one of the highest profile areas for investment.[33] American IVF practitioners have warned that for private clinics to survive economically they must decrease their costs by reducing research into the safety and effects of IVF on their patients.[34] Also eugenic notions of creating a better human product are more likely when a profit motive exists.

The commercial exploitation of reproductive technologies has been pervasive and has never indulged in the pretext of being value free: we have only to consider why female instead of male forms of contraception have proliferated; or look at the horror stories of the Dalkon Shield, D.E.S., thalidomide, and the fact that there have been deaths due to IVF; and to ask who exploits the products and who are the guinea pigs?[35] Businesses profit continuously from female reproductive power: from marketing of infant formula and its current unabated distribution (and the subsequent related deaths) in developing countries; to the monopoly of pharmaceutical companies on contraceptive drugs and techniques, to the manufacturing of electronic fetal monitors and attempts to install such devices into every delivery room in America.[36] Women's reproductive ability and labour in another frontier has been appropriated by the market forces and medical industry has been more interested in the bottom line rather than the actual health needs of women and children.

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[33] Ibid., 5.

[34] CRIAW, "Submission from The Canadian Research Institute on the Advancement of Women to the Canadian Royal Commission on New Reproductive Technologies". Jacqueline Best. (Ottawa: CRIAW, September 1990), 8.

Language

Within the debate on reproductive technologies, the overtly political language employed plays a powerful defining role. Technology in itself is political, as it is an instrument of the societal matrix that includes organizational factors, societal aims and values, as well the physical techniques themselves. In considering technology one must consider where the technical techniques came from, why they are considered valuable, and how they are administered.[37] In the case of reproductive technologies, the techniques have been developed and are controlled by the medical/scientific community, therefore, the language employed is that of the medical/scientific community. Feminists[38] acknowledge that the "language sets the agenda" and that the scientific language in itself is insidious.[39] In the medical/scientific literature on reproductive technology, there is no recognition of women's active presence in reproduction. The medical literature speaks in terms of body parts, man's eggs, human placenta or human reproduction when they are implicitly describing distinctively female physiology and biochemistry. This so-called 'objective' language and attitude masks the fact that women are the central subjects of human reproduction and the host sites on which new reproductive technologies are to be used. This allows medical scientists (often with the support of the state) to proceed with reproductive engineering projects without any particular accountability to women.[40]

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[35] Steinbacher, 275.

[36] Ibid., 276.

[37] Spallone, 13.

[38] "Like feminism, there is not, nor could be a single definition of feminist since feminists have many different affinities - of sexual preference, class and race. ...But all feminists share a commitment to, and enjoyment of, a woman-centred perspective." Feminist as defined in The Dictionary of Feminist Theory, Humm, Maggie, (Columbus: Ohio State University Press, 1990), 75-76.

[39] Spallone, 13.

[40] Ibid., 16.

The language of reproductive technologies is littered with misnomers that serve to obfuscate the issues and ultimately disassociate women from their bodies and their bodies from their specific functions. Men who sell their sperm to sperm banks and research institutions are called sperm donors as opposed to sperm vendors which is what, in reality, they are.[41] Surrogate motherhood is a commonly used term, however, the woman in question is the biological and/or birth mother. Suggested alternative terms are 'surrogate wife' (a more accurate description as the surrogate is substituting for the contracting man's wife, who may be infertile or unwilling to become pregnant), breeders, or calling the practice contractual conception.[42]

Removing eggs from a woman's ovaries is described as "recovery" of the eggs, a complete misnomer as the woman is losing her eggs to the agent or recipient, and the term recovery assumes one has lost something or lost control of something. This notion makes sense only if the women in question are regarded using an objectifying notion, such as chattel.[43]

New metaphors that disassociate women from their bodies continue to be developed in the medical/scientific community in regards to new reproductive technologies; i.e., a spontaneous abortion (miscarriage) is now referred to as embryonic wastage, and the ovaries of a mature woman are now production lines of eggs. In this manner women are increasingly seen through the dominant ovarian ideology as egg storers, egg layers and egg hatchers. Notions of animal husbandry come to mind when one reviews these terms. The

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[41] Williams, 17.
[42] Ibid., 19.
[43] Morgan, 64.

uterine environment, the maternal milieu and the embryo carrier are all terms to discuss the site where new reproductive technologies take place, without reference to the fact that the site is a woman and her body.[44] This disassociation of the language from the physical reality of the site, and talking in terms of eggs, sperm and embryos, is morally less problematic then admitting that women and their bodies are the subjects and sites of human IVF and human embryo experimentation.[45]

In the language of fertility clinics, reproductive technologies are characterized as benevolent, therapeutic and voluntaristic. However, fertility clinics are the front-line of the medical industry which represents real coercion and control over women and their bodies. It is difficult to conceptualize exercising "free choice" (let alone informed free choice) in the context of what amount to coerced voluntariness.[46] In their discourse on reproductive technologies, feminists are struggling to establish a language from a woman-centred[47] perspective which speaks of human reproduction in terms of people, women's fertility, pregnancy and birth.[48]

Informed Consent

The application of any medical technique or service by a physician requires informed consent. In the arena of NRGTs, issues are often raised about whether women's "free choice" to avail themselves of any particular technique also includes fully informed consent.

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[44] Ibid., 65.

[45] Spallone, 22.

[46] Morgan., 69.

[47] Woman-centredness is defined as a branch in feminist theory which is based on a notion of women's difference and which argues for the creation of a holistic world culture. It argues that female experience ought to be a prime topic of study and a source of values for culture as a whole. Defined in The Dictionary of Feminist Theory, Humm, 1990, 239.

[48] Spallone, 7.

Is it possible for women to give informed consent if they have been strongly socialized to submit to the medical community? Or do social considerations override any personal doubts they may have, e.g. the practice of amniocentesis in India is done to determine the sex of the foetus and most often results in the aborting of female foetuses. The decision to abort female foetuses is an individual decision that is encouraged and sanctified by the societal matrix in India. The long term societal effects of the practice which will drastically alter the gender balance of the population in India has yet to be determined. It is not known what will happen when the supply of adult women of marrying age in India is significantly lower than that of men, will women become more subject to the will of men (their fathers and husbands) or will their social and class status improve as they are in increasingly in demand as wives? With the conglomeration of individual actions (i.e., choosing to abort female foetuses) resulting in such dire consequences, can women be 'informed' enough before making their 'individual' choice.

Informed consent is defined and discussed by Dan Brock in Life and Death: Philosophical Essays In Biomedical Ethics. According to Brock, obtaining valid consent requires three basic steps: a) informing the patient of their medical condition, and of the alternatives available for treating it, b) ascertaining that the patient is sufficiently competent to understand their situation and make a decision, and c) permitting the patient to freely decide about treatment.[49] However, in this doctor-patient relationship, the ethical or moral side of the decision to accept one technique over another is not addressed. Medical events

[49] Brock, Dan W. Life and Death: Philosophical essays in biomedical ethics. (Cambridge University Press, 1993), 22.

are practices concerning 'facts' involving proven techniques and medical risk management, not social implications.

The doctrine of informed consent is an important aspect of the general norms that structure the physician-patient relationship. It requires a mutual process between physician and patient of informing and discussion (whenever the patient is capable of discussion), thereby leading to a mutually acceptable treatment decision. The doctrine ought to shape in important respects the nature of nearly all encounters and decision making between physicians and patients. It is designed to provide the opportunity for the patient to become more actively involved in the ongoing decision-making process than has often been the case in medicine.[50] However, the equal status of the woman patient in the medical relationship is uncertain when generally social/political arrangements, vis-à-vis women, favour the medical professional.

The requirements of informed consent aim to ensure patients can take an active, full role in the ongoing process of decision making about their medical care, and that no treatment is undertaken that does not first meet their approval. This is not an uncontroversial view of the proper physician-patient relationship and, more specifically, of the role of patients in decisions about their health care. There is a long and strong authoritarian tradition within medicine that denies patients this role. In its more extreme form, this tradition denies any significant patient participation and leaves the ultimate choice of treatment solely with the physician.[51]

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[50] Ibid.,
[51] Ibid., 23.

The values underlying informed consent are the patient's well-being, and self-determination. Other values are served by informed consent, especially when it is viewed as an institutionalized social practice. The underlying objective of informed consent it to foster general public trust in the medical enterprise, encourages more careful scrutiny and review of those recommendations by the medical profession, thereby resulting in sounder recommendations.[52] However, in the context of NRGTs, informed consent is an easily obtained writ which leaves the medical practitioner unaccountable to the individual and to the social ramifications of the treatment.

Giving due weight to the value of personal well-being while respecting individual self-determination morally requires gaining and honouring the informed and voluntary consent of competent patients for their medical treatment. The moral ideal of informed consent expressed here is a high ideal, but one that has not been evenly reflected in the day-to-day reality of reproductive technologies and their practice. There can be little doubt that fully realizing this ideal would involve significant transformations of the values and definitions applied to women, 'normal' reproduction and infertility, as well as the traditional health care process.[53]

Following Brock, James Jans' defines informed consent as a person's voluntary agreement to participate in research, based upon adequate knowledge and an understanding of relevant information.[54] However, Jans' raises the important questions of: How much knowledge is adequate? Can we ever be sure of understanding on the part of the

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[52] Ibid., 35.
[53] Ibid., 52.

patient/participant? In the arena of informed consent, often there are no right answers.[55] Moreover, informed consent requires a physician to lay out all of the information a patient needs to have to understand a particular treatment, what the treatment itself will involve and what risks come with it. Only then can the patient exercise true autonomy. If a proposed treatment carries more risk than we think is acceptable, we reserve the right to refuse it.[56] The question arises, does informed consent have meaning if the social matrix and values by which the patient has been raised prescribes or implies certain actions in a given situation?

Bioethics

In her work Bioethics and the New Medical Technology, Margo Mabie writes that the myriad and range of new medical technologies demand that we consider far more than the medical effectiveness of a particular procedure. NRGTs call into question our traditional concept of the family and how it is created. Prenatal testing, which can detect many genetic and developmental problems in the unborn, may lead to an increase in the age-old practice of abortion. Gene therapy, by which we might intervene to reformulate the genetic makeup of future generations, is on the horizon. With the ability to foresee or fiddle with various human traits comes the worry that we will grow more intolerant of imperfection, an inherent aspect of human life.

Ethics is the area of philosophy that considers human conduct. Bioethics focuses more specifically on how the gleanings of the biological sciences are to be applied to the practice of medicine. Scientific knowledge and the medical techniques are in and of

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[54] Jans, James, "Coping with Informed Consent and Other Ethical Quagmires" in Concordia University Magazine, (Montreal: June 1996), 31.

[55] Ibid.,

themselves, according to Mabie, amoral. It is how we get and use scientific knowledge that is moral or immoral. It falls to all of us to understand the issues and frame a bioethical system for ourselves, both as individuals and as a society.[57] The bioethical positions we codify in law or regulation both reflect and shape all of the values by which our society coheres.

Bioethics has not traditionally been feminist. Women's interests are routinely discounted or ignored altogether. Sexism has been most apparent in reproductive matters, where, for example, plenty of work on abortion still proceeds without any reference to women's concerns. And when the new reproductive technologies were beginning to burst on the scene in the early 1980's, their possible impact on women seemed to be the last thing on anybody's mind. Now, despite the voluminous feminist literature on them, the mainstream debate seldom reflects issues it raises.[58]

Many of us are coming to suspect, as Susan Sherwin argues, that "the organization of bioethics reflects the power structures that are inherent in the health care field, which in turn reflects the power structures of the larger society."[59] Despite considerable progress made by women in recent years, men, mostly white, middle-class, heterosexual men, are still in charge, both in society generally and in the medical profession, and they consciously or subconsciously, choose social arrangements that reflect their perceived interests. Worse still,

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[56] Mabie, 16.

[57] Mabie, xiii.

[58] Purdy, Laura, Reproducing Persons: Issues in Feminist Bioethics, (Ithaca, NY: Cornell University Press, 1996), 1-2.

[59] as cited in Purdy, 2.

individual practitioners may still be gripped by common sexist - even misogynist - attitudes for which medical education currently provides no antidote.[60]

Despite its birth in the 'radical' 1960s, bioethics has for the most part followed a conservative and patriarchal course. Analyses sensitive to gender and other markers of disadvantage have often been rejected as uninteresting, bad scholarship, biased, ideological, or 'political,' and thus as having no place in a serious intellectual endeavor such as bioethics.[61]

Amniocentesis and chorionic villi assay, two types of genetic prenatal testing, have led many parents to seek abortions because of the presence of a genetic disorder. The number of abortions for this reason is likely to go up as more genes are isolated and located.[62] However, bioethics does not adequately consider genetic diseases that are deadly but do not preclude a meaningful life?[63] Huntington's disease is one. Dormant until sometime between the ages of 30 and 50, it then manifests itself in the loss of muscular control and intellectual capacity, and is fatal. Can a case be made for aborting a foetus with this disorder, along with Tay-Sachs and cystic fibrosis? A decision to abort that foetus suggests our desire for perfection and long life has grown so fanatical that a good first 30 years or more of life are of no value.[64] The view of aborting all imperfect foetuses makes a value judgment on the value of life. On the other hand, one may manage to live a full and

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[60] Purdy, 3.
[61] Ibid., 4.
[62] Mabie, 25.
[63] Ibid., 26.
[64] Ibid.,

meaningful, symptom-free first part of life, but that task, difficult in itself, may prove impossible if employers or insurance companies learn what one's genetic profile discloses.[65]

Other people worry that a full-blown programme of gene therapy to eliminate genetic disorders might at the same time radically alter the gene pool - the aggregate of genetic information carried by an entire population.[66] If its gene pool is diminished, the human species may be less flexible and thus less able to adapt to changes in the environment. They warn that the changes we make in our own bodies represent changes in our overall ecology.[67] That might disastrously upset the balance of nature and redirect its course. One change in the gene pool will precipitate other changes that we cannot anticipate. We understand the ideas of the ripple effect, but we have not mastered the art of forecasting it.[68] In November of 1994, Dr. John Fagan, a molecular biologist called for a 50 year moratorium on the most dangerous applications of genetic engineering and called on researchers to explore safer more productive avenues of research. Fagan underscored his concerns by announcing that he would return to the US National Institute of Health $613,882 US in federal grant money and withdraw $1.2 million US in grant proposals for research that could have been used for potentially dangerous genetic engineering application.[69]

Is technology by which infertility can be overcome any less ethical than the technology by which the farsighted are able, by the artificiality of eyeglasses, to see more

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[65] Ibid., 27.
[66] Ibid., 28.
[67] Ibid.,
[68] Ibid.,
[69] "An Ethical Stand Against Genetic Engineering," Biomedical & Health Care Ethics Resources on WWW, Centre for Applied Ethics, University of British Columbia.

accurately?[70] Every couple who have undergone the dreary process of infertility studies and any of the procedures for conception would agree that the inherent artificiality is not a compelling ethical reason to invalidate the procedures[71]

An example of a bioethical dilemma due to intervention by the technological imperative is the case of the 'orphaned embryos,' of Mario and Elsa Rios, a wealthy couple who had placed two embryos in an embryo bank, then died in an airplane crash.[72] What is to be the fate of these orphaned embryos? Should they be thrown out? Should they be adopted by an infertile couple? If they are adopted, what claims do they have on their genetic parents estate? These are examples of moral issues arising out of a widening spectrum of possibilities generated by medical technology.[73]

Feminist ethics might be taken to include discussions that:

1. Emphasize the importance of women and their interests. Stressing justice for women seems to be the minimum condition for describing any work as 'feminist'.

2. Focus on issues specially concerning or affecting women. We need to be broad-minded, in part to avoid the kind of sectarian warfare that could undermine this still-fragile enterprise.

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[70] Mabie, 36.
[71] Ibid., 36.
[72] Ibid., 37.
[73] Ibid.,

3. Rethink fundamental assumptions. Feminists need to reconsider both substantive principles and philosophical methods.

4. Incorporate feminist insights and conclusions from other fields and disciplines.[74]

Critiques of NRGTs

Critiques of NRGTs cover a broad spectrum of views which are often dissenting. The critiques include a certain section of feminist theorists, the medical community and policy makers. There is no one common view amongst feminist theorists about NRGTs and their implication for women. The feminist view points cover the complete spectrum of views of NRGTs from complete agreement, to selective use, to complete opposition and a call for banning the technologies. However, a lack of consensus amongst feminists in the early 1980s has seemed to result in a disregard for their analyses of NRGTs by the medical community and policy makers (even though these dissenting views exemplify the essence of academic debate).

In general, feminist theorists are concerned with reproductive technologies because they are controlled by malestream medicine and because they are altering forever women's experience of reproduction. These technologies also encourage women to see themselves primarily as mothers and they provide a potential means for state control of women's reproductive functions.[75] Feminist resistance to and critiques of new reproductive technologies, in particular, are part of the women's health movement, which is attempting to foster women centred health care and medical

[74] Purdy, 24-25.
[75] Williams, 4.

research.[76] Analysis of new reproductive technologies must be woman centred and focus on the impact on women's lives, bodies and the lives produced within women's bodies.

