Weaving “Birth” Technology into the ”Value and Policy Web” of Medicine, Ethics and Law: Should Policies on ”Conception” Be Consistent?

Margaret A. Somerville*
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Abstract

The introduction consists of three stories: the Chinese story, the Australian story and the Bangladesh story.

KEYWORDS: conception, technology, ethics
SECTION 15. REPEALS

Acts or parts of acts inconsistent with this Act are repealed to the extent of the inconsistency.

SECTION 16. APPLICATION TO EXISTING RELATIONSHIPS

This Act applies to surrogacy agreements entered into after its effective date.

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† The author dedicates this article to her mother, Gertrude Honora Gasley, and her father, the late George Patrick Gasley, with gratitude for life.
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† Due to the transdisciplinary and international nature of this article, citations to legislation, cases outside of the United States, and medical journals, are in the citation form appropriate to the particular forum or discipline.

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The introduction consists of three stories: the Chinese story, the Australian story, and the Bangladeshi story. Together they were seminal to the formulation of the query, "Should Policies on "Conception" be Consistent?" In exploring this question, it became apparent that there was the interrogatory description of the activity contemplated by "wearing 'birth' technology" into the "value and policy web" of medicine, ethics

1. The decision as to the preferable terminology to use in the area to be discussed in this paper is a difficult one. This is the case because certain usages have developed that are well understood, but are not precise. For instance, "birth technology" has tended to become a term of art and to be employed to describe the area in general, but this is only one form of reproduction technology. After consideration, the terminology adopted is "reproduction technology," as the general term, and "pro-reproduction technology" and "anti-reproduction technology" as more specific terms. Then, within these latter terms, even more specifically still, one can speak of "pro-conception technology" and "pro-natal technology" and "anti-conception technology" and "anti-natal technol...
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and law," which explains the origins of the title to this article.

Before turning to the stories referred to above, three preliminary matters need to be mentioned. First, it is intended that the term "conception policy" should include all pro-reproduction or anti-reproduction policies, attitudes and values, as manifested or implemented by the regulation or use of pro-reproduction or anti-reproduction technology. Further, this term is meant to include all forms of surrogate motherhood, whether or not it involves the use of technology, and whether such techniques are applied prior to, at or after fertilization.

Second, while the full range of reproduction technology is discussed in this paper, the focus is on how "birth" technology can be integrated both within the general area of reproduction technology and with the wider institutions of society and of the law. This approach is adopted because, although anti-reproduction technology remains controversial, its ethical and legal ramifications have been much more fully explored than have those of "birth" technology. This remains true al-

ogy," respectively. Thus, for example, while both abortion and sterilization are anti-reproduction technologies, the term "anti-natal technology" would be appropriate to describe abortion, but not sterilization, which would be more accurately described as anti-conception technology, although its ultimate effect is also anti-natal. This scheme of terminology is demonstrated diagrammatically below and some interesting comparisons can be seen:

Reproduction Technology

Anti-Reproduction Technology

Anti-Conception Technology (e.g. sterilization)

Anti-natal Technology (e.g. abortion; selective reduction of multiple pregnancy)

Pro-Reproduction Technology

Pro-conception Technology (e.g. IVF)

Pro-Natal Technology (e.g. embryo transfer; intra-uterine fetal surgery; caesarian section)

It should be noted that some pro-reproduction technology (for example, artificial insemination by donor (AID)) is both pro-conception and pro-natal, in terms of both definition and effect. In contrast, while any anti-conception, anti-reproduction technology is necessarily anti-natal in effect, it does not fall within the definition of anti-natal technology. Further, this diagram would need to be expanded to accommodate "pure" research as compared with clinical research or "practice." This could be done by adding the word "research" after technology wherever it appears. Finally, it needs to be explained that for stylistic reasons, pro-reproduction technology (that is, pro-conception and pro-natal technology collectively) are referred to in this text as "birth" technology.

2. I am indebted to Dr. Stuart Spicker, of the University of Connecticut School of Medicine, for bringing to my attention the matter of my differing use, in this paper, of each of the terms consistency and inconsistency, and for his general review of this paper.
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though recently new anti-reproduction technologies, such as the "abortion pill," selective reduction of multiple pregnancy, and the emergence of "uses" for the aborted fetus, for instance, as the source of tissues for transplantation, are raising new and critical issues.

Third, consistency can be sought, or inconsistency identified, at many different levels and from many different perspectives. These include the intention or aim motivating any given conduct; the basis and structure of the analysis undertaken; the policy and approach adopted; the principles applied; and the outcomes which result, in particular, whether these outcomes were accidental or intentional. The presence of this variety of levels and perspectives needs to be kept in mind throughout the following discussion as it moves through them. Moreover, both this movement and these levels may not always be, and sometimes cannot be, identified precisely.

Fourth, there can be a fine line between characterizing certain matters as inconsistent or simply labelling them as different. There is an important distinction between these terms. The characterization of inconsistency usually connotes some obligation to try to achieve consistency, whereas a label simply of difference usually does not. Then, should opposites (such as black and white) be classified as inconsistent with each other or as consistent opposites? This raises the issue of whether there are some matters with respect to which it is inappropriate to assess consistency. There may also be degrees of inconsistency or consistency, which can be described in terms of a continuum starting, at the one end, with deep inconsistency, continuing to superficial inconsistency, then to superficial consistency, and ending with deep consistency. However, the intention here is not to investigate these abstract philosophical concepts. Rather, the above explanation, as a whole, is intended to convey a warning, that could be summarized as: there may be inconsistency in the use of the terms consistency and inconsistency in this paper. 4

A. The Chinese Story

A story appeared in the brief announcements of international news, under a caption indicating its origin as "Peking (UPI)." It
stated: "Chinese researchers say they have perfected a sperm treatment method enabling sterile men to father children. A woman who was artificially inseminated gave birth in March, it was reported yesterday." 3

At first glance, it seems amazing to think that a country, with one of the most coercive population control programs in the world, 4 is concurrently undertaking a program of research to promote fertility. Clearly, this story raises the issue of the consistency or inconsistency of some of our policies, in terms of their being pro-reproduction or antireproduction, as exhibited by our research into and use and regulation of modern reproduction technology. Such an enquiry touches on issues relating to fertility and sterility, children, the family, natural and artificial means of conception, and avoidance of conception or of birth.

It has become increasingly apparent that, often, what we are dealing with in our medical-ethical-legal dilemmas, are pieces of a puzzle which, eventually, will have to be fitted into an overall structure or, sometimes, several different structures if we are to evolve finally, a coherent, composite picture. It should be noted that the word coherent and not consistent is used deliberately in the previous sentence. Something may be coherent, but not consistent. That is, consistency may not always be an aim, or even a possibility, but when inconsistency is present it needs to be coherent. Stated another way, we need first to articulate and acknowledge that inconsistency may sometimes be tolerable, or unavoidable, or perhaps rarely, even desirable. Second, when inconsistency is present, we need to identify and to deal with it expressly.

We need, also, to recognize that consistency or inconsistency in any situation can be by chance or design. Two related issues will be considered in this respect: whether there is any obligation to attempt to remedy inconsistency resulting from chance, and to try to achieve consistency, and whether, and if so, when, deliberate inconsistency is acceptable. These general questions cannot be addressed in the abstract because the answers will vary depending on the situation. But, formulating them raises sensitivity to the fact that we need to examine any

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4. S.L. Isais, Reproductive Rights (1983); An International Survey (1982-83) 14
COLUM. HUM. RTS. L. REV. 311, 318 (1983); S.L. Issues: Incentives and Population
5. I am indebted to my colleague, Dr. Ollu S. Martines, Faculty of Medicine,
McGill University, for this observation and for other helpful comments concerning
terminology.

consistency should be an aim is a different question from that which asks whether we need to be aware of its presence. Further, it may well be that in exploring our laws to determine whether or not they are consistent, we will discover new and valuable insights.

B. The Australian Story

One of the health care services provided by the Australian Federal Government is known as ITPAS, the "Isolated Patients Travel Assistance Scheme." This scheme provides that persons in the "Outback" of Australia, who need medical care, can receive reimbursement for the costs of their travel to a center where that care is available, provided that the particular treatment has been given a claim or item number by the relevant State Department of Health. This number is also the one used by physicians to obtain reimbursement from the government for providing the treatment. (It should be mentioned here that Australia has, to a very large extent, a socialized health care system.) While there were claim numbers for abortion and for tubal ligation and vasectomy procedures, there were none for clinical in vitro fertilization (IVF) treatment. It is not clear whether this was because the procedure was considered too experimental to be supported by state funds allocated for standard medical care; whether the Government was indicating some disapproval of this procedure; whether the anti-reproduction procedures were considered necessary health care and IVF was not (although other pro-reproduction procedures, for instance, reversal of tubal ligation or of vasectomy by micro-surgery, have claim numbers3); or whether this omission was an attempt to avoid, as much as possible, a political "hot potato." The major inconsistency here, has to do with the large amount of funding that the Australian Government has provided for research on, and clinical application of, IVF and related procedures. This would indicate that the failure to include IVF within the health care scheme and as a result, within the "travel fund," while including anti-reproduction procedures, does not necessarily imply that the government has an anti-natal policy. What other factors could explain this inconsistency? Is it that although Australia does not have an anti-natal policy, it also does not have a pro-natal one? Or is it that although IVF and embryo transfer, like reversal of sterilization, are pro-natal, there are other objections to its use, relating to either the means used or its implications and symbolism, which result in an ambivalence with respect to its use, that is reflected in this differential funding? Or could the explanation be a pragmatic one, that there are many more couples wanting to use IVF than can be accommodated and, therefore, it would be simply adding to the problems and cost of "birth" technology units to give access to these "less available" persons, who by their mere presence would increase the demand for services already in short supply? This, of course raises questions of equal rights. But, it may be that this situation does not involve a denial of rights — unlike, perhaps abortion or sterilization where these procedures are needed to protect the health of the woman — but a failure to confer a benefit.*

C. The Bangladesh Story

A "population control" expert from the Research Triangle in North Carolina, who was responsible for a family planning program funded by the United States government in the areas of Bangladesh and Egypt, casually mentioned during a discussion of her work that a large sum of money had just been spent to build a micro-surgery unit in Bangladesh for the reversal of sterilization implemented through tubal ligation or vasectomy. This seemed astonishing and it was difficult to think of any reason why a population control agency would have undertaken this project. But, as the story-teller explained, if people could be reassured that, if they changed their minds after having been sterilized, all possible steps would be taken to achieve reversal and that the facilities were available to make this relatively safe and reasonably likely to be successful, they were more likely to undergo voluntary sterilization. This would make the encouragement of sterilization by more coercive measures, unnecessary. Further, persons who opposed sterilization on religious grounds, because it involved mutilation of the body, might feel free to accept the procedure if it were reversible, since, arguably, it would fall outside this religious prohibition. Hence, an apparent inconsistency, that of spending money to do what would appear to be promoting reproduction namely, the reversal of tubal ligation and


4. It is interesting to note, however, that there was considerable reluctance on the part of the Government to pay for these procedures. Letter to the author from Dr. Earl Owen, The Microsurgery Centre, Sydney, Australia (April 23, 1985).

5. See infra section III(B)(2).
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It is interesting to compare this non-coercive anti-natal approach with a non-coercive pro-natal approach taken in Quebec, where the Government is alarmed by the low birth rate, which could result in a shrinking population. The Government "wants to make having babies more fun" and has considered means of promoting birth, including provision of day care, tax incentives and flexible working hours. This raises the further issue, addressed later in this text, of the range of solutions that we should consider for such a problem. As an editorial in the Montreal Gazette points out, one would have expected that the Government would have at least mentioned increased immigration as one possible solution to this problem. 18

II. Decision-Making

The approach taken in this section is to identify, first, some of the principles and, second, some of the values that can govern decision-making in the "birth" technology context. These principles and values are not unique to this area. However, it is essential to identify them in order to provide the necessary tools to test the consistency or inconsistency of given approaches. The testing of situations against these principles and values (which is the focus of the third section) then provides insights, which would not otherwise be available. These insights can, in turn, reveal otherwise hidden consistencies or inconsistencies.

11. Infra section IV.
12. Paper Has Birth Defect, The Gazette, Montreal, Oct. 25, 1984, at B-2. The editorial asks, "How much immigration can Quebec absorb without negative social and economic effects? Perhaps a good deal. This is the enormously important matter that Quebec should explore, not just for economic but for humanitarian reasons. There are thousands of suffering people who could make a real contribution here."

15. See, e.g., REPORT OF THE COMMITTEE OF INQUIRY INTO HUMAN FERTILIZATION AND EMBRYOLOGY 1984 Cmd. 9314, section 11.4, at 59, [hereinafter referred to as the Warnock Report], refers to "the first recognizable features of the embryo . . . appearing[as] as a significant marker in embryonic development. See also COUNCIL FOR SCIENCE AND SOCIETY, HUMAN PROCREATION: ETHICAL ASPECTS OF THE NEW TECH-
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gestions that embryo research should be limited to the time before cell differentiation takes place. In this same line of thought, it is interesting to consider what constitutes an early human embryo, because one way to disconnect research on human embryos from research on other humans would be to establish that the research was not carried out on a human embryo. For instance, if cells capable of forming a second embryo are taken from an embryo, for research, is this research on an embryo? If research on embryo cells is not considered to be research on an embryo, embryo research when these cells are in the non-compact state and this state has been intentionally induced? If research on embryo cells is acceptable, but research on an embryo is not, is any objection to research on the non-compact embryo, an objection to inducing the non-compaction, rather than to any subsequent research on these cells, or is it still research on this embryo?

Conversely, if fetal research is allowed, why is embryo research prohibited after fourteen days? Both the Warnock Report16 from Great Britain and the Waller Report17 from Australia, adopt a fourteen day limitation regarding research on embryos, and yet both countries contemplate the possibility of carrying out fetal research.18 Could this be because there is a sense of utilitarianism and reification19 with respect to the embryo, especially if it was created only for the purpose of research, which is not felt regarding the fetus? Is our real concern that such utilitarianism and reification, if generalized, could be a precedent which would threaten other members of our society and we wish to avoid this?

Or does a related principle, that of hidden mutilation,20 explain why fetal research may be allowed, but not experimentation on embryos after fourteen days? According to this principle we are more willing to undertake conduct when the mutilating consequences of this conduct are hidden, than when this is not the case. Thus, "in utero" fetal research, carried out prior to abortion, may be both less apparently life-denying (in that the death of the fetus may be regarded as a secondary, unavoidable effect of the decision to have an abortion and not the primary aim of either the research or the abortion, and as inevitable in any case if the abortion is going to be performed) and less obviously mutilating (because it is carried out "in utero") than research on older embryos.

The occurrence of the occasion for undertaking fetal research also involves more of a chance element (unless the fetus was conceived expressly to carry out research on it) than the occurrence of the occasion for embryo research, or at least if those situations where the embryo was created for the purposes of research.21 This may also explain why there is often less opposition to using so-called "spare" embryos (those conceived for possible clinical use in the treatment of infertility) than using those conceived simply for the purposes of laboratory research.22 "Spare" embryo research and experimentation on non-viable, aborted, or to be aborted, fetuses are also consistent in that they can be analyzed on the basis that they both involve taking a utilitarian approach to a situation in which research has become relevant, but which was not planned primarily to create a research opportunity. It should be noted that this is not meant to imply that such research can necessarily be justified through such analysis.

Could it also be that the presence of differing overt and latent principles in relation to embryo research explains the wide variety of reasons given for requiring experimentation on embryos to cease at


21. See infra section III(A)(1), for a discussion of the distinction between a primary aim, in abortion, of evacuating a woman's uterus and one of killing the fetus.

22. See infra section II(A)(4).

23. See Waller Report, supra note 17, where the majority opinion is to this effect. See also Warnock Report, supra note 15, section 11.22-11.30 at 66-69.

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16. Id.
17. id. 18. id., id., ADVISORY GROUP OF THE DEPARTMENT OF HEALTH AND SOCIAL SECURITY, SCOTTISH HOME AND HEALTH DEPARTMENT, WELSH OFFICE, THE USE OF FETUSES AND FETAL MATERIAL FOR RESEARCH (THE WARNOCK REPORT) (1972); id., id., NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL, ETHICS IN MEDICAL RESEARCH INVOLVING THE HUMAN FETUS AND HUMAN FETAL TISSUE (1983). It is noted in the Warnock Report, supra note 15, at 64 n.7, that it is illegal to stringently control early embryo research, but not fetal research. However, the report does not recognize that the fourteen day limitation period, in itself, may be inconsistent with allowing any fetal research.
gestions that embryo research should be limited to the time before cell differentiation takes place. In this same line of thought, it is interesting to consider what constitutes an early human embryo, because one way to disconnect research on human embryos from research on other humans would be to establish that the research was not carried out on a human embryo. For instance, if cells capable of forming a second embryo are taken from an embryo, for research, is this research on an embryo? If research on embryo cells is not considered to be research on an embryo, is research on the full complement of cells comprising the embryo, embryo research when these cells are in the non-compacted state and this state has been intentionally induced? If research on embryo cells is acceptable, but research on an embryo is not, is any objection to research on the non-compacted embryo, an objection to inducing the non-compaction, rather than to any subsequent research on these cells, or is it still research on this embryo?

Conversely, if fetal research is allowed, why is embryo research prohibited after fourteen days? Both the Warnock Report from Great Britain and the Waller Report from Australia, adopt a fourteen day limitation regarding research on embryos, and yet both countries contemplate the possibility of carrying out fetal research. Could this be because there is a sense of utilitarianism and reification with respect to the embryo, especially if it was created only for the purpose of research, which is not felt regarding the fetus? Is our real concern that such utilitarianism and reification, if generalized, could be a precedent which would threaten other members of our society and we wish to avoid this?

Or does a related principle, that of hidden mutilation, explain why fetal research may be allowed, but not experimentation on embryos after fourteen days? According to this principle we are more willing to undertake conduct when the mutilating consequences of this conduct are hidden, than when this is not the case. Thus, "in utero" fetal research, carried out prior to abortion, may be both less apparently life-denying (in that the death of the fetus may be regarded as a secondary, unavoidable effect of the decision to have an abortion and not the primary aim of either the research or the abortion, and as inevitable in any case if the abortion is going to be performed) and less obviously mutilating (because it is carried out "in utero") than research on older embryos.

The occurrence of the occasion for undertaking fetal research also involves more of a chance element (unless the fetus was conceived expressly to carry out research on it) than the occurrence of the occasion for embryo research, or at least of those situations where the embryo was created for the purposes of research. This may also explain why there is often less opposition to using so-called "spare" embryos (those conceived for possible clinical use in the treatment of infertility) than using those conceived simply for the purposes of laboratory research.

"Spare" embryo research and experimentation on non-viable, aborted, or to be aborted, fetuses are also consistent in that they can be analyzed on the basis that they both involve taking a utilitarian approach to a situation in which research has become relevant, but which was not planned primarily to create a research opportunity. It should be noted that this is not meant to imply that such research can necessarily be justified through such analysis.

Could it also be that the presence of differing overt and latent principles in relation to embryo research explains the wide variety of reasons given for requiring experimentation on embryos to cease at
fourteen days, in that none of the reasons given may be the real one underlying this requirement? If this is true, it should not be surprising to find a lack of consistency between such explanations. Among these reasons is that prior to fourteen days, the embryo has no cell differentiation and no nerve cells present and, therefore, there is no possibility of pain or sentience, but after this time early neural development occurs. A second reason is that fourteen days represents the time past which implantation can no longer take place and this is a determining factor. But why is the point of implantation thought to be of such importance? Is it because one will not, by choice, deprive an embryo of all chances of implantation and yet allow it to continue to exist, which means that it must be destroyed prior to or at the time when it loses any such chance? Or could it be that fetal research cannot validly be distinguished from the precedent set by experimentation on "post-implantation time" embryos, and that fetal research is either unacceptable, in itself, or has unacceptable ramifications or is prohibited? Or are we simply, and as a matter of convenience, adopting a "marker" approach, in that the time past which implantation is not possible is a convenient marker for differentiating between one group of unborn humans (embryos), and another group (fetus), for the purposes of ensuring that conduct with respect to the former group does not set a precedent for the latter group, but that this marker has no intrinsic validity as such a differentiating factor or event? The Dunstan Report, from England, seems to have reached a conclusion that would indicate a positive response to this question; it proposes that a fourteen day limit must depend on factors extrinsic to the embryo, because the first "date relevant to the intrinsic development of the fetus," such as the development of human morphology, does not occur until about the fourieth day after fertilization. A third reason given for allowing certain treatment of embryos only up to fourteen days after fertilization is that this is the time of biologic individualization—that is, the final determination of whether the embryo will give rise to one individual or identical twins, which is marked by the appearance of one or two "primitive streaks," respectively. It may be believed that such individualization, not sharing in human life, is the important differentiating factor with respect to the conduct on our part that is allowed or required regarding an unborn human. In short, what we are seeking here is the identification of a "marker" (examples of which, other than those just discussed, include viability or some other event, in an earlier or later stage of development), that is being used to distinguish some groups of human cells from other groups of human cells—which (or whom?) include all of us—for the purposes of treating the former inconsistently, in terms of the "interventions" we normally accord to, or allow regarding the latter, which include those defined as persons. It has even been proposed that a fourteen day limit on human embryo research is a matter of intuition: "It could be justified in terms of 'natural fitness' as representing a term beyond which the intuitive judgment of concerned and sensitive people might find further prolongation [of the life of the embryo] repulsive." Possible the most pragmatic explanation for adopting the fourteen day limit is that, after this time, the law governing abortion would apply to any conduct which involved dealing with the embryo. It is worth noting that this may be questioned, because if there is neither an intention to evacuate an implanted embryo from a woman's uterus, nor the occurrence of this, most abortion law would not apply. However, pursuant to such reasoning, research after fourteen days should be avoided because it risks attracting legal liability. It should also be asked whether research that would not be allowed to be carried out on an embryo "in utero" should be permitted on an "ex utero" embryo, which again could indicate a fourteen day limit on in vitro embryo re-