In "The Politics of the Body," Ruth Roach Pierson provides an overview of the women's movement in Canada from 1969 onwards, with emphasis on the politics over the physical bodies of women. A central concern of the Canadian women's movement since the late 1960s has been gaining control over their own bodies and their reproductive capacities, seeking to wrest control away from the state, the medical establishment, institutionalized religion, pharmaceutical companies, advertisers, pornographers, institutionalized censorship, and the violence of men.[77]

Parts of the women's movement over the last two decades have criticized the intrusion of the male dominated medical establishment and of medical technology into the 'natural' process of birthing; examples being the extremely high rates of cesarean-sections, induced labours, and episiotomy, which were performed, it was charged, more for the convenience of the male practitioner then for the health of the mother and child.[78] During this time, the movement for a return to 'natural childbirth' spread. Pregnant women took classes in techniques of breathing and pushed to facilitate delivery without anesthetics and to restore the practice of birthing at home with birth coaches and midwives.[79] At the same time, by the late 1980s, advances that women were making with the de-medicalization of birthing in some areas were matched by a growing loss of control in others resulting from the proliferation of NRGTs. This development was occurring in the absence of both carefully

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[76] Spallone, 32.

[77] Pierson, Ruth, "The Politics of the Body" in Canadian Women's Issues, Volume 1 : Strong Voices, editors Marjorie G. Cohen, Paula Bourne, Philida Masters, and Ruth R. Pierson, eds. (Toronto: Janes Loriner and Co., 1993), 98.

[78] Ibid., 102.

conducted research into the physical consequences of widespread use and informed public debate about the moral implications of these NRGTs.[80] Rather than taking measures to prevent chlamydia, one of the leading causes of infertility in women, the medical establishment was developing invasive NRGTs to 'give' fertility to women rendered infertile.[81]

At the core of all feminism - except perhaps the most aggressively deconstructionist theories - are two simple judgments. First, women are, as a group, worse off than men, because their interests routinely fail to be given equal consideration. Second, that state of affairs is unjust and should be remedied. As Valerie Bryson writes, "even in the most 'advanced' nations, it remains true that positions of public power are overwhelmingly held by men; meanwhile women as a group continue to work much longer hours than men and to receive far less financial reward, while fear of sexual violence restricts their lives and they are denied full control over their own reproduction."[82] Within this common framework, there is no one single feminist approach to the development of reproductive technologies and their regulation.

Christine Overall outlines three very broad approaches to NRGTs as conservative, liberal and feminist. The conservative point of view is exemplified by the Vatican eneydical "Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation : Replies to Certain Questions of the day."[83] It is developed from religious premises and

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[79] Ibid., 103
[80] Ibid.,
[81] Ibid., 104
[82] Purdy, 5.
[83] Overall, Christine, Human Reproduction: Principles, Practices, Policies, (Toronto: Oxford University Press, 1993), 6.

emphasizes 'traditional' moral values on men, women and human sexuality: it accents the importance of the nuclear family, heterosexuality and marriage as norms.[84] Donor insemination and contract motherhood are rejected as violating true sexual and family morality.[85] The conservative viewpoint recommends that access to NRGTs be limited to or based on marital status and sexual orientation.[86] Conservatives believe that human personhood begins at conception - thus abortion is wrong, as is embryo experimentation.[87]

The liberal point of view emphasizes the moral dignity of the individual and does not differentiate between the situation of women and the situation of men in procreative practices.[88] For liberals, human personhood is placed either late in gestational development or at birth. Thus liberals are not opposed to abortion, embryo experimentation and fetal-tissue transplantation.[89] The liberal viewpoint advocates the advancement of reproductive freedom, the right to privacy, the right to reproduce and believes NRGTs enhance reproductive rights and freedoms. Liberals evince confidence in scientific innovation and interventions in reproduction and believe access to NRGTs should be open. The liberal view relies on publicity or partial regulation provided by the free market to enhance reproductive choice - buying/selling of gametes/embryos/contract mothers.[90]

Feminists don't speak with one voice vis-à-vis NRGTs. Liberal feminists consider these technologies should be regulated to promote equal access and to protect women from their indiscriminate or unnecessary use. Radical feminists worry about the fact that these

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[84] Ibid.,
[85] Ibid.,
[86] Ibid.,
[87] Ibid.,
[88] Ibid., 7.
[89] Ibid.,

technologies are developed and implanted in an environment which is male-dominated, even woman hating. For radical feminists these technologies can only be liberating if women control them. Radical and Marxist feminists concentrate on patriarchal power reified in the ideological forces that control the deployment of technology. Socialist feminists argue that the new reproductive technologies will further oppress women as long as they are used in the context of capitalist patriarchy.[91] Notwithstanding this range of feminist viewpoints, feminist approaches usually have in common the following:

- a focus on women's lives, beliefs, values, needs,
- a concern for women's reproductive health,
- a regard for the well being of children,
- need for input on reproductive policy and ethics from all members of society, and
- a critical of view of pronatalism - the cultural endorsement of childbearing, or biological determinism.[92]

Feminists see reproductive issues as challenges within the broader context of sexism, racism, etc. Feminists criticize discrimination vis-à-vis access to NRGTs.[93] They support reproductive choice but raise questions about the conditions under which genuine

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[90] Ibid.,
[91] McCormack, 369.
[92] Overall, 8.
[93] Ibid.,

reproductive choice can be fostered.[94] Feminists see preventing infertility as more important than cures of infertility.[95]

Feminists disagree over the extent to which women's needs (re: childbearing) are socially constructed, they also disagree about the legitimate extent of reproductive choice and access to expensive techniques, i.e. IVF and surrogacy.[96] Some feminists call for a moratorium on further development of NRGTs so as to assess the threats to health of mothers and children.[97] Although feminists' firsts concern is the health and well being of women, Overall stresses, that it is not up to feminists to protect women from what is interpreted as their own 'false consciousness' and it is dangerous for feminists to claim to understand better than infertile women themselves the origins and significance of their desire for children.[98]

History of feminist thought vis-à-vis NRGTs.

Writing during in the 1970s, Shulamith Firestone and Marge Piercy, envisioned reproductive technologies to be liberating instruments which could help women achieve a non-sexist society.[99] In her work The Dialectic of Sex (1970) Firestone revolted against the nuclear family, she assumed that biological motherhood, i.e. pregnancy and childbirth, was at the heart of women's oppression. She believed that if technology replaced the core experiences of pregnancy and childbirth - hence erasing the differences between sex-roles -

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[94] Ibid.,
[95] Ibid., 9.
[96] Ibid.,
[97] Ibid., 10.
[98] Ibid., 31.
[99] as cited in Van Dijck Jose, Discontinuous Discourses: Mapping the Public Debate on New Reproductive Technologies 1978 - 1991, (San Diego: University of California, 1992), 119.

the hierarchy between the sexes would be nullified.[100] For Firestone, technology could free women from their biological destiny.

Piercy envisioned a culturally androgynous society based on feminist values, where the reproductive process occurs outside the body. For Piercy, NRGTs would help remove reproductive differences and are therefore desirable.[101] These views are troubling for many feminists as they view a woman's capacity to reproduce as a problem, rather than the way in which reproduction is valued and organized within society.[102] Feminists who disagree with Firestone and Piercy regard NRGTs as a pre-eminent instruments of male control; they view the discourse as a struggle of women against the men who have power over science and medicine.[103]

As the feminist assessment of patriarchal power changed, the emphasis in feminist criticism shifted from the institutions of power to the interrelation between medicine, politics, law and their discourses.[104] In addition, the dualistic construction of gender was replaced by a stratified concept, in which gender is intrinsically interwoven with other factors such as race and class.[105] The awareness that representation is intrinsically part of an ideological struggle results in a growing interest in the politics of representation.[106]

In the early 1980s, a group of feminists started to vocally oppose the 'capitalist takeover' of the reproductive process. In 1984, in Groningen (The Netherlands), the

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[100] as cited in Van Dijck, 1992, 120.
[101] as cited in Van Dijck, 1992, 120.
[102] Van Dijck, 121.
[103] Ibid.,
[104] Ibid.,
[105] Ibid.,
[106] Ibid.,

Feminist International Network on Reproductive Technologies (FINNRET which later in 1985 turned into the Feminist International Network of Resistance to Reproductive and Genetic engineering FINRRAGE) was founded to function as an organized discussion platform on NRGTs.[107] FINRRAGE campaigned against implementing all NRGTs because they were viewed as a threat to the lives and rights of women.[108]

The FINRRAGE manifesto, 'Test Tube Women,' was edited by Rita Arditti, Renato Duelli Klein and Gena Corea. The manifesto describes NRGTs as the instruments of oppression, that are in the hands of men and that thus may be used to control and oppress women as science is inherently patriarchal. NRGTs are viewed as pitting men against women (i.e. powerful against powerless) and women are constructed as helpless victims.[109] Klein views NRGTs as disastrous for women and argues that feminists ought to view IVF as a political issue. She argues that male scientists hold all the power with respect to both technology and politics and use this power against women.[110] FINRRAGE considered the best opportunity of fighting this conspiracy was for women to go out and learn about NRGTs, gather the facts and make these facts as widely available as possible and to translate scientific jargon into everyday language.[111]

Maria Mies opposes the assumption of radical feminists that NRGTs in the hands of women would be beneficial. Mies considers that it makes no difference which gender controls the NRGTs. Technology is invariably capitalist. Men deploy technology in the

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[107] as cited in Van Dijck, 1992, 122.
[108] as cited in Van Dijck, 1992, 122.
[109] as cited in Van Dijck, 1992, 122.
[110] as cited in Van Dijck, 1992, 124.
[111] as cited in Van Dijck, 1992, 125.

service of capitalism and use women as a resource to multiply capital.[112] The only remedy, according to Mies, is that women should resist the use of all reproductive technologies. Feminists should not even argue with advocates of these technologies, since their logics are mutually exclusive.[113]

While members of FINRRAGE published their works in journals targeted at members of their own group, other feminists tried to address a broader audience, including those professionally interested in relating science to social issues.[114]

Anita Direcks and Helen Bequaert Holms are feminists working for women health organizations; they critically evaluate IVF as a technological device and criticize the way it is 'marketed' by both medicine and journalism.[115] Comparing IVF to D.E.S., they reveal a serious deficiency in the representation of IVF in medical journals and the lay press; both present this kind of infertility treatment as a mechanical process, deliberately omitting or minimalizing the large quantities of hormones and drugs that are administered to women.[116] Direcks and Holms identify IVF as an unconditional threat to women. They, along with Corea, Klein and Mies, unequivocally view IVF as a technological arrangement, stipulated by patriarchal-capitalistic institutions.[117]

A second group of feminists in the 1980s started calling for a different view of technology, one which would allow for personal and professional interests of women to play

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[112] as cited in Van Dijck, 1992, 126.
[113] as cited in Van Dijck, 1992, 127.
[114] as cited in Van Dijck, 1992, 129.
[115] as cited in Van Dijck, 1992, 130.
[116] as cited in Van Dijck, 1992, 130.
[117] as cited in Van Dijck, 1992, 132.

a role in the definition of reproduction.[118] Noami Pfeffer reacts to 'radical' feminist views towards NRGTs as she views them as ignorant about infertility and having failed to take into account infertile women's experiences with NRGTs.[119] Radical feminists, she says, view infertile women as vulnerable to manipulation by the medical industry, and as ready to sell out women's power over their bodies in return for a baby of their own.[120] According to Pfeffer, radical and Marxist feminists are sensationalist instead of examining the reality of exploitative and substandard treatment presently offered by infertility programs. Pfeffer believes NRGTs should be evaluated on their merits as well as their disadvantages.[121] Marge Berer criticized the FINRRAGE manifesto on three counts: 1) they deploy conspicuous rhetorical tactics to sell their arguments, 2) they construct women as helpless victims, and 3) they play into the hands of religious anti-abortionists.[122]

Berer urged feminists to look for alternative modes of representation and to avoid the discursive pitfalls laid out by the dominant discourse. She noted that anti-abortionists also depicted women seeking abortions as helpless victims - the same depiction of women as the FINRRAGE manifesto.[123]

Both Berer and Pfeffer warn against a monolithic formulation of power which can easily be turned against women; allowing for differences among feminist interpretations of reproductive technologies will strengthen, not weaken a feminist standpoint.[124]

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[118] as cited in Van Dijck, 1992, 133.
[119] as cited in Van Dijck, 1992, 133.
[120] as cited in Van Dijck, 1992, 133.
[121] as cited in Van Dijck, 1992, 134.
[122] as cited in Van Dijck, 1992, 134.
[123] as cited in Van Dijck, 1992, 135.
[124] as cited in Van Dijck, 1992, 136.

Chapter 3 -The Technological Imperative

Societies with the greatest access to modern science and technology tend to be post modern, democratic and secular.[125] The knowledge made available by new scientific and technological innovations: 1) are a previously unimaginable control over life and death, 2) have a major impact on societal attitudes, values, beliefs and symbolism, and 3) have a major impact on the fabric of society including society's ethical and legal tone, and for some the spirituality of the individual and the community.

Technological Imperative

In Under Technology's Thumb, William Leiss presents the idols of technology, the false notions that have grown up around modern society's fervent commitment to technological progress. The first of these notions is that society's easy acceptance of technological innovation gives use the impression that modern conditions compel us to make our values and institutions conform with the technological innovations. Secondly, the notion that our commitment to science and technology marks a qualitative break with all previous human history; Our everyday language and culture is so saturated with technical jargon that we pay little attention to out innate drives that include an uneasiness with peoples and customs different from our own. Thirdly, in our technologically saturated society every technological breakthrough is presented as a triumph for humanity and we do not worry about the distribution of costs and benefits that attend its use. Finally, the achievements of

modern science and technology are seen as clearly superior to every earlier human approach to the investigation of natural forces. This has created an attitude of arrogant superiority toward all other ways of interpreting the human experiences of the surrounding world.[126]

Leiss offers a diagnosis of the powerful fatalism in our understanding of the relationship between modern technologies and society and proffers an attempted cure through the establishment of a firm foundation, through informed citizenry and enlightened public policy, for making choices about our future.[127]

There are those who emphasize the beneficent aspects of the impact of technology on social change, chiefly the expanding realm of personal choice and individual freedom which, it is claimed, flows from the results of technical innovation. At the other extreme, there are those who see modern technology as a corrosive force on the traditional institutions on which our society depends.[128] In Leiss' view both are fatalistic interpretations in that they regard social institutions as being forced to adjust to changes brought about by technological changes, and both ignore or play down the reciprocal influence that conflicting social interests exert on the process of technical innovation and application themselves.[129]

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[125] Somerville, Margaret A., "Are We Just "Gene Machines" Or Also "Secular Sacred"? From New Science To A New Societal Paradigm" in Policy Options Politiques March 1996, 3.

[126] Leiss, William. Under Technology's Thumb, (Montreal & Kingston: McGill-Queens University Press, 1990), 5-6.

[127] Ibid., 7.

[128] Ibid., 8.

[129] Ibid.,

Leiss states we should not use the undeniable pressure of the technological imperative, which is felt throughout all institutions in contemporary societies, as an excuse for avoiding the need to make reasoned choices about our future.[130]

Leiss's quotes Emmanuel G. Mestheme to provide an example of the notion that modern society compels us to conform our values to the latest technological developments. Mestheme writes that; "[t]echnology, in short, has come of age, not merely as a technical capability, but as a social phenomenon. We have the power to create new possibilities, and the will to do so. By creating new possibilities, we give ourselves more choices. With more choices, we have more opportunities. With more opportunities, we can have more freedom, and with more freedom we can be more human."[131]

Leiss argues that the 'rationality' of a culture's selection of techniques should be judged primarily in relation to the socially legitimated goals for individual behaviour in that culture.[132] The development and use of techniques never occurs independently of determinations of who can use them and for what purposes. Such determinations reflect and affect the social division of labour and the tempo of social change, which in western societies is a patriarchal society and rapid social change.[133] In established social patterns, techniques are almost always combined with class, status, and role determinations that specify who can

[130] Ibid., 10.
[131] as cited in Leiss, 1990, 25.
[132] Leiss, 30.
[133] Ibid., 31.

perform the operations associated with techniques and under what culturally legitimated conditions.[134]

Strictly speaking, there are no imperatives in technology. The chief mistake often made in the analyses of technological advancements is to isolate one aspect (technology) of a dense network of social interactions, to consider it in abstraction from all the rest, and then relate it back to that network as an allegedly independent actor.[135] The significance of technological innovations in human societies is an integral part of the whole cultural matrix.[136] Technology stands as the middle term between techniques and modes of social reproduction; indeed technologies may be thought of as the synthesis of the other two.[137] Technologies are by definition imbued with the values, class, status and role determinations of the social matrix. Practical and operational aspects stemming from technical innovations present an abstract capacity for action in the world; prevailing modes of social reproduction in a given society determine who can act and in what ways.[138]

From Leiss's standpoint, technologies are a mixture of techniques and social responses, therefore, the pressures of the technological imperative appear a misperception; we over-emphasize the characteristics of techniques and undervalue the dynamic aspects of the societal matrix in which they are used.[139]

The social matrix and the technique together join to form the technology. The techniques themselves are amoral. Scientific knowledge is in and of itself amoral. What

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[134] Ibid.,
[135] Ibid., 33.
[136] Ibid.,
[137] Ibid.,
[138] Ibid.,

makes the technology loaded is the mode of social reproduction with which the technique combines to form the technology. Therefore, reproductive technologies are the resulting combination of the reproductive techniques and the cultural matrix and value system within which they have developed. Reproductive technologies reflect various aspects of the societal matrix. Their development has been in response to a variety of needs or demands of the societal matrix. NRGTs are an example of techniques that have class, status and role determinations that specify who can perform the operations associated with the technique and under what culturally legitimated conditions.