24. See infra section III(A)(4). See also the Warnock Report supra note 15. Some members of the Warnock Committee "argue[d] that it cannot be consistent with the special status that the Inquiry as a whole has agreed should be accorded to the human embryo, to cause it to exist, yet to allow it no possibility of implantation." Warnock Report, supra note 15, section 11.25 at 67.


26. Id. This would appear to assume that conception, presumably because the very existence of the fetus depends on it, is not such a date. It merits noting that the embryo and fetus have in common the event of conception. Consequently, this could not be used to differentiate between them. Further, conception is a difference in kind, not just degree, and as such, is not within the definition of "marker event" contained here.

27. See infra section III(D), for a discussion of the role of intuition in relation to decision-making concerning "birth" technology.


29. Id. at 76.

30. For adoption of an approach contrary to that suggested here, for consideration with respect to fetal research, see Research on the Fetus, Report and Recommendations of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 40 Fed. Reg. 33330 (Dec. 20, 1975), which allows much broader research on non-viable "ex utero" fetuses, than on non-viable "in utero" ones.
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In summary, the overt values displayed in a “birth” technology situation may not be the only ones present. We also need always to consider the possibility of the presence of latent values. When we identify these, we can be presented with a very different overall picture of the situation under investigation.

2. Overt and Latent Decision-Making

There can also be overt and latent decision-making as well as overt and latent values. When we look at the health care dollars that are available for “birth” technology, for example, we may only examine decision-making concerning the allocation of these funds in the immediate situation — that is, the more overt decision-making. More latent decision-making is also important — for instance, the institutional or governmental decision-making which either limited those dollars or, alternatively, made funds available for research or clinical applications of “birth” technology in preference to some other area of health care or, in preference, even, to some other area of societal support, such as education. The further removed that the decision-making is from its perceived impact on a particular individual, the less likely it is that the decision-maker will be “blamed” for causing unacceptable outcomes. However, this may be changing. For instance, in Canada, the government may well be sued in the future for failure to provide adequate medical care,32 although it seems unlikely that the care which there are

31. See, e.g., Additional Protections Pertaining to Research, Development, and Related Activities Involving Fetuses, Pregnant Women, and In Vitro Fertilization, Miscellaneous Amendments, 45 Fed. Reg. 1758 (Nov.’s HFW 1978) (codified at 45 C.F.R. §§ 46.102, 46.203, 46.204, and 46.209), in which the definitions of “pregnancy” and “fetus” were amended, in that “pregnancy” required “confirmation of implantation through presumptive signs of or by a medically accepted test for pregnancy” (46.203(b)) and “fetus,” likewise, required that “implantation be evidenced” (46.203(c)).

32. See, e.g., the Plaintiff’s Declaration in Marquis v. Ville de Varennes v. Centre Hospitalier Valleyfield, Oct. 31, 1980 (C.S. Que.) No. 500-05-013638-802, in which the Hospital Defendant’s failure to provide a fetal monitor was alleged as negligence. The hospital defended on the grounds, inter alia, that the Minister of Health of the Government of Quebec had refused funds for this equipment and, therefore, that the Government, rather than the hospital, should be held liable. The plaintiff’s claim was denied before trial.

obligations to provide would be defined to include “birth” technology. It is also relevant to latent or even hidden decision-making (where the decision-making is intentionally concealed) that patients have become better informed and more aware of their “rights.” This may eliminate one hidden decision-making mechanism, which, possibly, has been widely used, but not often publicly identified; this is simply not to tell patients or their families that certain treatments (for example, hemodialysis for terminal renal failure33) exist. It should be pointed out, that this text does not address the issue of how it should be decided whether in a given society “birth” technology should be funded in preference, for example, to other areas of health care or even other governmental activities. The aim in this section is simply to make the point that there is a choice between using latent and overt decision-making mechanisms in addressing such choices.

3. Distinguishing “Right” Decision-Making Procedures and “Right” Decision Outcomes

One can then ask whether there are any “right” decisions. For instance,

[At the same time we have a high incidence of premature births requiring long periods of high-cost intensive care, we are cutting back on neighbourhood health centres, health counselling and other programs that might teach women better diet or exercises to decrease the chance of premature birth. It doesn’t make sense.”]

Even more to the point in the context of the current discussion, is the question that if the rate of infertility and hence the need for treatment, such as IVF, is increasing due to sexually transmitted disease, how should funds be allocated between preventive measures (for instance, appropriate education of teenagers) and curative treatment (such as IVF) aimed at overcoming the adverse effects of sexually transmitted disease? What could be considered a “right” decision in such respects? And how should our decisions regarding funding, for instance, of research or of clinical applications of “birth” technology, have factored into them other competing, legitimate claims, such as those described


34. Murray (a social psychologist), Wall Street Journal, Nov. 23, 1983.
search (or perhaps more accurately stated, a fourteen day permission). This is because up to that time "in utero" research may not be covered by any law regulating abortion or fetal research.11

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above? This is an especially difficult problem when all the claims arise in the same area and, consequently, it is not easy to dispose of the ones that we do not wish to recognize by distinguishing or "detaching" them from the ones which will be honored. It is important to recognize that such difficulties might be present in a given situation and the experience of some ethics committees, set up to choose organ transplant recipients, is illuminating in this respect. In one case, after a year, it was not possible to find any "lay" members willing to serve because the decision-making was too stressful. Can we only handle our decision-making if it is not overt and is psychologically distanced both from us, as decision-makers, and in terms of seeing its impact on others?

But, despite the stress that decision-making, including that concerning "birth" technology, may cause us, we cannot avoid making choices, both because failure to choose is in itself a decision, and because we cannot or do not want to allocate all our resources to health care. Today, there is more we can do than we are willing to do or even ought to do. Further, we must be consciously aware that the approaches open to us are not simply to promote or prohibit a certain activity, such as a given form of "birth" technology; we have also an option of adopting a policy of neutrality towards its use. However, in choosing which of these approaches to follow we need to be aware, also, that although the outcomes may be consistent, under different approaches (for instance, the outcome may be the same under a "promoting" or "neutral" approach, or, likewise, even under a "prohibiting" or "neutral" approach where neutrality makes the technology unavailable), the symbolism that each of the approaches carries will be different and may be very important in reflecting or forming attitudes to that form of "birth" technology. Further, in terms of whether or not there is consistency between different approaches, both the nature, itself, of the approach taken and the different outcomes that can result from different approaches, are relevant.

The above discussion of consistency and inconsistency in relation to decisions concerning "birth" technology can be summarized as fol-

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35. This detachment of problems may be from either a certain designated area, or from one's professional field of interest, or from oneself. It could be termed a "limiting device" and, almost certainly, has a psychological basis, perhaps as some form of coping, if not defense, mechanism. Such detachment can often be put into effect through a process of labelling. If it is not possible, or too difficult, to solve a problem, or the person does not wish to address it, a problem can be avoided by reclassifying it as falling outside the scope of a given involvement.

36. J. F. Miller, E. Williamson, Glue J. et al., "Fetal Loss After Implantation," LANCET 1980; ii : 554-556. These authors tested a statistical model that postulated a 78% loss of all human conceptions. While they concluded that this estimate was too high, their study, evaluating the rate of spontaneous abortion after implantation of the conceptus, revealed a post-implantation pregnancy loss rate before 20 weeks of at least 43%.
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4. Risk by Choice and Risk by Chance

Health care decision-making involves the allocation of benefits, potential benefits, harms and risks of adverse events. This includes the allocation of pain and suffering and ill health, or at least, the failure to relieve these in situations where this is possible. Here we may be affected by a phenomenon which results from different psychological reactions to the imposition of harm, or to harm caused by the crystallization of a risk, depending on whether the imposition of that harm on that particular person, or the allocation of that risk to him or her was, or appears to have been, by choice or by chance. We find a situation much easier to deal with when risks or harms appear to have been imposed by chance, rather than by choice. For example, when a child develops encephalitis as a result of contracting measles, we are distressed; but, when this occurs from measles vaccination, we are horrified, although in both cases the child was at risk of encephalitis and subject to a higher probability of risk in the former than in the latter case. Similarly, natural abortion, which occurs very frequently at early stages of pregnancy, is an example of the realization by chance of the risk of an adverse event. (More precisely, it is assumed that it is adverse, at least as far as the embryo is concerned.) But, where the em-
be outrage if a technique were developed by means of which embryos could be "intentionally crippled so that they would never meet the criterion of humanness," but otherwise would be allowed to develop normally in order to be used for research.

The increased relevance, in the context of "birth" technology, of distinguishing between risk by choice and risk by chance, and of recognizing that different consequences flow depending on which is present, is due to the fact that this technology has increased our ability to control certain events. This control means that we have choice, where previously no choice existed. We well might feel differently about decisions to undertake certain courses of conduct if they were not the only option, and about the inconsistencies in outcome that we create through our choices, especially if, not only the conduct, but also, the outcomes are intentional, as compared with situations in which the same outcomes occur entirely by chance.

5. Who Should Decide?44

The often asked question of who has a legitimate role in medical-ethical-legal decision-making — whether it should be the person, his or her family, the professions, the institution, an ethics committee, a court, the government — is complex to answer, and the appropriate solution varies with each situation. To some extent, the response depends on whether clear substantive principles are available to guide decision-making or whether reliance must be placed almost entirely on procedural safeguards.45 The appropriate decision-maker, where there are only procedural safeguards, might be a properly constituted and administered committee or, even, a court, whereas when clear substantive principles are available, it could well be an individual.

One relevant consideration in addressing the question, "who decides?" — a consideration often overlooked and one which may be of particular importance with respect to "birth" technology — is that a choice between regulation by means of ethics, as compared with law, may have to be made.46 The result of this choice can alter both whos...
bryo is destroyed by active and planned intervention, whether for the purposes either simply of abortion or of research, we are inflicting harm by choice. In fact, this constitutes an example of deliberately imposing the most serious harm, that of death, by choice. Consequently, the high rate of natural abortion does not, as is sometimes proposed, in itself justify induced abortion and is even less relevant to justifying embryo research.

It is suggested that this differentiation between risk by choice and risk by chance (although often not identified in these terms), plays a very important role in “birth” technology decision-making. For instance, in addressing one of the issues raised by the use of “birth” technology in conjunction with surrogate motherhood, which is that the prospective parents may refuse to take the baby after it is born, the Waller Report, from Australia, although not naming the distinction relies on it: “[t]here can be no reasonable comparison between a foundling or abandoned baby and one born after the planned use of advanced scientific and medical techniques employed in an approved programme used to circumvent infertility in a public or private hospital [and rejected by the prospective parents].” Similarly, surrogacy and adoption can be compared. In surrogacy there is a choice to become pregnant and a choice to relinquish the child. In adoption, it is usually presumed that pregnancy occurred by chance, or at least was undesired, and only giving up the child is by choice. The same is true for most abortions. Thus, it would seem to be unacceptable deliberately to create a situation in which there would be a decision, such as giving away a child for adoption, having an abortion, or allowing research on an aborted fetus, which, if ethically acceptable at all, is only so if the circumstances giving rise to this decision arose by chance. Another example of the same distinction between inflicting harm by choice and by chance being relied upon, expressly, but not identified as such, is a dissent in an Appendix to the Waller Report. It is proposed that, if the criterion for humanness were the capacity for sentience or awareness, there would be outrage if a technique were developed by means of which embryos could be “intentionally crippled so that they would never meet the criterion of humanness,” but otherwise would be allowed to develop normally in order to be used for research.

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37. Waller Report, supra note 17, section 4.15, at 54.
38. In this context the notion of circumstances arising by chance means that they were not planned, and not necessarily that they were unavoidable, which is a second possible meaning.
39. Sentence can be compared with awareness or some form of consciousness. Sentence is a capacity, possessed by even primitive organisms to react to their environment, either to gain food or to avoid danger. Awareness involves the attribution of some rudimentary form of consciousness. See Duskin Report, supra note 15, section 5.17, at 52.
40. Waller Report, supra note 17, section 3.2.4, at 68.
41. See also, infra section II(B)(1).
42. See supra, section III(A)(3).
43. The “Baby Doe” Hohlen Regulations provide an example of one body, the United States Government, using law to regulate the treatment of disabled newborn babies, and another body, physicians, opposing this and insisting that the matter should be governed by ethical principles. The approach of using Infant Care Review Commit
will be involved in the decision-making and the mechanism used to reach a decision. If a certain type of situation is to be governed by ethical principles alone, then it is necessary to seek a certain degree of consensus, because ethical views cannot be imposed in the same way that legal rules can. Further, when governance is by ethics, rather by law, it is less likely that the government will be involved, at least directly. We may regard this as either desirable or undesirable depending upon our view of the proper role of government in medical decision-making.44

Even if we decide to use law as a regulatory mechanism, there are choices as to the type of legal regime which we should implement. For instance, misuse of "birth" technology on the part of a physician might be considered unprofessional conduct and punished under medical licensing laws or, in some circumstances, might give rise to a claim in private law (tort, deceit, or contract) for malpractice damages, or might be the source of criminal liability. 45 The latter represents the most serious and forceful type of state intervention in regulating conduct. In this respect, it is worth noting that, although it is probably fair to state that the Warnock Committee in England adopted a moderate to liberal approach in designating which conduct involving the use of "birth" technology was acceptable, 46 in almost all instances it recommended the legislative enactment of criminal penalties for breach of the proposed parameters. 47

With respect to the question, "Who are the most appropriate decision-makers?" the Waller Report from Australia is interesting in two respects. First, it adopts a position that the parents are the only proper decision-makers concerning what should happen to the embryo. These decisions include those concerning whether the embryo should be disposed of, frozen, donated or subjected to research, if it is not used for IVF. 48 But,

[the Committee does not regard the couple whose embryo is stored as owning or having dominion over that embryo. It considers that those concepts should not be imported into and have no place in a consideration of issues which focus on an individual and genetically unique human entity... The Committee nevertheless does consider that the couple whose gametes are used to form the embryo in the context of an IVF Programme should be recognized as having rights which are in some ways analogous to those recognized in parents of a child after its birth. The Committee does not consider that those rights are absolute, just as the rights of parents are limited by the rights and interests of the child, and by the larger concerns of the community in which they all live.49

One could ask several questions about this apparently inconsistent approach. For instance, parents of a child today, unlike a father in the Roman law era, have no power of life and death over their child. But, it is being proposed here that they should have this power over their embryo. What does this indicate? These statements are not meant to imply that the parents might not be the most appropriate decision-makers regarding their embryo; rather, they are meant to raise the question of why the Committee analogized parents' rights over embryos to those over children and the appropriateness of this analogy. Did the Committee mean to imply limitations on the options open to the parents in dealing with their embryo?50 In all probability, among the reasons why the Waller Committee gave this decision-making power to the parents, was a belief in the parents' right to decide. (This is an example of respect for the parents, but of neutrality in this regard in relation to the embryo, which is noted because respect for the embryo is a theme of the Waller Report.) 51 Probably, the parents were also chosen as deci-

48. Waller Report, supra note 17, section 2.8, at 27.
49. Id.
50. For further discussion of the range of options open to gamete donors with respect to "their" embryos, see M.A. Somerville, Legislating for the New Reproductive Technologies. The Intimacy (Medical Procedures) Act 1984. Fertil Ground for Legal Speculation (forthcoming).
51. Again, there is no intention to imply, here, that the parents wishes should not be respected. Rather, it is important to identify which conduct committees respect for

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ten is something of a compromise between these two views. See G.J. Anass, The Baby Doe Regulations: Governmental Intervention in Neonatal Rescue Medicine, 22 EMERGENCY MED. 1984; 246-220. It is interesting to note that there is a very strong emphasis in the Dunstan Report, supra note 15, that decision-making should be physicians to the exclusion of other persons or bodies (for example, section 8.6, at 84) and that they should be guided by ethical codes more than specific laws (section 7.1.3, at 62).

45. See generally E. PICARD, LEGAL LIABILITY OF DOCTORS AND HOSPITALS IN CANADA (2nd ed. 1984).
46. It is suggested that the Warnock Committee adopted such an approach with respect to all the "birth" technology matters that it considered, except for surrogate motherhood, where a much more restrictive approach was taken.
47. Warnock Report, supra note 15, at 84-86.

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tion-makers because it is easier to give them control than to try to formulate the substantive and procedural rules which would inevitably be necessary if any other decision-maker had been chosen. Indeed, such formulation could well prove to be impossible. Further, if the parents were to make an immoral, controversial, or harmful decision in a given instance, this decision could then be characterized as their fault rather than the fault of a system which had wrong or evil rules. This is likely to be an important consideration in an area as fraught with polarization as “birth” technology. The Waller Report includes the ovan donor as a decision-maker regarding the embryo, but gives equal rights to the sperm donor. This can be contrasted with allowing the ovan donor, alone, to decide on the destiny of the embryo, which would be consistent with the approach taken to abortion in some jurisdictions, in that at the embryo stage the decision whether or not to abort is solely the woman’s. Whether or not the Waller Report’s suggestion that parents should decide on the fate of their embryos coincides with the law governing abortion in the State of Victoria would need further investigation at both the theoretical and the practical levels.

For a further reason, the Waller Report is also of interest regarding the question “who decides.” Subsequent to the release of the Report, which recommended that where the parents had died and no given directions concerning disposal of frozen embryos they be unfrozen, allowed to “succumb” and disposed of, the Victorian Parliament enacted legislation that required that such embryos be given a chance to survive through donating them for implantation in the uterus of another woman. Thus, this government-appointed, expert Commit-

53. Australians Reject Bid to Destroy Two Embryos, N.Y. Times, Oct. 24, 1984, at A18. It needs to be asked what are the harms or risks of harm in requiring that the Del Rios embryos be given a chance to develop and how these harms can be minimized. One problem is the publicity which has surrounded them and, no doubt, would continue to surround them were they identified, and how they would deal, psychologically, with this and its informational content. It could be that any children resulting from the Del Rios embryos would never know their genetic origins. But, in this case, there is a deliberate withholding of available information from the persons it most concerns, namely, the children, which raises ethical problems. Further, all children born from the use of “birth” technology in the particular unit that “created” the Del Rios embryos (Professor Carl Wood and Dr. Alan Trounson, Monash University, Melbourne, Australia) will be left in doubt, which can be a psychologically harmful state.

6. Initial Presumptions

The final decision-making principle which will be addressed, is that of the identification of the initial presumption from which our decision-making commences or ought to commence. These presumptions are of two kinds: “yes . . . but” or “no . . . unless.” For instance, “yes,” single women ought to be given access to AID, “but” there may be exceptions to, or conditions precedent to, such access. Alternatively, “no,” single women ought not to be given access to AID, “unless,” for example, they are living in a stable relationship with a man. The choice of the initial presumption is not neutral in terms of decision outcome. This is so because the persons challenging the initial presumption will have the burden of proving that it should not apply; that is, they must prove that they fall within an exception to the initial presumption and, in cases of equal doubt as to whether or not the initial presumption is displaced in favor of the exception, the rule that the initial presumption establishes, and not the exception, will govern.