Technology touches us all, in every aspect of our lives. Every artefact we make or touch or use is the product of technology; most foods have been processed by some form of technology; even raw food is grown, harvested and transported by technological means. Yet how we use technology, what technologies we think appropriate, whether a particular technology brings benefits or burdens, and to whom, whether it is useful or out of reach - is very much influenced by one's person, gender, class, race and demography.[140] Our place in the societal/cultural matrix determines what techniques we can access and the extent of our being influenced by the technological imperative.

Sue Cox echoes Leiss' analysis that the dominant way of thinking about technology equates change with progress. Technology is an inherently political phenomenon. It shapes and is shaped by existing power relations and dominant social values. The design,

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[139] Ibid., 35.

[140] Kirkup, Gill and Laurie Smith Keller, eds.; Inventing Women : Science, Technology and Gender, (Cambridge: The Open University, 1992), 1.

development and use of many technologies tends to reproduce and exacerbate existing social inequities.

Cox hypothesizes that when a society is characterized by a sexual division of labour, the impact of technological change is experienced differently by women and men. Men, who predominantly occupy the "design context" of technology, employ the decisions, materials, personnel and techniques necessary to developing or creating technology. Women typically remain in the "user context" (which includes the motives, intentions, advantages and adjustments called into play by the use of the tool or technique).[141] Cox concludes that women often appear to be the passive recipients of technological innovations which, more often than not, have little affinity for their actual needs and preferences as users. In some cases, such innovations have harmful effects on the health and autonomy of those who use them.

Through rejecting dominant ways of thinking about technology feminists activists are empowered to challenge the alluring promise of NRTs. Questioning the ways techniques, such as IVF, have been presented as purely therapeutic medial interventions designed to "help" the infertile - feminists have initiated an ambitious campaign of research and activism

Feminists have exposed many worrisome social, political and economic dimensions of NRTs, from the health hazards of fertility drugs, the traumatic experience of IVF, to the commercialization, commodification and fragmenting of reproduction and motherhood.

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[141] Cox, Sue. "Strategies for the Present, Strategies for the Future: Feminist Resistance to the New Reproductive Technologies". Canadian Woman Studies/Les Cahiers de la Femme, (Volume 13, No. 2.), 86.

Feminist activists have built a strong and often controversial case against the development and expanding use of NRTs.[142]

Aspects of the female experience have been taken over and defined as needing medical supervision. This has extended to the role of women as the bearers of children. Medicalization of the female role of gestation has expanded to include the detection of foetal genetic disease, but the techniques used and the outcomes of various tests are neither ethically nor emotionally straightforward. We become involved with the conflict between a desire for health and perfection and a partial rejection of some of the logical outcomes of prenatal screening at both broadly social and very specific psychological and emotional levels.[143]

According to Gill Kirkup and Laurie Smith Keller, an understanding of the historical and cultural relativity of modern science and technology frees us to be open to other methods and systems of thought which can now be seen as valid explanations of the world within their own context. It also enables us to see science as a product of a gendered culture and to speculate about the possibility of a 'gender-neutral' or feminist - humanist science. It gives feminists firm ground, on which to stand in order to do a job of deconstructing science. During the 1980s that ground was inhabited by a growing number of feminist theorists and feminist scientists. It is, however, important also to be able to evaluate what has been and is useful about science rather than occupy this ground simply to propose anti-science or anti-technology positions.[144]

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[142] Ibid., 87.
[143] Kirkup and Keller, 3.
[144] Ibid., 6.

Keller examines the nature of technology and its relationship to science, a debate of considerable interests to feminists. For many people technology is simply 'the appliance of science,' a view promoted through the formal teaching of technological subjects as applied science. However, if we accept that modern science is an historically and culturally specific activity, we are left with the question of whether cultures without science can have technology which is both rational and systematic. Since they patently can and do, then the relationship between technology and science is not the simple cause and effect that might be presumed. The association of technology with modern science has had negative as well as positive effects. Women have always engaged in technological activities, making containers, clothing and various domestic artefacts, but their exclusion from industrial and technical processes has caused them to be seen as non-technological and their technological activities to be redefined as art and craft.[145]

According to Keller, technology differs from science in that science is about discovering and explaining and technology is about designing and making. So technology encompasses design and method, though modern technology borrows heavily for its knowledge base from modern science. Science, for example, may investigate the properties of steel and plastics and build a body of knowledge about these materials, whereas, technology uses that knowledge, plus practical knowledge acquired in practice, to mould steel and plastic to practical ends like providing strong joists for buildings or tools for the kitchen.[146]

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[145] Ibid., 7.

[146] Laura Smith Keller in Kirkup and Keller, 25.

While medicine as a science can be seen as the application of biological theory, it is also a flexible social construct and encompasses a varied set of activities. Catherine Kohler Riessman examines how aspects of life have become defined as medical issues, accessible to medical solutions. A feminist critique of medicine argues that women's power and control over their own bodies has been removed from them, and has become a professionally guarded area of expertise for doctors who, it sometimes seems, think that they know more about what is good for women than they do for themselves. Campaigns such as the one against the automatic hospitalization of childbirth, which redefine childbirth as 'natural' rather than 'illness,' have been supported by feminists. Such campaigns are not necessarily feminist ones. Riessman describes how demands for 'scientific birth,' especially the use of pain relief, came in the nineteenth century from middle-class women who saw it as a way of taking control over the difficult process of childbirth. She is also very clear about the nature of class difference with respect to what benefits women gained from the increasing medicalization of childbirth. Self-help health groups were important parts of the women's movement of the 1970s; they disseminated information about health issues and remedies. However, Riessman suggests that this is often 'de-professionalization' of medicine rather than the 'de-medicalization' of women's bodies. She describes the whole notion of medicine as one of a 'contradictory reality' for women, in which it is important that scientific claims are treated with scepticism, without dismissing the life-enhancing, and sometimes life-saving, potential of medicine.[147]

[147] Kirkup and Keller, 76-77.

In her exploration of women and medicalization Riessman discovered that in their analyses, feminists have not always emphasized the ways in which women have simultaneously gained and lost with the medicalization of their life problems. Nor have the scholars always noted the fact that women actively participated in the construction of the new medical definitions, nor discussed the reasons that led to their participation. Women were not simply passive victims of medical ascendancy. To cast them solely in a passive role is to perpetuate the very kinds of assumptions about women that feminists have been trying to change.[148]

There are times when the interests of women from the middle and upper classes are served by the therapeutic professions, whose political and economic interests are in turn served by transforming these women's complaints into illnesses. In other words, both historically and currently, there has tended to be a 'fit' between medicine's interest in expanding its jurisdiction and the need of women to have their experience acknowledged. Riessman has emphasized that this 'fit' has been tension-filled and fraught with contradictions for women, who have both gained and lost with each intrusion medicine has made into their lives.[149]

Why has women's experience been such a central focus for medicalization? In addition to the complex motives that women bring to each particular health issue, physicians focus on women as a primary market for expansion for a number of reasons.[150] Women's social roles make them readily available to medical scrutiny. Women are more likely to

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[148] Riessman, Catherine, Kohler; "Women and Medicalization: A New Perspective", in; Inventing Women : Science, Technology and Gender, Gill Kirkup and Laurie Smith Keller, eds., (Cambridge: The Open University, 1992),123.

come in contact with medical providers because they care for children and are more likely to accompany sick children and aged relatives to the doctor.[151]

Women have greater exposure to medical labeling because of their pattern of dealing with their own symptoms, as well as medicine's response to that pattern. Women make more visits to physicians than men, although it is not clear whether this is due to the medicalization of their biological functions, 'real' illness, behaviour when ill or cultural expectations. When they visit the doctor for any serious illness, they are more likely than men to be checked for reproductive implications of the illness. They are also more subject to regular checks of their reproductive systems in the form of cervical smears or gynaecological exams.[152]

Finally, women's structural subordination to men has made them particularly vulnerable to the expansion of the clinical domain. In general, male physicians treat female patients. Social relations in the doctor's office replicate patriarchal relations in the larger culture, and this all proceeds under the guise of science. For all these reasons, it is not surprising that women are more subject to medical definitions of their experience than men. In these ways, dominant social interests and patriarchal institutions are reinforced.[153] Riessman's analysis is indicative of the fact that the social matrix and the medical system within which the techniques are applied reinforce the social matrix.

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[149] Ibid., 140.
[150] Ibid., 141.
[151] Ibid.,
[152] Ibid., 142.
[153] Ibid.,

The medicalization of human problems is a contradictory reality for women. It is part of the problem and of the solution. As women have tried to free themselves from the control that biological processes have had over their lives, they simultaneously have strengthened the control of a biomedical view of their experiences. As women visit doctors and get symptom relief, the social causes of their problems are most often ignored. As doctors acknowledge women's experiences and treat their problems medically, their problems are stripped of any political content and popular movements are taken over. These contradictions have caused women in different class positions to seek and resist medical control.[154] Societal values are not considered as an influencing factor in any medical conditions. In this manner the societal values that medicine reflects are left unquestioned. The techniques are amoral, and medicine claims to apply its diagnoses neutrally, therefore the values of the social matrix, within which the techniques are applied, are not addressed.

In Human Reproduction: Principles, Practices, Policies, Christine Overall presents a feminist view on NRGTs. Overall's work on the issue of reproductive ethics has been in part the outcome of personal experiences that turned out to have a more general political significance.[155] Our society devalues procreation and mothering, and often regards mothers as ignorant or incompetent. According to Overall, human reproduction is not merely a set of individual biological processes, nor a private family event, but is determined by and through complex social interactions reflecting cultural values about nature and the value of baby-making.[156] Overall explores the nature of women's reproductive autonomy and procreative

[154] Ibid., 143.
[155] Overall, 1993, 1.
[156] Overall, 3.

freedom and the ways in which many social norms and restrictions serve to undermine them.[157]

In Western culture, the medical establishment does not necessarily promote the best interests of women and children.[158] The scientific ideology behind NRGTs focuses on the enhancement of fertility and the view that procreation is central to, even definitive of, women and womanhood.[159] It assumes a pronatalist view that all women want to be mothers. It views the woman's body as an imperfectly functioning mechanism, whose operation can be improved and the products (babies) can be perfected.[160]

Both Leiss, Overall and Cox among others, view reproductive technologies as the powerful combination of the reproductive techniques and the societal - cultural matrix and value system from within which they have developed. NRGTs are a reinforcement of the patriarchal social matrix of our society. The technology applied in surrogacy arrangements (either AID or IVF) are an expression of the social value that views women's bodies as a baby machine, i.e., as a means of production. The commodification of women and the birth practice are an expression of pronatalism within our social matrix, specifically the cultural view that equates womanhood with motherhood.

The objectification of women is clearest in 'surrogacy' arrangements, or what could be called 'contracted gestational parenting,' where a woman is contracted to give her baby to

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[157] Ibid., 5.
[158] Ibid., 3.
[159] Ibid., 4.
[160] Ibid.,

the genetic father and his social partner.[161] The surrogate child is depicted as an object which 'belongs' to one claimant or another on the grounds of one's greater intention in initiating production. The surrogate mother is merely the gestator that produces the contracting couple's baby in their stead and could easily be seen as a mechanical womb or baby machine.[162]

The impact of the societal matrix is particularly strong in the application of cases of designer babies, choosing gametes of specific characteristics in IVF and surrogacy arrangements. For 15 years Dr. Eldon Schriock has helped infertile couples have babies. Sometimes the women he sees are impregnated through test-tube fertilization of eggs from their ovaries or from another woman's.[163] Sometimes sperm is sought from another man, in which case the couple are given catalogues from numerous sperm banks to thumb through and select male gametes from a veritable smorgasbord of donors. They can pick by height or weight, ethnic heritage or race.[164] Schriock explained "[t]hat's been standard (practice) for as long as I've been practicing and it's never made headlines. But now women are starting to pick eggs by some of the same criteria and people are shocked."[165] Richard Sheinin questions whether there are there deeper 'psycho-social, sexual issues at work in the response to human fertility issues, as Schriock suspects. Are men and women fearful of tampering with the female body, viewed as the mysterious source of life for millennia?[166]

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[161] Shanner, Laura, "The Right to Procreate : When Rights Claims Have Gone Wrong" McGill Law Journal , volume 40, No. 4, (Montreal: 1995), 853.

[162] Ibid., 854.

[163] Sheinin, Richard; "How Much Should We Intervene" The Gazette, (Montreal: January 24, 1994), F1-F2.

[164] Ibid., F1.

[165] Ibid.,

[166] Ibid.,

In 1993, two infertile black women in England and Italy chose to be impregnated with eggs donated by white women. As a result, there is troubled discussion of 'designer babies' and 'genetic engineering.' However, these choices by the women involved do not involve 'genetic engineering,' which by definition would involve the substitution of new genetic material into a man's or woman's genetic material in order to determine physical characteristics of that person's offspring.[167]

In these cases of "designer babies" what has come into play is the perceptions of these women towards the class, status and value of white babies within our social matrix. While the choices made in the cases may be disturbing Sheinin questions, and rightly so, is it the public's business to question the motives of the women in these cases?[168] The option of the creation of designer babies that NRGTs offers is not addressed by our current social values. These designer decisions result in a sense of violation of morals and values. For millennium (traditionally) pregnancy and childbirth have been viewed as the miracle of life, whereas now the miracle of life can be genetically tailored to our tastes.

It seems that people are rebelling against the sacredness of the notion of birth. It has only been in the past 100 years that medicine encroached upon childbirth, whereas previously it was the domain of women. Our prevailing social - cultural matrix is allowing techniques to be developed and the technologies to run unfettered. Reasoned debate about NRGTs considers they are working to change our social value system vis-à-vis women.

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[167] Ibid., F2.
[168] Ibid.,

The Role of Technology in the Arena of 'Choice'

Previous to the advent of NRGTs there was no need for the treatments. The techniques were developed during the same time period as the trend to the naturalization (de-professionalization) of the birthing process during the 1970s. When the post-war generation (baby-boomers) reached adulthood, they began to desire families. This generation was also economically more powerful than any before. Those that discovered they were infertile began to express a need for the recently developed reproductive techniques. The need transformed to demand as the techniques became available. In turn the demand can be described as the users expressing a freedom of choice to access the techniques. If users have a freedom of choice to access the techniques it is also perceived as the right to access the techniques. This evolution from need to the right to access the techniques is the evolution of the market for the techniques that comprise NRGTs. As with other technologies, because it exists a subsequent need for the technology develops. The mercantalization of the technology has become the rational for its development, and it has simultaneously created the imperative for its use.[169]

NRGTs are presented as if they offer a number of possibilities. The pervasive use of liberalist rhetoric to market these "services" and "products" conspicuously resembles the feminist rhetoric of choice that prevailed in the late 1980's and the early 1990's. The promotion of NRGTs that offer women the opportunity to regulate their own fertility reflects feminist arguments in the abortion debate. The free market rhetoric hides the fact that there is no choice involved in matters of high tech reproduction, unless those seeking the services are independently wealthy. In addition it renders NRGTs an issue of personal choice rather

than a collective issue.[170] It also implies that those who have sufficient disposable income (money) to pay for the NRGTs have the right to genetically linked progeny.

Choice and Prenatal Screening

Research by Wendy Farrant (1985) in Britain points to the fundamental inadequacy of provisions by the health service for women undergoing prenatal diagnosis. Farrant finds everything from emotional support to information on the medical techniques used is insufficient. These findings reduce women's autonomy and ability to make free and informed choices, even in cases in which women want the option of prenatal diagnosis.[171]

The very existence of screening programmes creates anxiety in women and further 'medicalizes' pregnancy. For instance, most women will have had no experience of neural tube defects, so being given a test for them arouses new fears. Barbara Katz Rothman (1986) describes how the very existence of prenatal diagnosis puts a woman into a horrifying dilemma. If she has amniocentesis to screen for genetic abnormalities, she must risk damaging a normal foetus, and then must decide, if something is 'wrong,' whether to abort a wanted child. Throughout the long wait for the results, she must regard her pregnancy as 'tentative' - even after she has felt the foetus move. Even a 'reassuring' result on amniocentesis may fail to allay a woman's fears, Rothman says, because it has raised the fears in the first place, and cannot pretend to diagnose all possible defects.[172]

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[169] Van Dijck, 162.

[170] Van Dijck, 190.

[171] Birke, Lynda, Susan Himmelweit and Gail Vines; "Detecting Genetic Diseases: Prenatal Screening and its Problems" in; Inventing Women : Science, Technology and Gender, Gill Kirkup and Laurie Smith Keller, eds. (Cambridge: The Open University, 1992),153.