B. Some General Values Affecting Decision-Making in a “Birth” Technology Context

1. “Quality of Life” and “Sanctity of Life”

It is relevant to consider the value of the “quality of life,” as compared with the value of the “sanctity of life,” in relation to modern medical technology, including “birth” technology. In the past, because
sion-makers because it is easier to give them control than to try to formulate the substantive and procedural rules which would inevitably be necessary if any other decision-maker had been chosen. Indeed, such formulation could well prove to be impossible. Further, if the parents were to make an immoral, controversial, or harmful decision in a given instance, this decision could then be characterized as their fault rather than the fault of a system which had wrong or evil rules. This is likely to be an important consideration in an area as fraught with polariza-
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ment enacted legislation that required that such embryos be given a

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tee, which solicited wide public consultation, was not the final decision-

maker since its suggested approach was not applied. This raises an is-
iue, that should always be addressed in relation to any committee's

recommendations, whether or not these are followed, for the insights

such an enquiry can provide, namely, whose wishes did the Committee

articulate — its own, the Government's, the society's, or some other

person's or group's? Theoretically, the legislature represents the wishes

of the people, but it is interesting to speculate whether this would prove
to be true here. Indeed, it can be asked whether one can say that there
are "wishes of the people" in a pluralistic, democratic society regarding

issues which involve a major degree of polarization among members of

that society and which touch on both personal and public morality.

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note 15, at 81, states that with respect to the use of "spare" embryos, it is the "feelings
[of the parents] which matter and should be respected." 52. See infra section III(A)(3).

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that the Del Rios embryos be given a chance to develop and how these harms can be

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as to whether or not their "parents" were Mr. and Mrs. Del Rios. Id.
medicine was relatively powerless, people were usually either reasonably well or dead. Today that is not the case. We need to ask to what extent the adoption of a “vitality principle” (that is, the principle that life should be maintained at any cost, in the broad sense of that term) causes unjustified suffering. Should this be modified and how? This query is relevant in the area of “birth” technology in that the use of such technology, for instance, prenatal surgery, may convert what would otherwise have been a lethal condition into a chronically disabling one. Likewise, it may make it possible to detect the presence of a pathological condition prenatally, which in turn gives rise to a consideration of the suffering that the fetus would endure in life. This then raises the issue of abortion for those for whom this procedure is an acceptable option.

It seems appropriate to ask what lessons the “wrongful life” cases have to teach us about how we value life and what relevance this has in relation to policies governing “birth” technology, within this discussion of the differences between applying “sanctity of life” and “quality of life” values. In a limited range of circumstances, these cases establish the principle that it is not always better to have been born, than not to have been born at all; that is, in life can constitute a legally cognizable injury or damage. Consequently, damages are awarded to the plaintiff for having been born, although, often, this is denied as the basis for the award. It is more likely that damages will be characterized as compensation for enduring a life which involves a net balance of suffering due to the plaintiff’s state, rather than for enduring life in itself. Further, any court which has awarded damages for “wrongful life” has simply filtered the question that, if the plaintiff had not been born, he or she could not be claiming damages.

In this latter respect, some comparisons between the “wrongful life” cases and situations involving the use of “birth” technology might provide insights that prove useful. In the “wrongful life” cases there is no possibility of the plaintiff’s existence without the damage; that is, the damage can be regarded as “intrinsic,” to the plaintiff. In the “birth technology” situation, there is no possibility, usually, of the child’s existence without the use of the technology. To this extent the situations are similar. But, unless simply the use of the technology is considered a damage to the child conceived, any damage suffered can be regarded as more “extrinsic” to the child than “intrinsic,” in that life without the damage would have been a possibility for the child, except where the damage alleged is that he or she suffers from genetic disease. To this extent the two situations differ. Claims for damages for injury caused through use of “birth” technology are more similar to those “wrongful birth” cases in which parents sue for negligently caused damage to the child while “in utero.” The child, if born alive and viable, would have an action in tort for negligently inflicted prenatal injury.

The application of the reasoning used in the “wrongful life” cases to the use of “birth” technology could also be used to found arguments that it is better not to be conceived than to be born of a surrogate mother, or, in some instances, better not to be conceived than to be conceived through “birth” technology. But, it would seem highly likely that such “harm” would be off-set under a “benefits set-off” rule. That is, the benefits and harms accruing from any wrongful act must be set-off against each other, and damages are only awarded for any resulting net harm. Harm caused to a child through the use of “birth technology” would be counter-balanced by the benefit of life, certainly “undamaged” life. Consequently, although in theory, a tortuous cause of action would lie, damages might not be able to be recovered.

54. M.S. Golbus, Advances in Fetal Diagnosis and Therapy, in DEATH, HUMAN LIFE MEDICAL, LEGAL AND ETHICAL IMPLICATIONS 73, 82 (M. Shav & E. Doohara, eds. 1983) [hereafter referred to as Shav & Doohara].


56. Somerville, supra note 55.

57. This raises the interesting question of whether even genetic disease can be regarded as avoidable when birth technology is used to create the child who becomes a plaintiff in a “wrongful life” case. For instance, if donor gametes were used, could the child argue that different gametes should have been used when he or she would have avoided the genetic disease which constitutes the alleged damage? Or would this be to argue that one has a right to be a different person (and that breach of this right sounds in damages), rather than to argue “wrongful life”? That is, the plaintiff may no longer be proposing only that there was a breach of obligation in having conceived him or her.

58. In this regard, the Durstell Report, supra, note 15, is again of interest. It states that the prospective parents should be told “that it would be better for them to remain childless than to bring a child into being by means which will deprive him of knowledge of his genetic father [A.I.D.J., or of continued contact with his bearing mother [surrogate motherhood].” Durstell Report, supra note 15, section 8.2, at 80.
medicine was relatively powerless, people were usually either reasonably well or dead. Today that is not the case. We need to ask to what extent the adoption of a “vitality principle” (that is, the principle that life should be maintained at any cost, in the broad sense of that term) causes unjustified suffering. Should this be modified and how? This query is relevant in the area of “birth” technology in that the use of such technology, for instance, prenatal surgery, may convert what would otherwise have been a lethal condition into a chronically disabling one. Likewise, it may make it possible to detect the presence of a pathological condition prenatally, which in turn gives rise to a consideration of the suffering that the fetus would endure in life. This then raises the issue of abortion for those for whom this procedure is an acceptable option.

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ered. However, this is much less likely to be true where the child is born seriously damaged. The most important message that these "wrongful life" cases carry, and are unique in carrying, is that conception is not always a benefit for the person conceived. In this respect, these cases are of more relevance to issues raised by the use of "birth" technology, than they are to many other medical-ethical-legal dilemmas. This is true, because the question in both "wrongful life" cases and with respect to the use of "birth" technology, is whether it is a damage to commence a life, and not whether it is a damage to continue a life. The latter is the issue more commonly faced in the context of a discussion of the values of "sanctity of life" and "quality of life" and of conflict between them. While many of the same considerations could apply in both deciding whether or not to commence or continue a life, this would not necessarily be the case, particularly, perhaps in that the symbolism and effects of choosing not to commence a life, as compared with choosing not to continue a life, could be very different with regard to their respective impacts on the values of "sanctity of life" and "quality of life."

A related issue, in terms of how we value life and whether "sanctity" or "quality of life" is the overriding value, is the relevance of allowing abortion of a fetus specifically on the grounds that it is defective. To do so would constitute another example of recognizing that life can be a damage and that it may be better not to be born. However, here the interests of the parents in not having to raise a defective child are also involved and color the basis of the decision-making. Finally, we could ask whether indications are increasing in society that life is not always a benefit, and whether we have been forced to face this issue because of the presence of modern medical technology. This technology is a decision-making factor whether there is a decision to use it, for example, in "making life" through the use of "birth" technology, or a decision not to use it, such as situations where, in a sense, we "take life" by our failure to use heroic measures to sustain life (either upon the patient's request to this effect or, in the case of an incompetent patient, when the suffering inflicted would be out of proportion to any benefit bestowed). In this respect, it is interesting to note that the Waller Report linked "birth" technology and artificial life support systems in its characterization of the maintenance of a frozen embryo as equivalent to life support treatment, and its proposal that this life support could be withdrawn in certain circumstances and the embryo allowed to "succeed" naturally. Such an approach means that the embryo would die by a more indirect means than if it were actively disposed of while still alive, by, for example, flushing it down a drain. Further, the death could, in a sense, be regarded as caused more by an omission of "extraordinary" treatment than by an affirmative act. All of these factors may have been enlisted by the Committee in order to ensure that its recommendation that the embryo be allowed to die would constitute the least possible affront to the value of the sanctity of life.

2. The Distinction Between Acts and Omissions

This raises the distinction between acts and omissions, which is also often an important distinction in decision-making in the medical context. Different values may be upheld, unaffected, or contravened depending upon whether an act or omission is involved; and we may dis-value harmful omissions less than harmful acts. One reason for this could be that it is often easier to characterize omissions, as compared with acts, as being due to chance and not due to choice. This is relevant because the operation of the "chance/choice phenomenon," discussed previously, could help to minimize feelings of responsibility for omissions in comparison with those for acts. It may also be that we experience a psychological bonding to a person with respect to whom we have acted, but do not experience this when we affect that same person by

60. Waller Report, supra note 17, at section 3.12. It is interesting to note the choice of language, in terms of the word "succeed," which is somewhat unusual in the context. Was the word "die" avoided in an attempt to treat the situation neutrally, or to side-step raising thoughts that the embryo was being killed deliberately? As has been said before, language, and particularly language used in relation to contentious medical-ethical issues, is not neutral. See R. Fein, What Is Wrong With The Language of Medicine?, N. ENG. J. MED. 1982; 306: 863-864. There is some interesting new use of language in the reproduction technology context. For instance, Professor J. Robertson, of the Faculty of Law of the University of Texas, has coined the phrase "collaborative non-coital reproduction" and Professor Rebecca Cook, of the Population and Family Health Center of Columbia University, New York, refers to "removing failed contraception," instead of abortion.

61. See infra section II(B)(2).

62. That is, give negative value weight (as compared with being neutral towards or giving positive value weights) to some matter.

63. Supra note II(A)(4).
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This raises the distinction between acts and omissions, which is also often an important distinction in decision-making in the medical context. Different values may be upheld, unaffected, or contravened depending upon whether an act or omission is involved, and we may disagree on what constitutes a more harmful omission less than harmful acts. One reason for this could be that it is often easier to characterize omissions, as compared with acts, as being due to chance and not due to choice. This is relevant because the operation of the "chance/choice phenomenon," discussed previously, could help to minimize feelings of responsibility for omissions in comparison with those for acts. It may also be that we experience a psychological bonding to a person with respect to whom we have acted, but do not experience this when we affect that person by

59. See supra section III(A)(3), for a discussion of Canadian abortion law in this respect.
60. Waller Report, supra note 17, at section 2.12. It is interesting to note the choice of language, in terms of the word "succeed," which is somewhat unusual in the context. Was the word "die" avoided in an attempt to treat the situation neutrally, or to sidestep raising thoughts that the embryo was being killed deliberately? As has been said before, language, and particularly language used in a context of medical-ethical issues, is not neutral. See R. Fein, What Is Wrong With the Language of Medicine?, N. Engl. J. Med. 1962: 306: 863-864. There is some interesting new use of language in the reproduction technology context. For instance, Professor J. Robert-son, of the Faculty of Law of the University of Texas, has coined the phrase "collaborative non-coital reproduction" and Professor Rebecca Cook, of the Population and Family Health Center of Columbia University, New York, refers to "remedying failed contraception," instead of abortion.
61. See infra section II(B)(2).
62. That is, give negative value weight (as compared with being neutral towards or giving positive value weight) to some matter.
63. Supra section III(A)(4).
an omission on our part." It could be that the law reflects this underlying psychological difference in that, in some instances, it is more likely to impose liability for an act than for an omission. It may also be that it is easier to characterize an omission as a failure to confer a benefit and not as an infliction of harm, than it is to characterize an act in this way, and that we feel much less guilty about the former. This distinction may be reflected in ethics, in that there is often a stronger ethical imperative to avoid inflicting harm (non-maleficence) than to do good (beneficence). It has been thoughtfully argued that the distinction between acts and omissions is morally irrelevant and that a rational approach to the ethics and the law governing the treatment of seriously handicapped newborn babies, for example, would not be based on such a distinction. Leaving aside other considerations, such as fears of setting dangerous precedents and even the inherent wrongfulness of any life shortening act, but not of some allowing-to-die omissions, this may be true from a purely rational perspective. But could it be that such acts are contrary to our intuitive responses, possibly because we bond to a person in acting, whereas such omissions do not conflict with our intuitive reactions, because in deliberately standing back, in deciding to omit to act, we do not bond in a like manner? We must never ignore our intuitive responses, but when our reasoned decisions conflict with them, both need further investigation.

We need then to ask whether there is a difference between some omissions. For instance, is there a psychological and symbolic difference between letting a newborn, seriously handicapped child die through withdrawal of life support treatment and letting him or her starve to death? Can we not afford to allow the latter because of its symbolism? Or, it has been argued that enacting a so-called "Human Life Amendment" to the United States Constitution could mean that there would be an obligation not to abort an embryo/fetus before viability, but that there would be no obligation for a woman to "house" in her uterus her "in vitro" fertilized embryo. Does this respective presence and absence of a legal obligation depend on the act/omission distinction in that an act of intervention must be justified in carrying out an abortion, but a failure to house an IVF embryo can be treated as an omission?"

3. Truth-Telling: Honesty and Integrity

Implementing the value of truth-telling, that is, the maintenance of honesty and integrity, can be particularly problematic in the context of "birth" technology. This is the case because there is often no harm-free course of action; telling the truth as well as its alternative, deception, can both cause harm. Situations in which this conflict arises are discussed in various parts of the text. Examples of such conflict include whether it is justifiable to deceive grandparents as to the fact that children born from donated gametes are not their genetic progeny, whether institutionalized deception in the family threatens the fabric of the community itself, and whether all persons have a right of access to genetic information concerning themselves in order to protect their health, and, in a few cases, to save their lives by gaining access to a compatible organ or tissue donor.

4. Personal Identification

Do we relate differently to newborn babies, or to incompetent or very old persons than to other persons more closely identified with us in terms of age and competence? Does this lack of identification affect our decisions? This is an especially important consideration if we are members of the group that exercises most of the important decision-making power in our societies and if the persons with whom we do not identify and who are affected by our decisions, are not. For instance, can we more readily "dispose" of persons with whom we do not identify, either by not allocating resources to fulfill their needs or by denying them treatment?"

64. R. C. Mistech, P. H. Steinecker, D. C. Thomasma, "Are Intravenous Fluids Morally Required for a Dying Patient?," ARCH. INTERN. MED. 1983; 143: 975-976.
66. J. Robertson, Medicolegal Implications of a Human Life Amendment, in Shaw & Dowdora, supra note 54, at 161, 169.
69. See infra section III(C).
70. Id.
71. See infra section III(B), for a discussion of identification with the
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5. Risk/Benefit Calculus and Medical Research

Other values relevant to “birth” technology are, first, the risk/benefit calculus which applies to any human conduct, especially that affecting others. In particular, one must look at the application of this calculus in the context of medical research. Second, the value of the activity of medical research itself must be assessed, especially when it is conducted on those unable to give informed consent to their participation, as is the case with children conceived through the use of “birth” technology. Who are we trying to benefit, the prospective parents, the child, or both? What are the known and unknown risks?

“Birth” technology may carry unique risks for a child born as a result of its use. For instance, psychological harm could result from learning that one had been cryopreserved and held in a state of suspended animation for an appreciable length of time. Or, physical harm could result if cells were removed at the blastocyst stage for genetic screening. Further, not only may the potential child be at risk, but the parents may also be at risk, sometimes in ways that may not be immediately apparent. For example, the psychological risks involved in entering a “birth” technology program and then failing to produce a healthy child are multi-dimensional. For instance, the psychological harm to an infertile couple appears to be greater if fertilization cannot be achieved, than if this is achieved, but either a pregnancy, or a successful pregnancy, is not. An example of a risk which could be avoided is that run by a childless woman in an IVF program, who agrees to donate some of her ova to another woman in the program. These ova will have been harvested by laparoscopy after drug-induced

super-ovulation. Some of the donor’s ova are fertilized with the sperm of the ova donor’s husband and some with the sperm of the ova recipient’s husband. The resulting embryos are then transferred to the uterus of each woman in accordance with their parental origins. The ova recipient achieves a successful pregnancy whereas the donor does not. Whether or not the donor knows that the ova recipient’s pregnancy was successful, she is aware that at least there is a chance that her genetic child exists yet she has no genetic progeny to whom she has access or with whom to create a family. It may be that allowing such a woman to run this risk is acceptable when the difficulties and risks of obtaining ova from other sources are examined and provided the woman has the risks explained to her and gives her informed consent. But one needs to be aware of such risks and that, for example, the risk of such psychological suffering to an ova donor could be avoided in part by using as donors women who already had their own genetic progeny.

From both ethical and legal points of view, it is particularly important to assess risks when research is involved. Further, it is important to determine whether the research is intended to be therapeutic or non-therapeutic, because this alters ethical and legal requirements. In the “birth” technology context, another issue arises in this respect if the research is intended to be therapeutic: for whom is the research intended to be therapeutic — for the particular infertile prospective parents, for a particular embryo, or for both? Research which is not intended to be therapeutic for the immediate subjects on whom it is carried out is classified as non-therapeutic, although it often has general therapeutic aims. The Warnock Report is of interest in this regard:

We believe that a broad division into two categories [of research] can be made. The first, which we term pure research, is aimed at increasing and developing knowledge of the early stages of the human embryo; the second, applied research, is research with direct diagnostic or therapeutic aims for the human embryo, or for the alleviation of infertility in general. Research aimed at improving IVF techniques would come into this second category. We exclude from the concept of research what we have called new and untried treatment, undertaken during the attempt to allocate the

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One especially pertinent enquiry in relation to personal identification in the "birth" technology context, is to ask whether researchers would ever use their own sperm or ova to create embryos and whether they would feel differently about the fate of these embryos, as compared with others. For instance, would they ever use such embryos for research or donate them to other persons to enable them to have children?

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With respect, there appears to be some confusion here, both regarding what constitutes research as compared with non-research, and what constitutes therapeutic as compared with non-therapeutic research. Further, it is unclear whether the Committee considered that research would be classified as therapeutic if such an aim were present only with respect to treatment of the "infertile" couple, or whether a therapeutic aim in relation to that couple's embryo was also needed; however, it would seem that the former would suffice. Research aimed at benefiting embryos, in general, or infertile persons, in general, is non-therapeutic; although the Committee seems to have classified it as therapeutic. It is also worth noting that although the Committee felt it worthwhile to distinguish between different categories of research, the relevance of the distinctions drawn is not demonstrated in any part of the Report.

Finally, in considering the application of principles governing medical research to "birth" technology and, in particular, to clinical research involving in vitro fertilization, the resulting embryos can be compared with recipients of artificial hearts. Like those recipients, the embryos can only exist through use of the relevant medical technology. But do different rules apply to the use of research technology to continue life, as compared with the use of research technology to commence life? The "artificial heart" cases also raise other questions which can and should be asked in relation to the use of "birth" technology.

First, when do we go beyond trying to benefit persons by offering them highly experimental, innovative medical techniques, and cross the line to the point at which they become medical martyrs, especially when that research technique is their only hope of continued existence?76 In this respect dying persons, including recipients of artificial hearts, and infertile persons may have more in common than is apparent at first glance. Infertility can be regarded as genetic death and can be compared with physical death. What is clearly a common factor is that persons in either situation are liable to feel desperate and to accept, sometimes far too readily, any avenue of hope held out to them. See-

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76. See J. Rachels, BarneY Clark's Key, (1983) 13 HASTINGS CENT. REP. (2) 17.
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ond, it could be asked whether persons offered artificial hearts have given a free and voluntary informed consent when they are not offered the full range of treatment options available, such as human heart transplantation, leaving them only the choice between agreeing to the artificial heart or death. 79 Likewise, persons seeking infertility treatment should be offered the full range of reasonably available options. It is not unlikely, when a given unit specializes in only one form of treatment, such as IVF, that this requirement, even if not overlooked, may not be adequately fulfilled. Third, the first recipient of an artificial heart, Dr. Barney Clark, was given a key to turn it off, which could be taken to indicate that there may not be the same obligations to continue life, or that there may be rights to discontinue it, when it is being "experimentally," as compared with "non-experimentally," maintained and prolonged. If this were true, it could have impact in relation to some "birth" technology situations, for instance, where the life of an embryo was regarded as being maintained through experimental means. Further, what would have been the situation if Dr. Clark had asked someone else to turn off his artificial heart for him? Would that person have been acting ethically and legally in doing so? Are there some things we may do with respect to ourselves that others may not do for us or to us? If this is true, the range of conduct which is acceptable with respect to embryos or fetuses would be more limited than would be that allowed with respect to competent, consenting adults.