[172] Ibid., 154.

Prenatal diagnosis also raises the fear that medical attention will be diverted from treatment, from caring for the handicapped and from research, to find the underlying causes. No longer are paediatric wards in New York filled with children with Tay-Sachs disease Rothman says, because most couples at risk are aborting affected foetuses. The result, she says, is 'privatization' of the tragedy of genetic disease. Abortion does not become an interim solution on the road to effective treatment and cure because if the loss goes unrecognized, is turned around into a solution, then the pressure is removed. This may well be a real danger, especially as government funds for biomedical research grow scarcer.

Yet prenatal diagnosis does not inevitably distort the direction of biomedical research or provisions for treatment and support for people with genetic diseases. "Prevention can lead to indifference, but this is not a valid argument for not trying to prevent the birth of children with genetic disease. It is an argument for working to prevent indifference."[173]

Rothman, along with some campaigners for disability rights, argue that prenatal diagnosis increases the social stigma of disability. Taking the pressure off society to care for less able members can lead to even less material and social support for disabled people. If a woman refuses to have the test, or refuses to abort an affected foetus, society may judge that it is she who is to 'blame' for bringing a handicapped child into the world, says Rothman. With little social support for women and families with less than 'normal' children, women are often forced to choose abortion. Rothman also argues that if women choose not to abort, the early knowledge of a defect adds nothing but anguish to the rest of the pregnancy. However, some groups advocating disability rights support the notion of screening because if

[173] Ed Yoxen, as cited in Birke, 155.

a family has decided to go on, with the knowledge of what it will entail, they may be more committed to the infant and make better parents.[174]

At the root of much condemnation of prenatal screening is the notion that it is aimed at creating 'perfect' babies. Opinions differ about who supposedly wants such perfection: is it women and families who are coerced by society, doctors driven to excess by ambition and power, or even governments in search of a 'master race'? "With new reproductive technologies, will our standards for our children rise?" asks Rothman.[175]

There is an element of truth in all these perspectives. In the short term, however, and given the enormous constraints on women, feminists must work to increase the choices offered to women to make up their own minds with the best possible information about how to manage run their own lives. Such a naively liberal argument acquires teeth if we look towards improving the social resources that would enhance freedom to choose. Access to information and unbiased counseling for women, now very limited, is a central issue. So too is the wherewithal from governments to support those affected by genetic disease.[176] "Genetic counseling" thus becomes a central issue for feminists. Feminists need to campaign vigorously in this field to influence how a woman is given information, what she is told and by whom.[177]

What about Down's syndrome itself? Many people argue that these foetuses should not be aborted, as the children seem to lead happy, if foreshortened, lives. Who is to decide? 'Selective termination' implicitly judges the value or worth of a life and the quality of that

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[174] as cited in Birke, 155.
[175] as cited in Birke, 156.
[176] Birke, 156.

life. As treatment of some conditions improve, (cystic fibrosis and sickle cell disease for instance), or our knowledge of other disorders increases (such as Down's syndrome), we need to reassess any judgments about the quality of those lives. As it is women who are most likely in our society to care for children, women are apt to consider carefully the nature of the child's life. Perhaps no individual is better placed to make such a judgment. "Science" is likely to be unhelpful in such a decision.[178]

Choice and Post-Menopausal Pregnancy

Abby Lippman considers how an arena of choice is created through technology in her examination of the rising issue of post-menopausal pregnancy. Post-menopausal pregnancy is an example of how 'new' reproductive technologies claim to 'rescue' women by seeming to offer them choice, control over their bodies and equity with men.[179] Lippman suggests that biomedical procedures may be more consistent with the oppression of women than with their liberation.[180] Technology is not neutral as it is developed within the class, social and value system of the societal matrix. Lippman aims to demonstrate how these procedures reinforce the ageism and patriarchism that underlie societal attitudes towards women, reinforce gendered stereotypes about women and even diminish possibilities for progressive social change.[181]

Aging is increasingly seen as a disease to be cured with technology. Women themselves cannot 'choose' to become pregnant after menopause, whereas physicians can

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[177] Ibid.,

[178] Ibid., 156-157.

[179] Lippman, Abby; " 'Never Too Late': Biotechnology, Women and Reproduction" McGill Law Journal Volume 40, No.4, (Montreal: 1995), 875.

[180] Ibid.,

[181] Ibid., 878.

'choose' those to whom to offer this technology.[182] This is an example of false choice, the woman in and of herself does not have the choice to become pregnant after menopause. It is the physician who chooses which women can become pregnant. Those that have the social and economic standing to access the expensive technique are the ones that the societal matrix allows to 'choose' to begin a post-menopausal pregnancy.

Technology is never neutral: when it is applied to women it is necessarily gendered in ways that reflect and support prevailing attitudes and customs. Post-menopausal pregnancy mirrors and reinforces the 'production of baby' metaphor that dominates much of the recent biomedical literature about pregnancy.[183] It partakes of a view of female aging as a disease causing agent, a view with great potential to constrain needed social changes.[184] This view inhibits the ability of society to review and modify the prevailing cultural and societal matrix.

Choice and Selective Termination in Cases of Multiple Pregnancy

The recent development of selective termination in cases of multiple pregnancy has introduced additional questions about women's reproductive self-determination.[185] Selective termination in pregnancy is a process performed in the first or second trimester in some instances of multiple pregnancy either to eliminate a foetus found to be disabled (through prenatal diagnosis) or simply to reduce the number of foetuses in the womb. By early 1989

[182] Ibid., 880.
[183] Ibid., 890.
[184] Ibid.,
[185] Overall, 45.

at least two hundred selective termination procedures had been performed around the world.[186]

In recent news stories and journal articles, some physicians and ethicists have expressed doubts concerning this procedure's moral justification and the formation of social policy governing and resource allocation for this procedure. Some commentators worry that selective termination may establish a precedent for euthanasia.[187]

Selective termination vividly illustrates many of the central ethical and policy concerns that are raised about the technological manipulation of women's reproductive capabilities. Such a problem is typical of many discussions in contemporary bioethics which abstract specific moral and social problems from the cultural context that produced them.[188]

The apparent need or demand for selective termination is in fact created and elaborated in response to prior technological interventions in women's reproductive processes, interventions that are themselves the result of prevailing cultural interpretations of infertility.[189] Deliberate societal and medical responses to the perceived problem of female infertility generate much of the need for selective termination, which is but one result of a complex system of values and beliefs concerning fertility and infertility, maternity and children.[190] According to the prevailing ideology of pronatalism, women must reproduce,

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[186] Ibid.,
[187] Ibid., 46.
[188] Ibid., 47.
[189] Ibid.,
[190] Ibid., 48.

men must acquire offspring, and both parents should be biologically related to their offspring, at almost any emotional physical or economic cost.[191]

The recent increase in the number of multiple pregnancies comes largely from two techniques used in the treatment of infertility, the use of fertility drugs which prod women's bodies into producing more than one ovum at a time, and GIFT and IVF techniques that use several eggs and embryos (respectively) to increase the likelihood that the woman will become pregnant.[192] A 'try anything' mentality is fostered by the fact that prospective IVF patients have consented to the treatment, but are often not adequately informed about the low clinical success rate.[193]

A case reported by Evens and colleagues dramatically illustrates the potential effects of these treatments. One woman's reproductive history includes three Cesarean sections, a tubal ligation, a tuboplasty (attempted repair of the fallopian tubes) after which she remained infertile; IVF with subsequent implantation of four embryos; selective termination of two of the foetuses, revelation via ultrasound that one of the remaining twins had sever oligohydramnios (a very small amount of amniotic fluid) and no evidence of a bladder or kidneys; spontaneous miscarriage of the abnormal twin and intrauterine death of the remaining foetus.[194]

The technique of selective termination in pregnancy was developed as a result of the previous technologies of IVF and GIFT. In an attempt to solve the problem of multiple pregnancy caused by the previous technological interventions, of IVF and GIFT, the new

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[191] Ibid.,
[192] Ibid., 49.
[193] Ibid.,

technique of selective termination was developed. In the case of selective termination the technique does not reflect the predominant social values and women suffer the emotional consequences of availing themselves of the technology. The technological imperative is keeping the decision, free will, in the realm of the individual. The women who avail themselves of the technology must decide whether to selectively terminate or not, they are lead to more technology and moral decisions. Whereas, the medical community and clinicians that created the problem of multiple pregnancies do not take any social responsibility for the technologies they have created. Selective termination should not be a moral or ethical dilemma for the women who avail themselves of the technology as it is a problem of the technology that the medical and scientific community ought to solve. The technique of selective termination does not reflect the values of the social matrix, as a consequence the women users suffer.

The debate surrounding NRGTs often overlook questions of why women access the various technologies, what factors lead women to take infertility drugs and/or to participate in an IVF programme? How do they evaluate fertility, pregnancy, motherhood, and children? Were they provided with support systems enabling them to understand their own reasons and goals for seeking reproductive interventions?[195] Rothman states that "[t]hey are the victims of a social system that fails to take collective responsibility for the needs of its members, and leaves individual women to make impossible choices. We are spared

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[194] Ibid.,
[195] Ibid.,

collective responsibility, because we individualize the problem. We make it the woman's own. She 'chooses' and so we owe her nothing."[196]

Technological solutions to some forms of female infertility create an additional problem of female hyper-fertility - to which the further technological solution of selective termination is then offered.[197] Women's so-called 'demand' for selective termination in pregnancy is not a primordial expression of individual need, but a socially constructed response to a prior medical intervention.[198] It is Overall's argument that it would be both socially irresponsible and unjust for a health-care system that contributes to the generation of problematic multiple pregnancies to withhold access to a potential, if flawed response to the solution.[199] Women do not seek selective termination for its own sake, or as a means to an end, but because the nature of their pregnancy forces them to choose this line of action.[200]

The drive to invent technology which can be used to control human fertility is not particularly typical of this time and age; pre-industrial societies sought means to regulate reproductive practices using infanticide, contraceptives, abortion, and ovulation rituals.[201] What is typical of this time and age is that NRGTs have expanded, at an accelerated speed, the options of humans to interfere with the process of reproduction.

Increasingly, women call upon doctors and their instruments to bring about the reproductive process, part of which can now occur outside women's bodies. The equation of need and demand, in relation to technology, is a logical fallacy. NRGTs were not developed

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[196] as cited in Overall, Christine, 1993, 50.
[197] Ibid., 50.
[198] Ibid., 51.
[199] Ibid., 52.
[200] Ibid., 53.

because they were desperately needed; after all, childlessness is not a life-threatening disease. The need for technology is never simply 'there,' but is always created, a process which is ideological rather than technical. The need is created by the pronatalism of the societal - cultural matrix. Creation of need is often based on projections of hope and/or fear.[202]

The assumption that technology is beyond ideology or culture is implied in the common perception that science and technology are exempt from social or political assessment: technology just is. However, the advent of technology can never be an explanation in itself.[203] Van Dijck's view echoes those of Leiss, Overall and Cox; that just because the technologies exist does not exempt them from proper analyses that takes into account the values of the societal and cultural matrix within which they exist.

According to Leiss and echoed by Overall, Van Dijck and others, the scope and pace of technological change have been and remain a looming presence among us, relentlessly throwing up new problems, and creating false consciousness and in turn false choices. Meanwhile, as a society we are still trying to apprehend and solve the previous generation of problems. No individual industrialized nation can insulate its economic wealth against continued challenge from innovating forces developing and becoming institutionalized elsewhere. Our institutional responses to technological developments seem somehow

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[201] Van Dijck, 7.
[202] Ibid., 10.
[203] Ibid., 11.

predetermined and thus cannot be fully guided by choice grounded in 'traditional' values or the values of our societal and cultural matrix.[204]

[204] Leiss, 7.

Chapter 4 -Reproductive Rights

Women's biological reproductive role infers a variety of reproductive rights and freedoms. However, a concept of women's reproductive rights and freedoms is an important issue that is often missing from women's rights debates. Women's rights have traditionally had the connotation of equality rights. In essence, the reproductive function of women has not been specifically addressed by our legal and judicial systems in the debates surrounding and the determination of women's rights.

The framework of the abortion rights debate was initially the framework most often used in the discussion of women's reproductive rights. However, the abortion rights debate is too simplistic to be imposed upon an issue as complex as that of reproductive rights. The abortion rights debate centres around the notion of freedom of choice. The term 'choice' arose as part of the rhetorical history of the abortion rights movement. The movement needed a regulative term, or idiograph, which would translate the narrative of illegal abortions and women's suffering into an actionable demand in the social arena.[205] The rhetoric of 'choice' expressed the pressing needs of women who were forced to get illegal abortions because they had 'no choice.' The rhetoric of 'choice' effectively enabled the articulation of women's interests in the public arena.

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[205] Celeste Michelle Condit as cited in Luthra, Rashmi, "Toward a Reconceptualization of 'Choice": Challenges by Women at the Margins" Feminist Issues, (Spring 1993), 43.

The concept of 'choice' has three serious limitations. First, the assertion of women's 'choice' in the matter of reproduction as exclusive and absolute absolves all others of the responsibility for pregnancy and children. Second, the rhetoric of 'choice' is vulnerable to political manipulation; the principles of individuality and control over one's own body have been used in the service of bourgeois individualism in the US. Thirdly, the principle of 'choice' evades moral questions about when, under what conditions, and for what purposes reproductive decisions should be made. For example, choice politics has ignored the moral and ethical issues involved in the selective termination (abortion) of 'defective' foetuses (or female foetuses in India).[206]

The adoption of a freedom of choice and a legal entitlement right for access to new reproductive technologies, and the funding required for the techniques establishes a framework that provides women the right over a product, i.e., it views the child as a product. If a couple who are infertile have enough financial resources they can hire a "surrogate mother" to bear a child for them. The couple are legally engaging the surrogate in a contract for delivery of a child. The real arrangement in essence defines the child as the product for purchase. However, only those with sufficient resources (usually upper-middle and upper class) can afford surrogacy. Also, most often it is women who have access to no other resources that market their reproductive power. Surrogacy is most often an example of class politics within the legal system.

Many stakeholders in the debate over reproductive technologies have turned to a rights based discourse to support their views. Feminist ethicists have frequently pointed out

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[206] Rosaline Petchesky as cited in, Rashmi, 1993, 45.

the assertion and protection of rights for individuals must be accompanied by recognition and acceptance of responsibilities; in the context of reproductive rights, responsibilities belonging to the state, to the health-care and educational systems, to physicians, and to individuals.[207]

The Right To Reproduce vs. The Right Not To Reproduce

Christine Overall, in Human Reproduction: Principles, Practices and Policies, argues that women have both the right not to reproduce and the right to reproduce. The right not to reproduce is defined as the right not to be compelled to beget or bear children against one's will, and the right not to have to engage in forced reproductive labour. In a weak (liberty) sense this is the right not to be compelled to donate gametes or embryos against one's will. In the strong (welfare) sense it is the right of access to abortion and other services related to contraception that enable women to avoid procreation. [208] This notion of the right not to reproduce has developed in Canada and US in the last 30 years. The choice debate arose from exercising the right to access abortion, i.e., the right not to reproduce.

In Canada, the Abortion Law (Section 251 of the Criminal Code) placed severe constraints on women's right not to reproduce.[209] Under Section 251, abortion was a crime except when the life of the mother was endangered. "Legal" abortions were defined as one performed in an accredited hospital after approval by the hospital's therapeutic abortion committee (TAC). The TAC's approval hinged on three doctors finding that the pregnancy

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[207] Overall, 12.
[208] Ibid., 21.
[209] Ibid.,

would be likely to endanger "the life or health" of the woman.[210] In effect, it stated that some women, those whose abortion requests were rejected by therapeutic abortion committees, and indirectly, those who had no opportunity to bring their requests to such a committee, had a legal obligation to procreate; it sentenced them to forced reproductive behaviour.[211] Section 251 treated abortions as a serious crime punishable by a maximum sentence of life imprisonment for the abortionist and two years for the woman.

Dr. Henry Morgentaler opened his first abortion clinic in Montreal in the late 1960s. Morgentaler has made the fight for decriminalization of abortion and access to safe abortions his life's work. Over the years he has opened clinics in Montreal, Toronto, Winnipeg and Nova Scotia. He has been arrested and charged with performing abortions a number of times and twice he has appealed conviction to the Supreme Court of Canada. The first was in 1974, at the time the Supreme Court was unwilling to rule on anything but the legal aspects of the case.[212] Mortgentaler's 1986 appeal to the Supreme Court stemmed from charges that were laid in Toronto in 1983. Morgentaler was granted an acquittal by a jury in 1984. However, the Ontario Attorney General appealed the acquittal in December of 1984. In October of 1985, the Ontario Court of Appeal handed down an unanimous decision that rejected Morgentaler's constitutional challenges to section 251. Morgentaler appealed his case to the Supreme Court of Canada, in October of 1986.

Canada's abortion law, section 251 of the Criminal Code, was struck down by the Supreme Court in January 1988. In the words of Supreme Court Judge Jean Beetz in the

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[210] Morton, F.L. Morgentaler V. Borowski: Abortion, The Charter and the Courts (Toronto: McClelland and Stewart, 1992). 27.

[211] Overall, 21.

Morgentaler decision, "[a] pregnant woman's person cannot be said to be secure if, when her health or life is in danger, she is faced with a rule of criminal law which precludes her from obtaining effective and timely medical treatment" (R.v.Morgentaler (1988) 1 SCR 30, 172).[213]

In 1988, the Supreme Court removed the Criminal Code impediments to women's access to abortion. According to the judicial decision, "Forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person" (R.v.Morgentaler (1988) 1 SCR 32).[214] However, this has not permanently removed a significant danger to woman's right not to reproduce.[215]

There is a danger that the recent expression of concerns and media discussion about the reasons for abortion in cases of genetic abnormalities may lead to renewed limitations on access to abortion.[216] There is also a growing and persistent claim that there is a need for protection of foetal life and alleged foetal rights. It has been claimed that without protection of foetal rights there is nothing to prevent abortion for the purpose of sex selection, harm to foetuses by the use of dangerous drugs, and the buying and selling of foetuses and foetal parts.[217] The call for 'fetal protection' and 'fetal rights,' are often made at the expense of a woman's right to bodily integrity.[218] There also has been growing use by anti-abortion

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[212] Morton, 76.
[213] as cited in Overall, 22.
[214] as cited in Overall, 22.
[215] Overall, 22.
[216] Ibid., 23.
[217] Ibid., 24.
[218] Van Dijck, 2.

groups of non-violent civil disobedience and of active interference in the operations of abortion clinics.[219]

In the face of these potential threats to the right not to reproduce, feminists are insistent that there is no need for the re-criminalization of abortion. No woman deliberately sets out to kill a highly developed foetus, and abortion is not sought by women for its own sake. It always remains the 'grim option'.[220]

The call for 'fetal rights' is symptomatic of a growing tendency by the judicial and medical systems to treat the pregnant woman as a potential adversary of her own fetus.[221] Changes in the language of ordinary discourse reflect this major shift. Twenty years ago it was the women's experience of pregnancy that was central. Now, the expectant mother is a woman carrying a fetus and increasingly regarded as separate, indeed somehow disembodied, from the developments in her own womb.[222] In turn, the fetus made visible through fetal images has achieved the status of a 'public fetus,'[223] a subject for judicial and medical intervention.[224]

To prevent the commodification of the foetus and foetal parts, and other undesirable uses of the foetus, there is no more need to assign personhood or rights to the foetus than there is to assign personhood or rights to blood or body parts.[225] Overall believes that instead of using criminal law to attempt to manage undesirable reproductive practices that existing

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[219] Violent civil - disobedience has also occurred, in 1992, Dr. Henry Morgentaler's Toronto abortion clinic was fire-bombed.

[220] Overall, 25.

[221] Pierson, 104.

[222] Ibid.,

[223] Barbara Duden as cited in Pierson, 104.

[224] Pierson, 104.

[225] Overall, 26.

regulations governing health care and the utilization of human tissues can be implemented. Ultimately, it will be necessary to minimize and finally eliminate the powerful underlying conditions of oppression that generate such practices as foetal commodification and sex selection.[226]

The right to reproduce is distinct from the right not to reproduce. In other words, it is independent. For Overall, the right to reproduce in the weak (or liberty) sense is the right (entitlement) not to be interfered with in reproduction or prevented from reproducing (this is at times compromised by state restrictions on where, when and how women give birth, including cesarean sections). In the strong (welfare) sense, the right to reproduce is the entitlement to receive all necessary assistance to reproduce, the right of access to any and all available forms of reproductive products, technologies and labour, including the gametes of other women and men, the gestational services of women, and the full range of procreative techniques.[227]

Non-feminist writers, such as American legal theorist John A. Robertson, defend the right to reproduce in the strong sense by claiming that it is simply an extension of the right to reproduce in the weak sense.[228] These rights would also, according to Robertson, justify compelling a contract (surrogate) mother to hand over a child to its purchasers, even against her will.[229] American attorney Lori B. Andrews, argues that the right to reproduce in the strong sense is probably founded upon the right to marital privacy. She claims this right

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[226] Ibid., 27.
[227] Ibid.,
[228] as cited in Overall, Christine, 1993, 28.
[229] as cited in Overall, Christine, 1993, 28.

protects the full range of married people's choices about both sexual and reproductive behaviour[230] and establishes NRTs as a private, not a public, concern.

As well, some feminist theorists may claim the right to reproduce in the strong sense because of a fear that otherwise access to NRTs may be treated by the state as a privilege, one to be gained only through possession of the requisite social criteria; such as being heterosexual and married.[231] However, recognition of the right to reproduce in the strong sense would create an active right of access to women's bodies and in particular to their reproductive labour and products.[232] For example, it would condone the hiring of contract mothers, and force the latter to surrender their infants after birth. Also it might be used to found a claim to certain kinds of children, i.e., of a certain sex, or genetic makeup that determines appearance or intelligence. Recognizing the right to reproduce shifts the burden of proof to those who have doubts about the technologies, and also suggests we each are owed a genetically linked child. The recognition of the right to reproduce in the strong sense could violate the right not to reproduce of some women, i.e., if their zygotes or embryos were used without their knowledge or consent.

According to Overall, a genuine entitlement to women's reproductive labour, or to buying or otherwise obtaining human infants, cannot be established. Contract motherhood, she states, entails a type of slave trade in infants, and it commits women to a modern form of indentured servitude.[233] Overall believes the potential motivation for surrogacy contracts should be reduced by making them unenforceable and making contract motherhood agencies

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[230] as cited in Overall, Christine, 1993, 28.
[231] Overall, 28.
[232] Ibid., 29.

criminal. She hopes that Canada will choose neither the legalization of contract motherhood, nor the criminalization of contract mothers. Overall believes, that we should opt to reduce the potential motivation for surrogacy contracts. This could be accomplished by making the contracts unenforceable and by rendering criminal the operation of contract motherhood agencies and the actions of professionals who participate in such arrangements.[234] It is important for Canadian social policy to resist the incursion of commercialization of reproduction and reproductive entrepreneuralism that exists in the US. Those most likely to be the service provider in surrogacy arrangements would be poor women and women of colour.[235]

At the same time, Ms. Overall states that there is no need to treat procedures, like IVF, as privileges to which access may be limited on arbitrary and unfair grounds, such as marital status and sexual orientation. While Ms. Overall cannot fully support and endorse procedures like IVF (which provides a 0-20 % chance of a live birth), she also cannot endorse the call by some feminists for a total ban on the procedure (currently access is limited to those with sufficient resources, as each attempt costs $3,500 - $5,000.)[236] Rather, without asserting a strong right to all possible reproductive assistance, we can critically examine the artificial barriers, such as marital status, sexual orientation and ability to pay, that get in the way of women's fair access to reproductive technologies.[237] We can also provide protection for women entering and participating in infertility treatment programs.

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[233] Ibid.,
[234] Ibid.,
[235] Ibid., 30.
[236] Ibid.,
[237] Ibid.,

Over the long term, Overall suggests society should be thinking about whether it is possible to incorporate high tech infertility treatments, such as IVF, into women-centred and women-controlled reproductive health centres.[238] She states that IVF should be made available to women who are fully informed and who genuinely believe they are making the right choice.[239] Overall believes women should make genuinely informed choices. This means a full knowledge of the short and long term effects, possible benefits, chances of success and failure, alternate approaches and treatments, and of the pronatalist social pressures to procreate. Her goal is to preserve and enhance access to reproductive services and techniques that benefit women while preventing further encroachments and access to women's bodies by the state and individuals.

Commenting on reproductive rights and NRTs, Laura Shanner considers procreating to be a fundamental human endeavour imbued with complex meaning. However, she is not convinced that the law is flexible enough to settle these matters in a widely pluralistic society.[240] According to Shanner it is a profound mistake to affirm a right to procreate.[241]

Shanner recognizes that the language used to shape the discussion of procreative rights tends to focus attention on certain elements. The rights model focuses on the claimant, the infertile adults seeking treatment. This paradigm distracts from other morally significant elements, such as the offspring, the clinicians, and the society in which families are formed.[242] The language used can also mask questionable attitudes that society and the

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[238] Ibid.,

[239] Ibid., 31.

[240] Shanner, Laura, "The Right to Procreate : When Rights Claims Have Gone Wrong" McGill Law Journal , volume 40, No. 4, (Montreal: 1995), 872.

[241] Ibid.,

[242] Ibid.,

medical community holds toward offspring, the status of women and the roles of doctors and patients.[243]

Debates regarding NRTs, funding for infertility treatments, and non-medical criteria for access to said treatments frequently invoke "rights to reproduce" or "procreative rights" - literally the right to have children.[244] Shanner views this right as being different from many other reproductive rights that are invoked in contraception, abortion and pregnancy management discussions.[245] Shanner argues that the claim of a procreative right to bear or beget children is not justified. She considers recognition of this claim may in turn support research into NRTs, then funding for and eventually access to NRTs.[246] The claim of legal procreative rights is a complex ethical dilemma. There are two problems with the claim. First, the distinction between positive (entitlement) and negative (liberty) rights claims means that those who need help getting pregnant must use different rights justification than those who need no help.[247] Secondly, a procreative right is claimed to be limited by the rights and interests of the future children; but a right of non-conception, of the future child, is internally contradictory.[248]

While reproductive rights are helpful in protecting the individual from undue government intrusion, Shanner concludes that the rights framework itself is inadequate and inappropriate to describe the legal and moral status of claims for assisted procreation.[249] Shanner poses a series of important questions about the right of access to NRTs: 1) Who

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[243] Ibid.,
[244] Ibid., 823.
[245] Ibid.,
[246] Ibid.,
[247] Ibid.,
[248] Ibid.,

ought to have access to NRTs and on what moral grounds should access be provided? 2) Should NRTs be a research priority? 3) Should insurance or public health programs pay for NRTs? and 4) Should NRT's be universally available (as the entitlement notion of the right to reproduce suggests)?[250]

In 1985, the Ontario Law Reform Commission (OLRC) studied the notion of procreative rights. The OLRC could not reach a definitive conclusion on whether the Canadian Charter of Rights and Freedoms guarantees a right to procreate. The Charter makes no specific mention of a right to procreate. The OLRC further observed that one of the strongest justifications to limit access to NRTs, despite equality protections, is the 'best interests of the child' argument.[251] The 'best interest of the child' argument sets up a contradictory rights argument in which the rights of the mother are weighed against the rights of the unborn child.

A negative right is a right of forbearance entailing an obligation upon others to leave the claimant alone i.e. the right to bodily integrity, the right not to be killed, and the freedom to choose one's own beliefs.[252] Most reproductive rights concerning abortion, sterilization and contraception are negative rights. A woman cannot be forced to become pregnant, have an abortion or be sterilized, i.e., a negative right implies the freedom from bodily invasion by government or the medical profession.[253]

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[249] Ibid.,
[250] Ibid., 825.
[251] Ibid., 832.
[252] Ibid., 839.
[253] Ibid., 841.

A positive right is a claim to some sort of assistance or positive support; which entails an obligation on someone else to provide goods or services required for a person to exercise the right, i.e., access to lifesaving medical services.[254] If a woman or family wishes to have assistance in reproducing; she/they must make a claim of a positive right, i.e. that she/they are entitled to a child and the state must help them bear one.[255] While there seems to exist a right to attempt to procreate without undue political interference, further argument is needed to justify a right to access to NRTs.[256] A right merely to seek help is empty without some claim either to receive help or to contract for it. When an attempt to conceive naturally has failed and NRTs are sought, a positive right of assistance is needed rather than the traditional negative right from government interference.[257]

In her discussion of the limits of the right to reproduce, Laura Purdy, asserts that human societies place tremendous emphasis on reproduction, and that pronatalism is still a powerful force in many cultures. It is generally expected that individuals will have children. Many people, and some governments, seem to feel that having children is a duty. In the United States, although there are some who believe that only the selfish fail to have children, concern about producing the next generation takes the form of a right to reproduce that says that you may have children if you are able and so desire.[258]

The strongest element in the right to reproduce, both legal and moral, is thought to be negative: individuals cannot usually be prevented from having children if they are able. The exception includes persons, such as prisoners, who are regarded as having forfeited their

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[254] Ibid., 840.
[255] Ibid., 841.
[256] Ibid., 843.

normal rights, and soldiers, who have been sent into allegedly urgent state business. Consistent with the general emphasis on negative rights (or freedom to act without interference), there are few positive rights available to help those who are experiencing difficulty exercising their right to reproduce.[259]

Many people see the moral right to reproduce as an absolute right that should not be qualified in any way. That position is, in part, a laudable reaction to past attempts to limit births among individuals and groups considered to be inferior. The justification for placing the right to reproduce beyond argument is that as this right has been denied to some in the past, one can no longer consider the possibility of limiting the right to reproduce without risking racist or sexist disaster. Seeing the right to reproduce as an absolute right thus entails a moral pessimism that considers even initially enlightened moral discussion as the first step toward a slippery slope to oppression. This refusal to discuss the morality of reproduction is also considered to be the most potentially successful way of combating prejudiced disapproval of reproduction on the part of poor women, specifically poor women of colour and of single, disabled, menopausal, or lesbian women.[260]

Yet, having children necessarily falls in the realm of morality. It affects the children themselves, other intimates, and society at large. It may be true that many calls for limits are morally untenable, but there may be justifiable limits on reproduction that need to be considered. In the end, the political dangers of asserting limits on reproduction might be great enough to out-weigh the harm that could come of unlimited reproduction. Finally,

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[257] Ibid.,
[258] Purdy, 35.
[259] Ibid.,

scientific advances and social conditions are exerting pressure to consider possible expansion of the right to reproduce. On the one hand, fans of the rapidly developing new reproductive technologies are pressing for enabling legislation, and on the other, deteriorating social conditions threaten to empty the right to reproduce of meaning for ever larger numbers of people.[261]

In his review of the public debate on NRTs in the United States, Jose Van Dijck, expresses concern with the increasing erosion of women's power to make their own reproductive decisions. The increasing availability of something, in this case the medical services of NRGTs, appears to provide the condition for claiming the 'right' to acquire it.[262] Recent accounts on IVF often interchange the notions of 'demand' and 'need.' In the 'free marketplace of choice,' reproductive technologies tend to be transformed into commodities and equated to regular material products.[263] Such an equation implies that the process of production, distribution and consumption of IVF is the equivalent of making and selling a consumer product, e.g., cars. In a consumer society, the 'right' to choose from a variety of products, for those with sufficient monetary resources, seems unproblematically transferable to medical services.[264]

As dominant rhetoric changes the emphasis from 'need' to 'right,' the most avid criticism alerting to these implications stems from feminist theorists, since the commodification of reproductive technologies has serious consequences for the status and

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[260] Ibid., 36.
[261] Ibid.,
[262] Van Dijck, 25.
[263] Ibid.,
[264] Ibid., 26.

role of women.[265] Overall, Shanner and Purdy articulate a cautious approach to reproductive rights that recognizes that the right to reproduce in the strong sense has untenable consequences; i.e., the use of women's genetic materials without their consent, and a potential debate of the rights and interests of, as yet, unborn children

Legal Reproductive Rights in The Canadian Context

Maureen McTeer, a law professor and an original member of the Royal Commission on New Reproductive Technologies focuses on the need to find a balanced relationship between technology, human reproduction and genetics.[266] New developments and experiments in the fields of NRTs build seamlessly one upon the other, and are increasingly integrated into health care systems and normalized in the public consciousness.[267] The NRTs are so complex and powerful that they challenge the integrity and definition of the human person, yet prosper virtually unregulated by the law and are largely absent from the broader public arena.[268] Meanwhile the speed and synergy of their development steadily narrows our legal and public policy options.

Many proponents of NRTs argue that their use is a matter of personal choice, and merely the enhancement of otherwise purely private reproductive acts, and should therefore not be inhibited or regulated by law.[269] There are two main reasons why such a view is inappropriate. First, the development and use of NRTs are not merely a matter of private moral conduct. Certain classes are more likely to take use, benefit or be harmed by the

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[265] Ibid., 27.

[266] McTeer, Maureen A.; "A Role for Law in Matters of Morality" McGill Law Journal Volume 40, No.4, (Montreal: 1995), 895.

[267] Ibid.,

[268] Ibid.,

[269] Ibid., 898.

technologies.[270] As well, the impact of the application of NRTs extends beyond the individual user to the society in general. Although discrimination against gender and physical disability is prohibited after the child is born; such NRTs make possible active discrimination before the child is born and as such could erode public support for the principle of equality.[271] Although the decision to terminate an unsatisfactory foetus is a personal one, the consequences of that decision are not.[272] Secondly, it is the purview of the law to maintain and enhance public order and to protect society's members from real or potential harm. NRTs have profound repercussions for individual autonomy and human rights because they significantly affect society's basic institutions, morality and sense of social cohesion.[273] However, these concerns must be balanced by the desires of some people to overcome infertility or disease/genetic anomaly in their offspring. For McTeer, the law, as the expression of public policy, is the instrument of that balance.[274]

McTeer posits that the approach to regulating NRTs needs to define the significant social interests at stake, examine how these interests are threatened by NRTs, and study how the law can intervene to protect these interests.[275] McTeer argues that this approach must be based on an enlarged concept of societal harm to allow for the protection of those most vulnerable to any abuses resulting from the research and development of NRTs, i.e., women, the physically/mentally handicapped, the disempowered and the poor.[276] Such a notion of

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[270] Ibid.,
[271] Ibid., 899.
[272] Ibid.,
[273] Ibid., 900.
[274] Ibid.,
[275] Ibid.,
[276] Ibid., 901.

harm demonstrates that the effects of NRTs reaches further than the individuals seeking to use NRTs for their own ends.