6. Self-help and Assistance by Others

This raises the issue of rights to assistance and whether certain conduct might be tolerated (or at least not punished) when undertaken by a person in relation to himself or herself, but the participation of others in it is prohibited, usually because a dangerous precedent is involved. Decriminalization of suicide, while retaining the crime of assisting or aiding or abetting a person to commit suicide, is a good example of such an approach. 80 But how ready should we be to adopt this type of approach?

78. It should also be asked whether it would be unethical, although it certainly would not be illegal, to refuse to assist.

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This is becoming an increasingly important issue in health care ethics and law, including in relation to ethical and legal issues raised by some forms of "birth" technology. If a person is not prohibited from doing something himself, what are the reasons that justify prohibiting others from assisting him or her to do it? A further question is whether there is any duty to assist another. The first of these enquiries is relevant to whether, for instance, if there is no prohibition on using "self-help" artificial insemination by donor, there would be any reason, in principle, to say that a mail order sperm service is, or should be, illegal. If it is not illegal, may it be advertised? A major case about to come before the courts in Canada is the tobacco companies' challenge, on constitutional grounds, including freedom of speech, to the Government of Canada's legislation banning the advertising of tobacco products. The second question relates to whether it could be concluded that there are duties to provide access to reproduction technology in particular, that of "birth" technology, in some jurisdictions, for example Quebec, where there are legal rights to health care services.

III. Consistency and Inconsistency of "Conception Policy" in Reproduction Technology Situations

I wish now to turn to a more specific investigation of various situations involving the use of reproduction technology, particularly that of "birth" technology, and to explore them in terms of the presence of consistency or inconsistency with respect to "conception policy." It should be noted that the aim here is to raise a range of issues which need further and fuller discussion, rather than to undertake a comprehensive and in-depth analysis of any one issue. For instance, consistency of attitudes towards various types of reproduction technology are examined, but a fuller exploration of the reasons for these attitudes, and an examination of the consistency or inconsistency between such reasons, is also required. Further, when one looks at outcomes which

80. See "Turkey-Baster Babies": Kept Secret in Lesbian World, The Globe & Mail, Toronto, Aug. 29, 1980, at 11. It is recognized, however, that a "commercial" service is more open to abuse and, consequently, would require stricter controls and regulation. It may be argued that to regulate conduct is equivalent to prohibiting it. But this is not true when the conditions do not conceal a hidden agenda of prohibiting the conduct, but are aimed, for example, at protecting health and safety.

81. See, e.g., Health and Social Services Act, R.S.Q., c. S-5, sec. 4.

83. See supra section 1, at 1-3.


are not identical, as mentioned in the Introduction to this text, it needs to be asked whether such outcomes should be labelled as inconsistent or just as different. For instance, if the different outcomes are the logical result of the use of two different premises, and the adoption of the one or the other of these premises simply represents a value judgment, it may be misleading to speak of inconsistency. In short, some liberties are taken in this section in terms of use of the labels "consistent" or "inconsistent." This is done because the aim in this part of the text is to identify and highlight consistency and inconsistency, and a position has been taken that it is preferable to err on the side of "false positive" errors, that is, of attributing such a label where it is inappropriate, rather than to miss valuable comparisons. That is, "false negative" errors are likely to be minimal. This needs to be kept in mind.

A. Consistency of Attitudes

1. Consistency of Attitudes Towards Abortion with Those Towards "Birth" Technology

In order to assess the consistency of attitudes towards abortion with those towards "birth" technology, it must first be asked what values are promoted or inhibited by allowing or prohibiting abortion. It will also be relevant in relation to both areas to explore how any conflicting values within or between them can concurrently be respected to the greatest degree possible. We need to ask who supports pro-choice or anti-abortion (pro-life)lobbies and why. It has been recently alleged that abortion has become a symbol for two entirely opposite experiences of motherhood and of life. Upper middle-class, professional women have felt compelled to establish control over their reproductive processes and are the most vocal advocates of legalized abortion; but they value children and put great stock in being good mothers. In contrast, many of the women involved in the pro-life movement are housewives. Abortion represents an affront to their major responsibility — namely motherhood — of M.A. Somerville, and P. Nathanson. It is funded by the Donner (Canadian) Foundation and is part of the McGill Centre's "Program on Medicine, Ethics and Law and the Contemporary Canadian Family."
This is becoming an increasingly important issue in health care ethics and law, including in relation to ethical and legal issues raised by some forms of "birth" technology. If a person is not prohibited from doing something himself, what are the reasons that justify prohibiting others from assisting him or her to do it? A further question is whether there is any duty to assist another. The first of these enquiries is relevant to whether, for instance, if there is no prohibition on using "self-help" artificial insemination by donor, there would be any reason, in principle, to say that a mail order sperm service is, or should be, illegal. If it is not illegal, may it be advertised? A major case about to come before the courts in Canada is the tobacco companies' challenge, on constitutional grounds, including freedom of speech, to the Government of Canada's legislation banning the advertising of tobacco products. The second question relates to whether it could be argued that there are duties to provide access to reproduction technology in particular, that of "birth" technology, in some jurisdictions, for example Quebec, where there are legal rights to health care services.

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which they perceive as the primary factor lending dignity and worth to their lives.” Further, for these housewives, motherhood is the resource with which they trade not only with their husbands, but with the outside world. Thus, it can be postulated that such women do not want to allow any conduct which might imply the devaluation of motherhood, and certainly do not want motherhood to be converted into a disposable commodity, as in some senses abortion can be interpreted as doing. This is only one possible analysis of certain attitudes towards abortion, but it provides a good example of the depth and breadth of the analysis necessary to determine what factors underlie either a given attitude or any law which either reflects or is antithetical to that attitude.

The above analysis of abortion by Luker may also help to explain why some anti-abortionists are also anti-“birth” technology, and pro-choice persons are more likely to be pro-“birth” technology. One possible explanation is that persons who advocate destruction of fetuses by abortion, counteract any anti-children message this may give by currently advocating creation of fetuses through the use of “birth” technology. Pursuant to such a view it can be seen as no accident that with the current, almost world-wide liberalization of abortion laws, we have had “breakthrough” developments in “birth” technology which allow previously infertile persons to have children.

But why would anti-abortionists oppose “birth” technology when they are pro-life? One possible explanation is that they regard “birth” technology as inevitably involving the loss of embryos, whether this loss is planned or unplanned, and that less life is lost overall99 (although,

85. Id. Luker describes and explains her perceptions in this regard in various places throughout her text. For example: “People see in the abortion issue a simultaneously pragmatic, symbolic and emotional representation of states of social reality that motherhood — the raising of children and families — is the most fulfilling role that women can have. Id. at 169. “Women who oppose abortion and seek to make it officially unavailable are declaring, both practically and symbolically, that women’s reproductive roles should be given social primacy.” Id. at 200. “Abortion therefore strips the veil of sanctity from motherhood. When pregnancy is discretionary — when people are allowed to put anything else they value in front of it — then motherhood has been denoted from a sacred calling to a job.” Id. 205.

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[899] also, less is brought into being) by prohibiting the use of “birth” technology. This line of reasoning is consistent with the pro-life position being not so much a pro-production of life stance as a pro-respect of life one, and with the basis for their opposition to the use of “birth” technology being that such opposition shows the most respect for human life. But, one can also look at a different factor, that of the “artificial” control of reproduction, whether that control is exercised to promote or prevent reproduction, and find a consistency of approach by persons who are anti-abortion, anti-“birth” technology and pro-life.

They are consistent in that they are against control or interference with the reproduction process whether it is through abortion to destroy a fetus or “birth” technology to “create” one. Thus, on one analysis they can be regarded as being more anti-interference, than as being pro-life. Similarly, but conversely, pro-choice persons tend to be more pro-control, than to be anti-life. It is important to identify such factors, because they indicate that while one can be pro-control of persons over their own bodies (that is, would support allowing abortion), where this would not necessarily require that the fetus be killed, it follows that killing the fetus unnecessarily would not be justified.

This raises the issue of separating abortion (evacuation of the uterus) from destruction of the fetus, which, with the development of reproduction technology, is increasingly likely to be a relevant consideration in any given abortion situation. The possibility of circumstances arising in which there could be both abortion and non-destruction of the fetus will lessen the “practical effect” gap between the pro-choice and the anti-abortion groups, although it is probably unlikely that their attitudes will be de-polarized. This in turn would give rise to the possibility of a person concurrently holding views that were simultaneously pro-choice, pro-abortion (in the sense of accepting the necessity of allowing abortion, even if as a necessary evil), pro-control, and pro-life.

To retain an anti-abortion view, if abortion does not put the fetus at any serious risk, is not to be pro-life, but to be anti-control. However, anti-abortion attitudes are almost always linked not just to preserving an identified fetus, but also are linked to certain attitudes to one’s off
which they perceive as the primary factor lending dignity and worth to their lives. Further, for these housewives, motherhood is the resource with which they trade not only with their husbands, but with the outside world. Thus, it can be postulated that such women do not want to allow any conduct which might imply the devaluation of motherhood, and certainly do not want motherhood to be converted into a disposable commodity, as in some senses abortion can be interpreted as doing. This is only one possible analysis of certain attitudes towards abortion, but it provides a good example of the depth and breadth of the analysis necessary to determine what factors underlie either a given attitude or any law which either reflects or is antithetical to that attitude.

The above analysis of abortion by Luker may also help to explain why some anti-abortionists are also anti-"birth" technology, and pro-choice persons are more likely to be pro-"birth" technology. One possible explanation is that persons who advocate destruction of fetuses by abortion, counteract any anti-child messages this may give by concurrently advocating creation of fetuses through the use of "birth" technology. Pursuant to such a view it can be seen as no accident that with the current, almost world-wide liberalization of abortion laws, we have had "breakthrough" developments in "birth" technology which allow previously infertile persons to have children. But why would anti-abortionists oppose "birth" technology when they are pro-life? One possible explanation is that they regard "birth" technology as inevitably involving the loss of embryos, whether this loss is unplanned or unattended, and that less life is lost overall!* (although,

81. Id. Luker describes and explains her perceptions in this regard in various places throughout her text. For example: "People see the abortion issue as simultaneously pragmatic, symbolic and emotional representation of states of social reality — states that they find reassuring or threatening." Id. at 7. "Most pro-life activists believe that motherhood — the raising of children and families — is the most fulfilling role that women can have." Id. at 169. "Women who oppose abortion and seek to make it officially unavailable are declaring, both practically and symbolically, that women's reproductive roles should be given social primacy." Id. at 200. "Abortion therefore strips the veil of sanctity from motherhood. When pregnancy is discretionary — when people are allowed to put anything else they value in front of it — then motherhood has been demoted from a sacred calling to a job." Id. at 205.