The broad understanding of societal harm will help ensure that all those affected by the use and development of technology in the field of human reproduction will have the opportunity to be heard and the legitimacy to exert real influence on public decision making.[277] McTeer's experience as a member of a Royal Commission charged with examining these very issues makes her less than optimistic that such an openness in public policy decision making can be achieved.[278]

There are others who believe that the public and not the courts should define the ethics of exploding genetic technologies.[279] Genetic technologies invade our privacy in unprecedented ways and challenge legal protections, social values, personal ethics and religious beliefs. With no social consensus about how to approach these issues, most of the decisions will get placed before the courts where judges with no particular qualification or preparation will have to decide, struggling to find some constitutional basis for resolving novel moral dilemmas.[280] The alternative is to develop sufficient public understanding to address the new field of choice through referendums and legislation; and to do so in a way that prevents the issue from being a political football like the abortion issue.[281]

The concept of reproductive rights is increasingly pervasive in the debates surrounding NRGTs. In principle there is some agreement that a level of reproductive rights

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[277] Ibid., 902.
[278] Ibid., 903.
[279] Mathews, Jessica, "Genetic Questions" The Gazette, (Montreal: June 22, 1996), B6.
[280] Ibid.,
[281] Ibid.,

exist. However, practical recognition of the right to reproduce in the strong sense is limited to those of a certain socioeconomic standing. The scientific community, that has created many of the techniques, has justified their work by citing the *United Nations Declaration of Human Rights*. Article 16 of the Declaration states that individuals have the right to "found a family." The Declaration was penned fifty years ago. The context within which it was written was a post-war world. At the time freedom from oppression was a primary concern, not the freedom to justify advanced medical techniques whose developments and capabilities at the time would have seemed Orwellian.

Chapter 5 - Chronology of Canadian Reproductive Technology Policy

The chronology of Canadian policy concerning NRGTs dates from the late 1980s. From that time, to the current attempts at policy development a number of policy options and development techniques have been employed. All of which have been in response to public influence and debate. The federal government is seeking to find a policy response to a public debate on NRGTs that has called for governance in both regulatory and prohibitive form.

On February 24, 1988, a Private Members Bill C-284 was introduced in Parliament by Liberal MP Sheila Copps. The aim of the bill was to amend the Criminal Code to include commercial surrogate relationships.[282] This was the first Canadian legislative act regarding new reproductive technologies.

Canadian Coalition for a Royal Commission on New Reproductive Technologies

The Canadian Coalition for a Royal Commission on New Reproductive Technologies conducted a two-year, large-scale, intensive lobby effort to influence the government to create a Royal Commission on New Reproductive Technologies.[283] The Coalition's members were a nation-wide coalition of women's groups, health groups, other groups and many

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[282] McCormack, 362.

[283] Eichler, Margrit. "Frankenstein Meets Kafka: The Royal Commission on New Reproductive Technologies," in Gwynne Basen, Margrit Eichler and Abby Lippman eds., Misconceptions: The Soical Construction of Choice and the New Reproductive and Genetic Technologies, Volume 1. (Hull: Voyageur Publishing, 1993), 196.

individuals.[284] In April 1989, the federal government announced in its Throne Speech that as a main thrust of its social policy for that session a Royal Commission on NRTs would be created. It was not until the fall of 1989 that the federal government appointed the Royal Commission on New Reproductive Technologies.

Appointment of the Royal Commission on New Reproductive Technologies

Established by an Order in Council on October 25, 1989, the Royal Commission on New Reproductive Technologies was mandated 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."[285] The Commission on New Reproductive Technologies was chaired by Dr. Patricia Baird, a paediatrician and geneticist from Vancouver. The other Commissioners included, Dr. Bruce C. Hatfield - private practitioner, Martin Hébert - lawyer, Dr. Grace Marion Jantzen - lecturer of Religion, Maureen McTeer - lawyer, Suzanne Rozell Scorsone, Director of the Office of the Catholic Family Life Archdiocese of Toronto, and Dr. Louise Vandelac, professor of sociology. The mandate obliged the Commissioners to jointly engage in the actions that would enable them to report their findings to the government.

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[284] The groups inlcuded: Canadian Advisory Council on the Status of Women, Canadian Association for Research in Home Economics, Canadian Abortion Rights Action League, National Action Committee on the Status of Women, Patient's Rights assocxiation, Planned Parenthood Federation of Canada, Provincial Advisory Council on the Status of Women, Reproductive Alternatives Society, Vanier Insistute of the Family, Women's Inter-Church Council of Canada, as well as Advisory Councils/Committees on the Status of Women from every province and other women's groups.

[285] The Royal Commission on New Reproductive Technologies Proceed With Care; Final Report of the Royal Commission on New Reproductive Technologies, Volume 1, (Ottawa: Minister of Government Services, Canada1993), 3.

The Commission was plagued with criticism from the outset. According to a number of critics there were serious problems with the Commission:

- an undemocratic structure was established by the Chair, which prevented commissioners from participating meaningfully in discharging their duties and which resulted in anomoic staff relations;
- a manipulative public participation process was instituted which gave the appearance of public participation while precluding genuine participation on the part of many; and
- the research process was cloaked in secrecy and rigidly controlled. The Chair treated the research as her unilateral responsibility, rather than that of the Commission as a whole - while failing to maintain the normal standards of Canadian social science research.[286]

The Commission was tightly controlled by the Chair, Dr. Baird. According to Margrit Eichler, Baird was determined, against all opposition, to carry through her autocratic decision-making. This was made possible by a federal government that went to extreme lengths to back up the Chair at times when serious challenges were posed.[287]

Four dissenting Commissioners (Hatfield, McTeer, Hébert and Vandelac) requested a meeting with the Chair of the Commission and the Clerk of the Privy Council, Paul Tellier, in August 1990 to discuss their concerns about the handling of the Commission. At the last minute the Chair did not attend and gave no explanation. Previously, in correspondence the

[286] Eichler, 197.

Clerk of the Privy Council had indicated that "commissions of inquiry stand, or fall, independently from the Government."[288] Shortly after the meeting, the federal government took the unprecedented step of appointing two new Commissioners, Bartha Marie Knoppers and Susan McCutcheon (thereby disempowering the four dissenting Commissioners who no longer constituted the majority of Commissioners), and changed the original Order-in-Council, so as to grant exclusive decision-making authority to the Chair. The Commissioners remained responsible for producing a final report even though they were deprived of their rights under the Public Inquires Act. The federal government's unexpected changing of the original Order-In-Council, is unique in the history of Royal Commissions in Canada. The federal government actively interfered with the internal workings of the Commission and its final report. The purpose of Royal Commissions of Inquiry is to put the discussion and research of issues of importance to society beyond the political realm, to publicize group sentiments on a national basis and to formulate national objectives. The government's action frustrated the meaningful research and genuine public discussion of the issues raised by science and medicine's new-found ability to create, manipulate and alter human life in the laboratory, by retroactively legitimating the undemocratic actions of the Chair.[289]

In December of 1990, the four dissenting Commissioners (Hatfield, McTeer, Hébert and Vandelac) threatened to sue the Commission because they felt it was ignoring some of the issues pertinent to its mandate. The Commissioners were fired by the government shortly after their suit was launched. The controversy then subsided. Their views as to the

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[287] Ibid., 198.

intended scope of the Commission have been all but ignored. Maureen McTeer, a former Commissioner, released an opinion document, The Tangled Womb, in 1992, in an effort to raise the pertinent issues she felt the Commission was avoiding. The concerns of the fired Commissioners were that the Commission was not studying the implications of the technologies as they affect women's lives, health and physiological well being.

The concerns about the research programme of the Commission stem from the fact that there had been three research directors during its four years. The first of which, Dr. Susan Mann of Ottawa University, was not appointed until eight months into the mandate when the research programme had already been established by the Chair, and stayed with the Commission for only three weeks.[290] Further cause for concern was the fact that two research contracts concerning the role of pharmaceutical companies were held by Burson Marsteller, the largest public relations firm in the US, whose other clients include the Pharmaceutical Association and many of the largest manufacturers of pharmaceuticals in North America.[291]

The Commission was granted two extensions to its mandate. Originally, the Commission was to report in October 1991, they were granted an extension to October 1992, at which time they were granted another extension to June 1993, and then a fourth extension to November 1993. While the Commission continued its work during the extensions, research and development of NRGTs continued at an alarming rate and in a policy void.

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[288] Letter from Paul M. Tellier to Maureen McTeer, July 13, 1990 as quoted in Eichler, 200.
[289] Eichler, 200.
[290] Ibid, 216.
[291] Ibid,. 217.

Many Canadian women were anxious to see if the Royal Commission on New Reproductive Technologies' report examined the technologies from a woman-centered perspective and would become an instrument of social change that would influence policy and ensure women control their own reproductive rights and freedoms. If the Commission's report was not able to assist in the establishment of a policy foundation for new reproductive technologies many critics considered that the future, as influenced by these unregulated technologies, would have distinctly dystopian possibilities.

Notwithstanding the controversy surrounding the administration and research standards the Royal Commission filed its final report in November 1993. The commission spent four years and $28 million during their investigation. The report, which made 293 recommendations, was released two years after the intended date of the final report. It urged the government to act quickly to legislate the rapidly evolving science, and business of human reproduction in Canada. They also stressed the necessity of criminal laws rather than voluntary restraints.

Final Report of the Royal Commission on New Reproductive Technologies

The Royal Commission's, two volume final report Proceed With Care, and fifteen volumes of research reports was submitted to the government on November 15, 1993. The recommendations of the Royal Commission on New Reproductive Technologies can be summarized in three recommendations:

1. Certain reproductive and genetic technologies are not in the best interests of Canadians, and should not be practiced in Canada.

2. Certain other practices are acceptable, but they should be highly regulated.
3. The prevention of infertility is an important health concern, and steps should be taken to reduce the incidence of infertility in Canada.[292]

The report recommended that the federal government establish a regulatory and licensing body, a National Reproductive Technologies Commission (NRTC), under which licensing would be required for the provision of reproductive technologies to people. The report also recommended five areas of regulatory responsibility in which the provision of the services would be subject to compulsory licensing through five sub-committees established for that purpose. The five areas of regulatory responsibility are:

1. sperm collection, storage, and distribution, and the provision of assisted insemination services;
2. assisted conception services, including egg retrieval and use;
3. prenatal diagnosis;
4. research involving human zygotes (embryo research); and
5. the provision of human fetal tissue for research or other specified purposes.[293]

The report further recommends the establishment of a sub-committee with primary responsibility in the field of infertility prevention, i.e. research into the causes of infertility, the promotion of cooperative research efforts, public education and other options for preventing and reducing the incidence of infertility.

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[292] Talking Points on New Reproductive Technologies, July 31, 1995.

In the "Preface from the Chairperson" with which each of the 15 research volumes opens, Dr. Baird commented that living at the end of the twentieth century we face unprecedented choices about procreation. This echoes the technological imperative where the simple existence of the technologies, provides us with the choice and then the right to access them. Baird recognized however, that "[o]ur responses to those choices - as individuals and society - say much about what we value and what our priorities are."[294] Baird stated that some technologies, e.g., assisted reproduction, are unlikely to become a common means of having a family. This is a tacit understanding of the reality that our ability to access and obtain NRTs is determined in part by our socioeconomic standing and that fertility issues affect various groups within society differently. Baird also stated that other techniques, such as ultrasound during pregnancy, are generally accepted and utilized widely. What Baird failed to mention is that we do not know what the long term iatrogenic effects of NRTs may be.

According to Baird, "it is clear that opportunities for technological intervention raise issues that affect all of society, in addition access to the technologies depends on the existence of public structures and policies to provide them. The values and priorities of society, as expressed through its institutions, laws and funding arrangements will affect individual options and choices." The technological interventions are imbued with the values of our societal matrix. The technologies are a reflection of society and also affect society. There is a socioeconomic basis to access granted by society to these technologies. If the

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[293] Royal Commission on New Reproductive Technologies. Proceed With Care: Final Report of the Royal Commission on New Reproductive Technologies (Ottawa: Minister of Government Services Canada, 1993), xxxiii.

[294] Baird, Patricia, "Preface from the Chairperson," in the Research Reports of the Royal Commission on New Reproductive Technologies, 1993.

market forces perceive a need for the technology they will create the service. However, only those who have sufficient economic resources can access the technologies. The values and priorities of society are expressed not only through its institutions, laws and funding arrangements but also through the technologies themselves. Only technologies that reflect the dominant ethos will be developed and accepted. The technologies mirror society's values and priorities back upon itself and affect individual options and choices.

With the advent of the Royal Commission's report, the stakeholders began to focus on what policy direction and approach the federal government would chose to manage NRGTs. Meanwhile, the procedures continue to be applied and develop in a policy void. The government must recognize that instituting regulations, whether stringent or strict, will be difficult as a culture of laissez faire predominates in the field re: regulation. The classic issue in public policy is that there is often a chasm that develops between the intent of the policy and the result of its implementation. The practical problems of rendering public policy theory into an applied policy practice and attaining the desired results is very difficult. The intent and the final product are often dissimilar.

Federal Government NRGT Policy Process

- Phase 1 - Voluntary Moratorium, July 1995
- Phase 2 - Bill C-47 - prohibitive measures - July 14, 1996
- Phase 3 - proposed regulatory framework - discussion document : New Reproductive Technologies: Setting Boundaries, Enhancing Health

Phase 1: Voluntary Moratorium on Nine Practices

On July 27, 1995, (twenty months after the release of the Royal Commission's Report) the Health Minister, Diane Marleau, announced that the government agreed with the three summary recommendations (general principles) of the Royal Commission on New Reproductive Technologies. As an interim measure, while they developed policy, the government announced an interim voluntary moratorium on nine practises that raise serious ethical and social problems and concerns:

- sex-selection for non-medical purposes;
- commercial pre-conception or "surrogacy" arrangements;
- buying and selling of eggs, sperm and embryos;
- egg donation in exchange for *in vitro* fertilization (IVF) services;
- germ-line genetic alteration;
- ectogensis (creation of an artificial womb);
- the cloning of human embryos;
- formation of animal-human hybrids by combining animal and human gametes; and
- the retrieval of eggs from cadavers and foetuses for donation, fertilization or research.[295]

The statement by the Health Minister, issued at the time, highlighted that the government is committed to ensuring that the new reproductive technologies reflect the

[295] Talking Points on New Reproductive Technologies, July 31, 1995

ethics and values of Canadians and that those Canadians who are most affected are protected.[296] The federal government believes the (unfettered) use of reproductive technologies threatens human dignity, and does not reflect Canadian values. Furthermore they noted "the creation of life should not be a business."[297] As for some clinicians creating life is already a profitable business, this is an idealistic view.

The Health Minister indicated that the government's call for a voluntary moratorium is an interim measure, designed to assuage concerns while a permanent management regime is developed in consultation with the provinces and stakeholder groups. [298] The interim measure is a first step towards a permanent management regime for these technologies. The government referred to a comprehensive approach that will include other elements developed in the coming months. The comprehensive approach has three phases, 1) the Voluntary Moratorium, 2) Bill C-47 - prohibitive legislation, and 3) a proposed regulatory framework. This comprehensive approach includes a reproductive and sexual health framework, which would have the prevention of infertility as one of its components. The announcement of a framework to prevent infertility is expected to be announced during the fall of 1997.

To encourage compliance with the moratorium the government took a number of steps: they announced that no federal department or granting agency would provide funding to individuals or organizations that engage in these practices; and the Minister of Justice wrote to provincial and territorial Attorney Generals expressing his support for the moratorium and raising concerns about the roles of lawyers as agents or brokers in

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[296] Health Canada: New Release "Health Minister Calls For Moratorium On Applying Nine Reproductive Technologies and Practices in Humans" 1995-57, July 27, 1995, 1.

[297] Talking Points on New Reproductive Technologies, July 31, 1995

commercial surrogacy arrangements.[299] The government stated then that they expected a high level of voluntary compliance with the moratorium as they consider that most people working in the field have high ethical standards.

The government's expectation that there would be a high level of compliance with the voluntary moratorium was naïve. It seems out of context for the government to issue a policy statement and then to generalize about the ethical standards of those working in the field affected by the voluntary moratorium. It is an illogical view; if we believe they have high ethical standards, then they will have a high level of compliance with the moratorium. This statement is reflective of the perennial problems of policy formation, how does the intent of the policy as expressed in policy statements actually come to fruition. What are the desired goals of the policy, and what are the actual effects of the policy?

The government recognized that are many different options for permanent management regimes in the field of NRGTs. They also recognized that the complexity of the issues are compounded by the fact that jurisdiction is shared with the provinces.[300] The government recognized that with the complexity of NRGTs the policy process would take "some time."[301] Throughout the NRGT policy development process the amount of time that has passed seems to be of little concern to the policy makers. However, as regards an issue so determined and defined by technological developments the passage of time has many serious implications on the technologies themselves and the policy process. The perception of which technological processes are normal or acceptable increases as time passes. We live

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[298] Health Canada: New Release, July 27, 1995, 1.
[299] Ibid., 2.
[300] Talking Points on New Reproductive Technologies, July 31, 1995

in a society that views technological advancements as positive. Therefore, as more time passes without any policy regulating new reproductive technologies the public's acceptance of advancements in the field increase as, overall, they view technology as a good. In turn, it becomes increasingly difficult for the policy makers to draft policy to regulate technological processes that have existed unfettered in society for some time (in the case of IVF since the early 1980s). The government must negotiate a difficult path as their policy process takes time, but they are also aware that scientific progress must not come at the expense of human dignity.[302]

Madame Marleau's stated that the government is committed to ensuring that those Canadians who are most affected are protected[303] This indicates that those who choose to avail themselves of the technologies require protection. Considering NRGTs are most often used by choice, it begs the question whether the government considers those who avail themselves of NRGTs are making uninformed choices instead of making choices with proper informed consent. The techniques are not equally accessible to all. Due to their high cost, access to and use of NRGTs is limited to those who have sufficient financial resources to be able to afford the techniques.

The announcement of the voluntary moratorium and the comprehensive approach, indicated by Madame Marleau, implies that the government is aware of the complexity of the issues. The fact that the Minister noted that it is important both to manage these technologies, and to protect the reproductive health of all Canadians, is indicative of a desire

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[301] Ibid.,

[302] Speaking Notes for the Honourable Diane Marleau Minister of Health, News Conference announcing a voluntary moratorium on new reproductive and genetic technologies. National Press Theatre July 25, 1997., 3.

to take pro-active measures and in the long run limit our increasing reliance on new reproductive technologies.

Fertility clinics from Montreal to Vancouver stated "they'll continue to buy and sell human sperm" and a Toronto clinic said it would continue to offer surrogacy arrangements despite the voluntary moratorium.[304] In an interview, Marleau stated that the reaction was not unexpected as it is the commercial trade of the clinics that is at stake. Eike Kluge, a professor of bio-medical ethics at the University of Victoria said the moratorium was motivated by politics rather than ethics. She considered it to be an ill-considered, politically correct response. Kluge sees no problem with selecting the sex of babies or paying women to bear babies.[305] The National Association of Women and the Law (NAWL) felt the scheme of voluntary compliance fell short of the type of enforcement mechanism that is required of the government. NAWL was concerned about the moratorium on the sale of sperm because sperm banks are one of the few ways for lesbians to obtain sperm for artificial insemination. Marleau acknowledged the need for a safe supply of sperm for donor insemination and suggested publicly managed sperm bank may be the answer.[306]

In January 1996, an Advisory Committee on the Interim Moratorium on NRGTs was established to monitor compliance with the moratorium. Chaired by Prof. Sheliah Martin, a law professor at University of Calgary, the Advisory Committee was put together under the auspices of Health Canada and reported to the deputy minister. With no power to discipline or enforce the voluntary moratorium the committee discovered that people will not give up

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[303] Health Canada: New Release, July 27, 1995, 1.

[304] The Canadian Press, "Battle brews over baby, sperm sales: Marleau promises fight against clinics" The Ottawa Citizen, July 29, 1995, A4.

certain practices voluntarily. The voluntary moratorium was not powerful enough to limit the action of those who want to profit in the arena of human reproduction. In the spring of 1996, Dr. Patricia Baird stated she did not believe the moratorium was working. She hoped the legislation the government had announced was pending would be broader in scope than the moratorium.[307]

At the time of the moratorium, Health Canada reported there were at least two clinics in the country that offered parents preconception sex selection. As well, in the period between the moratorium and the tabling of the legislation a University of Toronto student newspaper carried a classified ad seeking a white female, between the ages of 23 and 32, who was willing to donate (sell) her eggs for money.[308] The moratorium forbids the retrieval of eggs from cadavers and foetuses for donation, fertilization and research. It does not mention the retrieval sperm from a corpse. However, in 1995, two young Canadian widows asked that sperm be surgically removed from the bodies of their husbands so that they could attempt *in vitro* fertilization. Senior policy analysts at Health Canada recognize that practices can emerge at any time that were not previously foreseen due to the rapidly evolving nature of reproductive technologies.[309] For this reason the scope of the legislation was expected to be expanded beyond that of the voluntary moratorium.

Although health care falls under provincial jurisdiction the federal government can act to protect public health and safety. The federal government had considered amending the Criminal Code of Canada, but Health Minister David Dingwall, stated in an interview in the

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[305] Ibid.,
[306] Ibid.,.
[307] McIlroy, Anne. "Ottawa to regulate baby trade" The Globe and Mail, Monday, April 8, 1996, . A1.

spring of 1996, that they believe that separate legislation on new reproductive technologies is a better way to deal with a complex issue.[310]

Phase 2: Bill C-47 - An Act Respecting Human Reproductive Technologies And Commercial Transactions Relating To Human Reproduction

Tabled in the House of Commons by health parliamentary secretary Joe Volpe on June 14, 1996, "Bill C-47 - An Act respecting human reproductive technologies and commercial transactions relating to human reproduction," the legislation prohibits 13 unacceptable uses of new reproductive and genetic technologies (NRGTs). The Act "...prohibits the use of certain reproductive and genetic technologies in relation to human beings as well as certain commercial arrangements relating to human reproduction."[311] The comprehensive legislative framework would serve to protect the health and safety of Canadians who use or are affected by these technologies, it would ensure the appropriate use of reproductive material and protect the dignity and security of Canadians, especially women and children.[312]

The objects of the Act are:

(a) to protect the health and safety of Canadians in the use of human reproductive materials for assisted reproduction, other medical procedures and medical research;

(b) to ensure the appropriate treatment of human reproductive materials outside the body in recognition of their potential to form human life; and

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[308]Ibid.,

[309]Ibid.,

[310] Ibid.,

[311] Bill C-47 - An Act respecting human reproductive technologies and commercial transactions relating to human reproduction. Tabled by Health Minister Diane Marleau in the House of Commons on June 14, 1996,

[312] Health Canada News Release - 1996-44, Ottawa, June 14, 1996, Comprehensive National Policy on management of New Reproductive and Genetic Technologies Proposed., .1.

(c) to protect the dignity of all persons in particular children and women, in relation to uses of human reproductive materials.[313]

Of the 13 practices that the Act will prohibit, eight are derived from the voluntary moratorium introduced in July 1995 (indicated by an *) and five that were identified since the moratorium. The prohibited practices include:

- Sex-selection for non-medical purposes;*
- Buying and selling of eggs, sperm and embryos,* including their exchange for goods services or other benefits, but excluding the recovery of expenses incurred in the collection, storage and distribution of sperm, ova and embryos for persons other that a donor;
- Germ-line genetic alteration;*
- Ectogensis (maintaining an embryo in an artificial womb);*
- Cloning of human embryos;*
- Creation of animal-human hybrids;*
- Retrieval of sperm or eggs from cadavers or foetuses for fertilization and implantation, or research involving maturation of sperm or ova outside the human body;*
- Commercial pre-conception or "surrogacy" arrangements;*

[313] Bill C-47 - An Act respecting human reproductive technologies and commercial transactions relating to human reproduction., June 14, 1996, 2.

- Transfer of embryos between human and other species;
- The use of human sperm, eggs or embryos for assisted human reproduction procedures or for medical research without the informed consent of the donor(s);
- Research on human embryos later than 14 days after conception;
- Creation of embryos for research purposes only;
- Offer to provide or offer to pay for prohibited services.[314]

The ninth element of the voluntary moratorium that was not specifically included as one of the prohibited elements of the legislation; 'egg donation in exchange for *in vitro* fertilization (IVF) services'; is protected under the second prohibited practice of 'buying and selling of eggs, sperm and embryos, including their exchange...'

The proposed legislation is based on the power of criminal law and details enforcement in cases in which the Act is contravened. Under section 8 of the Act, any person who contravenes Bill C-47 is liable to a fine not exceeding $250,000 or imprisonment for a term not exceeding four years or both on summary conviction, and is liable to a fine not exceeding $500,000 or imprisonment for a term not exceeding ten years or to both on conviction on indictment.[315]

When the legislation was tabled, Dr. Patricia Baird stated that the government had shown leadership, but highlighted the fact that a licensing and regulatory body is still

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[314] Health Canada Fact Sheet -Ottawa, June 1996, Human Reproductive and Genetic Technologies Act - Prohibited Practices, 1-2.

[315] Bill C-47 - An Act respecting human reproductive technologies and commercial transactions relating to human reproduction., June 14, 1996, 5.

needed.[316] Whereas, Dr. Murray Kroach, a fertility doctor at a private clinic in Toronto, called the proposed law narrow minded. Dr. Kroach predicted clinics would find ways around the legislation by importing human eggs or sperm donated by American men and women, who are still paid for their services.[317]

The Act would prosecute scientists, doctors and infertile couples who violate the ban. However, Canadian women who act as surrogates would not be liable. Health officials have indicated their intent is not to punish the poor and vulnerable who find themselves in such arrangements. Those who donate sperm, ovum and embryos and receive no fee or exchange for the services they provide would not be prosecuted.

Bill C-47 passed second reading on November 5, 1996, and was sent to the Standing Committee on Health. A sub-committee was struck and began reviewing the legislation in the spring of 1997. The sub-committee was chaired by Bonnie Hickey (St. John's East, Lib.). The committee members were Colleen Beaumier (Brampton, Lib.), Keith Martin (Esquimault - Juan de Fuca, Ref.), Carolyn Parrish (Missisauga West, Lib.), Pauline Picard (Drummond, B.Q) and Joseph Volpe (Eglinton - Lawrence, Lib). The committee met eight times, two *in camera* sessions and six public meetings. Witnesses from the various stakeholder groups presented briefs at the public meetings that were held between March 13 and April 14, 1997. The Standing Committee reported to the House of Commons on April 16, 1997.

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[316] Moysa, Marilyn. "Rent-a-womb ban violators could face 10 years in jail" Montreal, The Gazette, Saturday, June 15, 1997., A17.

[317] Ibid.,

The amendments made to Bill C-47, by the Standing Committee on Health, were minor cosmetic changes that clarified the language used in the Bill. The language of Section 5, subtitled "Payment of surrogate mothers" was altered to clarify the notion of surrogacy and is now subtitled "Payment for surrogacy." Section 6 which prohibits the purchase and sale of "ovum, sperm, zygote, embryos or foetus" was expanded to also include "...or any part thereof." This serves to reinforce section 4 (g) that prohibits the use of gametes from foetus.' A subsection was added to section 6, that allows for consideration for the donation of sperm during the three year period following the coming into force of the Act. This is an interim measure to help ease the adjustment to compliance with section 6 for clinics and research facilities that routinely compensate sperm donors for their time. The elements of the Act reflect concern over commodification. The amended Bill C-47 was submitted, on April 16, as a working copy for the use of the House of Commons at the Report Stage.

On April 27, 1997, Prime Minster Jean Chretien requested that the 35th parliament be dissolved and a federal election was called for June 2, 1997. Bill C-47 was one of the pieces of legislation that died on the Order Paper when parliament was dissolved.

In June 1997, former Justice Minister, Alan Rock was appointed Minister of Health. It is now the decision of the government and the Minister of Health to decide whether to stay on the same policy course and re-table Bill C-47 during the 36th Parliament, or whether they will take adopt a new vision of how to establish a proper regulatory mechanism to govern reproductive and genetic technologies in Canada.

Phase 3: Proposed Regulatory Framework: New Reproductive Technologies: Setting Boundaries, Enhancing Health

At the same time Bill C-47 was tabled the Minister of Health released a discussion document titled "New Reproductive and Genetic Technologies: Setting Boundaries, Enhancing Health." In the discussion document the government recognized that the interim voluntary moratorium "has not been completely effective."[318] Reports of non-compliance by individual practitioners and fertility centres were received. The discussion document introduced the third phase of the government's NRGT policy development process and proposes a regulatory regime for public comment.[319] The regulatory structure, possibly in the form of an agency, would be established to develop national standards for the uses of reproductive materials in medical research and practice, issue licenses and enforce compliance with the legislation. The proposed structure would also maintain information registries and health surveillance systems on various aspects of NRGTs.[320] The proposed agency would be separate from Health Canada and would report to the Minister of Health.

Non-legislative elements, such as a Framework for Sexual and Reproductive Health are also being developed. The prevention of infertility is one of the areas addressed within the overall context of sexual and reproductive health.[321] It is very difficult in a field so influenced by a technological imperative to have legislation that covers all possible technologies. Long term management and future amendments to any legislation in the field will be required. As well, the government is examining the implication of a more open system of information sharing in egg, sperm and embryo donation that would protect the

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[318] "New Reproductive and Genetic Technologies: Setting Boundaries, Enhancing Health". June 1996 Minister of Health, 5.

[319] Ibid., introduction.

[320] Health Canada News Release, June 14, 1996, 2.

vulnerable and recognize, as a priority, the well-being of children. To expand upon the legislative provisions, the government will also work with provinces and territories, non-governmental organizations and the public to examine the place and future direction of prenatal diagnosis and genetics in Canadian society.[322]

The regulatory framework recognizes that the federal government has a role in safeguarding the public health and safety of Canadians, but that the provincial and territorial governments have jurisdiction in the delivery of health care. The proposed regulatory component would permit any province or territory to develop its own regulatory regime on an equivalency basis should they so desire.

The federal government's approach to management of NRGTs has two components: outright prohibition of unacceptable technologies through legislation; and development of a legislated regulatory regime to manage acceptable technologies.

The legislative framework set out by the Ministry of Health is based on several guiding principles: the need to balance individual and collective interests; protection of the vulnerable; the appropriate use of medical treatment; and accountability.[323] The final legislative package on NRGTs will deal with collection, processing, distribution and use of human reproductive and genetic materials and fetal tissue in the provision of medical procedures and the conduct of medical research. The legislation is intended to protect the health and safety of Canadians, to ensure the appropriate treatment of human reproductive

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[321] "New Reproductive and Genetic Technologies: Setting Boundaries, Enhancing Health"..8.
[322] Ibid.,
[323] Ibid.,.6.

materials, and to protect the dignity and security of all persons, especially women and children[324].

This third phase of the government's NRGT management regime is the most complex - the development of a regulatory component that would be introduced in a second bill to Parliament which would amend the prohibitions legislation (when it is re-tabled in Parliament and becomes law). The federal government has required a phased in implementation as it must consult with provincial and territorial governments, and other stakeholders to reach a broad consensus. This approach has been criticized by stakeholders who consider it would have been better to start with the regulatory component, and then work towards the prohibitive component.

[324] Ibid.,.

Chapter 6 - Conclusion

The development of a public policy to effectively manage and regulate NRGTs is a difficult task. Ideally an effective policy would include a woman-centred approach to reproduction and be characterized by: better primary health care, preventative programs to educate the public about causes of infertility, screening for pelvic inflammatory diseases, securing a higher standard of hygiene and nutrition for women, and recognition of the negative effects of environmental factors could decrease infertility (and the demand for new reproductive technologies).[325] Most infertility in the world is preventable according to the World Health Organization (WHO).[326] WHO estimates that for every live birth achieved through IVF, if the amount of money spent on treatment had been put towards infertility education, 100 women could be prevented from becoming infertile.[327] IVF is promoted as a cure for infertility and a means of avoiding genetic defects, while the medical and social causes of fertility problems and congenital conditions are being ignored. Some feminist theorists believe NRGTs are the wrong approach to the wrong question. They believe our focus should be on determining the causes of infertility and preventing it instead of supporting the notion of obligatory fertility through expensive technologies.

According to Leiss and others, the scope and pace of technological change have been and remain a looming presence among us, relentlessly throwing up new problems while we

[325] Ibid., 27.
[326] Spallone, 32.

are struggling to understand, solve and adequately address the older ones. No individual industrialized nation can insulate its economic wealth against continued challenge from innovating forces. Our institutional responses to date seem somehow predetermined and thus cannot be solely guided by choice grounded in the values of the prevailing societal matrix.[328]

Considering the characteristics of many of the new reproductive technologies, e.g. the poor success rate of IVF (0-20% chance of a live birth), the high costs that only the economically well off can afford, the possible health risks, the (at times) impersonal treatment that women who undergo many of the techniques suffer, and the pronatalist view of society, the raison d'être of reproductive technologies should be questioned and re-evaluated. A re-assessment of the reproductive technologies is especially important as they involve the manipulation of gametes and embryos and could alter forever our concepts of motherhood and identity, and could have the dystopian result of societies where populations are control by eugenicists via women's wombs.

On the one hand, it is true that society is still intensely pronatalist. It is quite likely that many women (and men) have children because 'it is the thing to do,' and only 'misfits' fail to reproduce. Undoubtedly, that same pronatalism together with the pressures on women to provide genetically related children for their husbands, leads some infertile (and fertile) women to seek conceptive help. Pronatalism should be eradicated, because having children without a genuine desire for the experience of childbearing and a vivid understanding of the sacrifices required to be a good parent in a society so unsupportive of human welfare will

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[327] CRIAW, 1990, 8.
[328] Leiss, 7.

likely lead to much suffering. It is unfortunate, but possibly true, that women would often be better off economically, both individually and as a group, if fewer women reproduced.[329]

On the other hand, Purdy believes that even in the absence of pronatalism many women would continue to want children. A special closeness arises from being children's primary caretaker and witnessing their gradual development into persons. In addition, some individuals' ties to their children are the strongest and most enduring human connections they will ever make. As long as we think human survival desirable, these interests are likely to unite into a desire, sometimes an extremely intense desire, to be involved in childbearing. For many people, a genetic link is an essential element in their desire for children. It is true that this wish is not particularly rational, and it may sometimes be morally questionable, in cases where experimental NRGTs are employed and the reproductive products of others are purchased. Nonetheless, it can be a powerful desire. In addition, it is important to remember that some of the factors that thwart its satisfaction may be a result of morally dubious social policies.[330]

Feminist theorists have struggled to define "reproductive choice," how NRTs can work to erode rather than enhance women's reproductive choice, how these technologies offer women choices that are new and sometimes dangerous choices; how critics are also concerned in light of fetal rights campaigns and increasing pressures to produce "perfect" babies, that NRTs may eventually close off women's abilities to refuse various kinds of technological interventions. Technological interventions are becoming increasingly common in 'normal' childbearing practices, whether the repeated use of ultrasound during pregnancy,

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[329] Purdy, 78-79.

mandatory prenatal diagnosis using amniocentesis for women over the age of 35, or the increased use of cesarean sections, it is becoming increasingly difficult for women to choose not to avail themselves of these technological interventions that may have iatrogenic effects.

During the public hearing of the Royal Commission on NRTs, feminist critics were presented as 'Luddites' willing to grant women choice only with respect to the politically correct technology of abortion (the National Action Council on the Status of Women's (NACSW) briefing to the Commission called for a halt to the opening of any new IVF clinics).[331]

The long-term goal of many feminist theorists is to shift the existing balance of power to enable women to have meaningful involvement in designing and developing appropriate social and technological responses to reproductive and health-related decisions while attempting to raise political awareness and consciousness.[332] The long term strategies must include proposals designed to address problems arising from the ways in which NRGTs are currently being used and/or regulated. The short-term goal is to slow the introduction of technologies that are likely to reproduce or exacerbate existing social inequities by developing and implementing proposals for more appropriate technologies.

A new and more positive paradigm would start from the assumption that reproductive policies must consider social repercussions of the technologies and focus on both fertility and infertility. The paradigm ought to be based on ethical systems which emphasize a developmental and holistic model of the mind/body, the moral accountability of institutions,

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[330] Ibid., 79.
[331] Cox,. 87.
[332] Ibid., 87-88.

and a more collective model of child-caring that would include the notion of an extended family.[333]

Fertility and infertility must be conceptualized as natural stages in the life cycle, and, considering the life span, people can expect that during major parts of their lives they are in phases of infertility or sub-fertility. Men's sperm production also changes with respect to physical health, environmental factors, age, and other elements. The bonds of affection men and women develop for each other which are expressed in sexual intimacy are imperfectly related to their stages of fertility.

Based on these broad principles Thelma McCormack proposes a set of feminist guidelines for public policy:

1. The de-medicalization of infertility.
2. Accessibility to NRGTs should not be contingent on the nuclear family.
3. Clinicians should be facilitators and not gatekeepers. Current practices, with respect to non-coital reproduction, create two classes of women: those who do not need permission to bear and those who must meet some sort of social criterion (the latter give up a substantial part of their privacy and their right to control and manage their reproductive processes) and any non-medical restrictions should be removed, as this would go a long way toward restoring women's self-confidence and self-esteem damaged by the stigma of childlessness.

[333] McCormack, 370.

4. No encouragement should be given to the uses of genetic technology to determine the gender of foetuses.[334]

According to McCormack, these constitute minimal tentative guidelines for developing public policies on reproductive technologies which would be consistent with a woman-centred approach to the management of NRGTs. In summary, the new reproductive technologies may only serve a small minority but the interest and strong feelings they arouse suggest that they serve as a text for the projection of our fears about the misuses of science and technology. We are no longer confident that science is liberating and women, in particular, have been critical of its methods and direction. New reproductive techniques are not anti-woman but modern social history, which is the sum experience of our patriarchal society, is more problematic. It is essential that public policies be formulated carefully and with regard for those most effected by them, i.e. adults of childbearing age.

For feminists that apply the notion of an entitlement to reproduce, the reproductive rights debate implies that the product of the reproductive services is perceived as property. As the debate revolves around property issues, the courts would be involved in resolving the disputes. This results in the commodification of the women providing the services and the babies attained as a result of purchasing the services. Recognizing the entitlement right to reproduce can alter society's primal definition of motherhood and children. This change can take place without their social consideration or consent.

Moral and ethical issues that embody the values of our society are not always best determined by the courts. The courts are institutions that by their nature reflect the

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[334] Ibid.,.371.

patriarchal social matrix and may not always allow for complete debate and discussion of all pertinent aspects of issues as complex as NRGTs. Issues of moral and ethical concern that can alter the societal status quo have in the past been determined, in Canada, by a free vote in the House of Commons (e.g., capital punishment). In the case of abortion there is currently no legislation. Many stakeholders consider that for the issue of abortion no legislation is the best option, as developing legislation and soliciting public views to implement a pro-choice policy may increase the activity and influence of anti-abortion groups. A common concern is the NRGT policy process not remain in a policy void, as abortion now does in Canada.

The debate about the appropriate policy options for NRGTs in Canada continues. Some stakeholders consider that the government has been granted an opportunity to re-evaluate its approach to determining NRGT policy and drafting legislation as Bill C-47 failed to become law before the election writ was dropped in April 1997.

The public hearings of the sub-committee on BillC-47 were held in the spring of 1997. They were an essential opportunity for various stakeholder groups to respond to the proposed legislation. Having had the Royal Commission's public hearings, and final report, the interim voluntary moratorium and hearings on the proposed Bill C-47 a synthesis of views amongst some stakeholder groups is taking place. Recognizing it is difficult to fathom there would ever be a consensus on a policy issue as contentious as NRGTs, important commonalties and views are beginning to arise. As well, many groups reiterate the recommendations of the RCNRT for a commission/regulatory agency to allow for discussion, regulation and licensing of these complex issues in a rational and effective manner.

The areas in which there is emerging consensus amongst stakeholder groups are: a call for a representative regulatory agency before legislation is developed, separate legislative treatment for reproductive and genetic technologies, the importance of the recognition of equality rights in all legislation on NRGTs, a concern about the criminalization of various practices and an overall recognition of the influence of the pace of technological development and its implications on the policy development and implementation.

NRGT policy developed by the federal government must find a balance between encouraging medical scientific research in the field while protecting human rights (McTeer). The government must 1) provide a publicly funded national body with the mandate to regulate, research, discuss, educate and offer public-policy options (as recommended by the Royal Commission) and 2) ensure whatever legislation is developed identifies the key values and principles to be protected, i.e. equality rights of women and children. The national body ought to be representative of all stakeholder groups and have a regulatory and monitoring capacity.[335] It should foster a public discussion of developing appropriate legislation to manage, regulate, and is some cases restrict, the NRGTs. It should exemplify a return to a more patterned view of justice that accounts for needs and other human capacities as well as productivities. The national body must ensure that proper focus is given to health protection and disease prevention strategies to address the known causes of infertility and limit our increasing reliance on NRGTs. If social problems were addressed the social matrix and values it contains would be examined.

[335] Feminist Alliance on NRGTs, presentation to the Sub-Committee on Bill C-47, April 1997.

There is consensus among some policy advocates groups (legal and feminist organizations) calling for separate legislative treatment of technologies related to reproduction and genetics, recognizing that prenatal genetics, i.e., prenatal diagnosis and prenatal screening must be considered with reproductive technologies. The unknown repercussions and iatrogenic effects posed by genetic technologies are of a different nature than those posed by reproductive technologies. The technologies are usually be applied in different contexts and by different practitioners. As well, the emerging genetic technologies are of a wider scope. They will affect the lives of more Canadians and will raises ethical issues of comparable if not greater magnitude.

The clash of the rights of the collectively vis-à-vis the reproductive rights of the individual are a hallmark of the NRGT policy debate. Sheilah Martin, Chair of the Advisory Committee on the Interim Moratorium, the National Association of Women and the Law (NAWL) and the Feminist Alliance on NRGTs (FANRGT) want to ensure the preamble and objects clearly emphasis equality rights. The prohibitions and other NRGT policy developments should be done in the name of the equality interests of women and children. Emphasizing equality rights will help ensure the individual rights are not attained at the expense of others. As the notion of reproductive rights is a more recent development, it is not likely that legislation can adopt the language of reproductive rights until there is a clear understanding of all that it may entail. Therefore, the (relatively) older, more accepted, notion of equality rights can provide the protection for women and children that is needed in NRGT legislation. Clear indication of the importance of equality rights may sustain these prohibitions in the face of constitutional challenges to Bill C-47 or future legislation that

aims to limit access to NRGTs. Sheilah Martin would like to have the policy focus on matters relating to equality rights, by diverting the focus away from individual rights or freedom in terms of reproductive practice or research it can be justified if the group rights caveat is in place.[336] It is expected that limitations of access to NRGTs will be challenged on the grounds of individual rights to reproduce and freedoms. A statement of Canadian equality values may help the public understand the nature of Bill C-47 and future legislation.

The criminalization of prohibited practices under Bill C-47 is of concern to stakeholders, from the medical and legal communities as well as feminist organizations. Such policy would criminalize medical scientific research, doctors, scientists and lawyers. It would also subject certain reproductive decision making and choices by women to the sanctions of criminal law. It is seen as limiting the freedom of the many. The medical and legal communities are concerned that it will limit scientific inquiry (Canadian Bar Association) thereby decreasing the size of the scientific market and economic opportunities in the field in Canada. Feminist organizations are concerned about the impact of criminalization on women's reproductive autonomy and whether women who are the most disadvantaged would be criminalized. Those supportive of the need for a criminal law recognize it is intended to be a power of last resort. As well they focus on the principal of criminal justice that the sanctions applied must be in proportion to the seriousness of the offense.

The NRGT policy development challenge is to find a balance of encouraging medical scientific research in the field while protecting human rights. A national regulatory body

[336] Martin, Sheilah, presentation to the Sub-committee on Bill C-47, April 1997.

representative of all stakeholders must be established, which can assist in the development of regulation in the field of NRGTs and has the power where necessary to recommend criminal prohibition where necessary.

It must be recognized that technologies are only tools. The issue of importance is how Canadian society can ensure our values and principles are protected and respected and have appropriate protection provided to the most vulnerable. The challenge in policy development is that the issues and developments of NRGTs are going to become increasingly complicated over time. The technological developments and our increasing reliance on a rights based discourse makes attaining public policy solutions difficult. NRGT policy development requires rational discussion and careful formulation of policy and legislative options involving stakeholders.

The recent policy development approach of step-by-step legislative action will almost certainly be overtaken by events (as is evidenced by the fact that the cloning issue that arose in the spring of 1997 would not be covered by the proposed prohibitive BillC-47). A policy approach that starts with prohibitive measures would require rapid amendment with each new technological development. By nature a legislative system adapts at a pace that is much slower and can never match that of scientific and technological development.

As controversial as its management was, the Royal Commission on New Reproductive Technologies began the arduous task of canvassing public and stakeholder opinion on NRGTs in Canada. This inventory of public opinion on NRGTs is the building block upon which the results of the public response to the voluntary moratorium, Bill C-47 and the regulatory discussion paper have been added. A synthesis of opinion is developing

out of this long process. The reasoned opinions collected in the past eight years are the foundation from which legislative and regulatory acts can be drafted.

Canada is at least 15 years behind England and France in the development of NRGT policy. The current challenge to the Canadian government is to proceed with action based on a common recognition that has been identified through extensive soundings of Canadian and international expertise and viewpoints. The common recognition is that the government must shepherd is NRGTs is a technologically driven field of inquiry that gets more complicated and difficult as time passes and that all edicts must assert the equality rights of women and children to ensure they are not disadvantaged.

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Appendix

SIGNIFICANT EVENTS IN THE HISTORY OF WOMEN'S REPRODUCTIVE RIGHTS.

1800's	Artificial insemination is practiced. In 1884 a case was reported where artificial insemination was performed without the knowledge or consent of the woman involved
1960s	The sexual revolution drives a movement to decriminalize abortion in Britain, US and Canada
1968	Dr. Henry Morgentaler begins to perform abortions in Montreal.
pre1969	Canadian women could not legally get information on or prescriptions for artificial contraceptives since both banned by the Criminal Code
1969	Prime Minster Trudeau legalized public distribution of contraceptives, therefore dissemination of information about contraceptives is no longer illegal in Canada
1969	Federal Omnibus Reform Bill, Abortion law reformed. Abortion legal in accredited hospitals with Therapeutic Advisory Councils, 3 doctors, then allowable in cases where a woman's "life or health" were endangered. "The state has no business in the bedrooms of the nation." CMA and CBA were working for the reforms.
1970	Dr. Morgentaler arrested for the first time
1970	Abortion Caravan leaves Vancouver for Ottawa to pressure the government to decriminalize abortion
early 70s	public concern arises over safety of the Pill and IUD - Depo Provera was given to Canadian women with mental and physical infirmities although it was never licensed in Canada (as recently as 1992 women were being offered Depo Provera as birth control)
1973	Dr. Henry Morgantaler charged with performing illegal abortions in Montreal
1973	Roe vs Wade decision by US Supreme Court (is considered to have caused the start for the anti-choice campaign that continues today)
1974	Quebec Court of Appeal overturns Dr. Morgentaler's acquittals by juries, sentenced to 18 months

1974	Dr. Morgentaler appeals to Supreme Court
1975	Supreme Court rejects Dr. Morgentaler's appeal, ruling on the law not politics Morgentaler is sentenced to 18 months in prison.
1976	Further charges against Dr. Morgentaler results in an acquittal; and the Attorney General of Quebec declares safe medical abortions in free standing clinics legal in Quebec.
1978	1st IVF baby is born - in England, with technology developed by Steptoe and Edwards.
1981	Joe Borowski wins the right to challenge Canada's abortion law. Supreme Court granted standing to challenge the constitutional viability of the law, as he believes it violate the right to life of the unborn.
May 1983	Dr. Morgentaler opens clinic in Winnipeg, charges are laid before the Toronto clinic opens
June 1983	Dr. Morgentaler opens clinic in Toronto, charges are laid within 2-3 months
1985	1st child genetically unrelated to uterine mother born.
1985	OLRC report released
1986	P.E.I bans TAC (Therapeutic Advisory Councils) and becomes the 1st pro-life province.
1987	Ontario. A foetus is declared a child in need of protection and therefore apprehended, done by apprehending the woman who was around it.
May 1987	Baby R case, a woman in a Vancouver hospital refuses a Cesarean section, the obstetrician knowing she is on welfare has the child legally apprehended after its birth. The Provincial Court ruled the unborn child had been in need of protection and further recommended the infant be kept in custody.
1987	1st sex selection clinic in Canada opens in Toronto.
1988	January, Section 251 of the Criminal Code is struck down by the Supreme Court in the Morgentaler case.
Summer 1989	Dodd and Daigle the first cases of paternal injunctions heard and decided.
1989	Dr. Morgentaler opens a clinic in Nova Scotia and is charged with violating a provincial law that bans abortions outside of hospitals.

1989	The Royal Commission on New Reproductive Technologies is struck. Headed by Dr. Patricia Baird.
November 1989	Conservative government introduces Bill C-43. Both pro-choice and anti-choice groups are against the legislation. The Bill died on the order table in May 1990.
Fall 1991	Dr. Morgentaler's application to the Local District Health Council in Ottawa to establish a teaching abortion clinic is shelved.
May 1992	Dr. Morgentaler's Toronto clinic is fire bombed.
1993	Final Report of the Royal Commission on New Reproductive Technologies is released, after a 2 year delay.
1994	Ontario removes full medical coverage for IVF except in cases where both fallopian tubes are blocked.
July 1995	Voluntary Moratorium on 9 practices announced by Health Minister Diane Marleau
Spring 1996	Advisory Committee established
June 14, 1996	First reading in the House of Commons of Bill C-47- An Act respecting human reproductive technologies and commercial transactions relating to human reproduction. Tabled by Health Minister David Dingwall.
Spring 1997	The House of Commons is prorogued as an election is called. Bill C-47 falls of the order paper, it had not reached 3rd reading in the house.
June 1997	Alan Rock appointed as Health Minister