87. This may or may not be true as a scientific fact with respect to unplanned loss of embryo life, but is definitely true with respect to planned loss. The fact that

also, less is brought into being) by prohibiting the use of "birth" technology. This line of reasoning is consistent with the pro-life position being not so much a pro-production of life stance as a pro-respect of life one, and with the basis for their opposition to the use of "birth" technology being that such opposition shows the most respect for human life. But, one can also look at a different factor, that of the "artificial" control of reproduction, whether that control is exercised to promote or prevent reproduction and find a consistency of approach by persons who are anti-abortion, anti-"birth" technology and pro-life. They are consistent in that they are against control or interference with the reproduction process whether it is through abortion to destroy a fetus or "birth" technology to "create" one. Thus, on one analysis they can be regarded as being more anti-interference, than as being pro-life. Similarly, but conversely, pro-choice persons tend to be more pro-control, than to be anti-life. It is important to identify such factors, because they indicate that while one can be pro-control of persons over their own bodies (that is, support allowing abortion), where this would not necessarily require that the fetus be killed, it follows that killing the fetus unnecessarily would not be justified.

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spring, and with this to the concept of the family. Abortion may be opposed because it denigrates from such values and, consequently, would still be opposed even in situations where the procedure would not be anti-life.

Even if we accept the notion that pro-choice advocates are pro-control and anti-abortionists are anti-control, and that this explains their attitudes towards "birth" technology, we still need to query whether there may be yet other deeper reasons which explain these differing attitudes to control. For instance, correspondence in the Lancet® refers to the coldness of "birth" technology, as well as the lack of respect for humans that it shows. That is, opposition to "birth" technology on the ground that it involves an unacceptable control factor may not be opposition simply to this control factor itself. Rather, the opposition may stem from a further belief that this control indicates a lack of respect for persons and a form of depersonalization of them and detachment from them that is unacceptable. To the contrary, it can be argued that when "birth" technology results in creating a family, the ends, if not the means, are humanizing. Increasingly, there is also a perception, particularly on the part of some feminists, that "birth" technology is one more means for men to use to control women.

This leads to the further question: Are we inhibited in speaking out against "birth" technology, or, similarly, do some people oppose "birth" technology because of fear? Could it be that fear is a consistent motive, but that the outcome of being fearful is inconsistent, due to the varying content of our fear? For example, we may be fearful because we believe that we are contravening a religious dictate and that this will have repercussions for us, if not in this life, in another one. Likewise, we may be fearful concerning repercussions in this life, for example, we may fear that we might lose our research grant if we are considered by our peers to be too restrictive in our approach to "birth" technology research, or, conversely, we might be considered by other persons, who have the ability to affect research funding decisions, to be not restrictive enough. Which of these scenarios would apply in a given situation is simply a question of the governing political reality with respect to who has ultimate control over the research funding in question.

Can it be argued, also, that abortion and some forms of "birth" technology (and perhaps all forms, if "birth" technology as a whole is seen as dehumanizing reproduction and making it simply a technologi-
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promote pro-natal outcomes. Nor is there consistency in terms of a person's attitudes being uniformly anti-interference, anti-control of reproductive functions, if that person is, at the same time, pro-contraception. The factors which distinguish contraception from abortion flow from the event of conception. At this time, there is genetic uniqueness (or at least there is fourteen days after fertilization when the embryo can no longer divide to form identical twins) and, for some persons, from a religious viewpoint, enrolment may then have occurred. These differences can be relied upon to distinguish the human embryo from human gametes for the purposes of differentiating the type of conduct which is allowed with respect to each. Consequently, a person can be pro-control of gametes (pro-contraception), but anti-control of embryo (anti-abortion and anti-some forms of "birth" technology). However, some forms of contraception (for example, intra-uterine devices (IUDs) or certain types of low dose oral contraceptives) do not prevent fertilization, but only implantation. (These would be better called contra-implantatives.) Often, persons who are pro-contraception, but anti-abortion, do not distinguish between these methods of contraception and other methods which inhibit fertilization, yet they would oppose any "contraceptive" technique which they consider constitutes abortion. This contradictory attitude may simply reflect a failure to recognize that fertilization may have occurred. Or, if there is such recognition, there may be either denial that fertilization has occurred, or acceptance of the situation, even though it is inconsistent with the person's exposed values. It may also be that because there is no certainty that fertilization has taken place, a woman using an IUD and her partner can rely on this uncertainty to avoid facing the issue that their use of contraceptives may have caused an embryo to be destroyed. Alternatively, such persons may be adopting a view that interference with an embryo is only unjustified after implantation has occurred; this view would have ramifications with respect to the acceptability of carrying out research on early embryos, at least if such persons were to hold consistent views. It would indicate that research on pre-implantation embryos, and, indeed, research on any embryo that had not and could not implant in a uterus, could be acceptable to them.

90. I am indebted to my colleague, Professor W. F. Foster, of the Faculty of Law, University of Melbourne, for raising this consideration.

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3. Consistency of Attitudes Towards Abortion and Contraception in Comparison with Those Towards Embryo Research

The issue is raised whether it is inconsistent to allow abortion and post-fertilization means of "contraception" on the one hand, yet prohibit embryo research on the other. In this regard, we need to examine whether discarding an in vitro fertilized embryo is equivalent to abortion and, if it is, why this should be required at fourteen days, whereas legal abortion can take place much later. Could this be related to the fact that discarding is not to the destruction of the embryo, but to the research that is carried out on it? Or is it that destruction of the embryo is an unwanted secondary effect in abortion, but the primary aim at some stage in all laboratory (non-clinical) embryo research? Would it make a difference, therefore, if the research were aimed at prolonging the life of the embryo; for example, the research was to develop an artificial placenta? Or is it the creation of an embryo solely for research purposes which is objectionable and differentiates embryo research from abortion situations? But, one may then ask why is embryo research up to fourteen days acceptable, when this also involves the creation and then destruction of the conceptus?

It can also be asked whether our treatment of the embryo is consistent when, for instance, we prohibit research on it, yet simultaneously allow methods of contraception, such as the IUD, which, as already pointed out, probably function by preventing implantation rather than by preventing fertilization? Is it inconsistent to object to embryo research, but not the use of the IUD or, even, the practice of early abortion? These situations differ in light of the motives of the person who intervenes and the type of interventions involved. Experimentation on the embryo is clearly using the embryo for a purpose not of benefit to itself, but of benefit to others. It is treating it entirely as a thing, as an object. In comparison, in use of the IUD, the primary aim is to allow the woman not to undertake a pregnancy which she does not wish and there is no use of the embryo. In both cases, there is consistency in that the embryo will not survive, but the reasons for seeking this result and the fundamental nature of the interventions on the embryo differ.
promote pro-natal outcomes. Nor is there consistency in terms of a person's attitudes being uniformly anti-interference, anti-control of reproductive functions, if that person is, at the same time, pro-contraception.

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In this respect, it is interesting to note the provisions of the Canadian Criminal Code that until very recently, when they were struck down as unconstitutional by a majority of the Supreme Court of Canada, in _R v. Morgentaler_, the Court provided a law, which allowed abortion to protect the mother's life or health, would not be unconstitutional, provided its substantive and procedural requirements were clear and did not unnecessarily infringe the woman's right to security of her person. Have we avoided focusing on elimination of the fetus, because the implications for handicapped persons in our society are too serious? We would be providing a strong, direct, and express message that handicapped persons are not wanted, that different "rules" apply to them, and much more. Or do we not want to acknowledge that we condone the death of the fetus in abortion, but rather wish to believe that we are primarily protecting the mother's health? Further, if we allow abortion of fetuses for relatively minor reasons relating to the mother, why not allow the procedure if the fetus has serious handicaps? It can be asked whether it is important for, among other reasons, that of emotional justification of abortion, that the reason for allowing the abortion is attached to the mother (and possibly in particular the mother's health) and not the fetus. This may help us to ignore the fear of attrition and to rationalize its destruction as a secondary effect, which, while regrettable, is unavoidable. Is this the reason why we may not be ready to accept abortion on the grounds of sex selection unrelated to any additional genetic risk, even in jurisdictions that allow abortion on de

In this respect, it is interesting to note the provisions of the Canadian Criminal Code that until very recently, when they were struck down as unconstitutional by a majority of the Supreme Court of Canada, in R v. Morgentaler, governed the carrying out of abortion in Canada. The relevant section of the Code provided that abortion could be legalized when "continuation of the pregnancy...would or would be likely to endanger...[the woman's life or health]" which was interpreted to include mental health. There was no legislative provision allowing abortion on eugenic grounds or on the basis that the fetus was seriously handicapped. While such considerations were taken into account "via" the protection of the mother's mental health, it is relevant that we chose not to confront directly that we were prepared to accept the abortion of seriously handicapped fetuses. It is also interesting that a majority of judges in the Supreme Court of Canada in the Morgentaler case accepted that a law, which allowed abortion to protect the mother's life or health, would not be unconstitutional, provided its substantive and procedural requirements were clear and did not unnecessarily infringe the woman's fundamental right to security of her person. Have we avoided focusing abortion on elimination of the fetus, because the implications for handicapped persons in our society are too serious? We would be providing a strong, direct, and express message that handicapped persons are not wanted, that different "rules" apply to them, and much more. Or do we not want to acknowledge that we condone the death of the fetus in abortion, but rather wish to believe that we are primarily protecting the mother's health? Further, if we allow abortion of fetuses for relatively minor reasons relating to the mother, why not allow the procedure if the fetus has serious handicaps?

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The hardening of the Roman Catholic attitude [to abortions] in the nineteenth century, and the closing of options hitherto kept open, was the product of fear, of a reaction to the result of new medical skills. Hitherto abortion had commonly been procured indirectly, by a potion or some other provoke given to the mother. Now doctors, with new and antisepctic techniques, were able to attack the fetus directly, and the incidence of direct abortion mounted alarmingly. The Church saw in this a threat to the sacredness of human life, and responded with the strongest measures open to it: a complete prohibition, backed by the most severe penalties.

4. Consistency of Attitudes Towards Reproduction Technology in Comparison with Those Towards Other Medical Procedures

It is not sufficient, if one is attempting to determine whether attitudes about various forms of reproduction technology or the policies concerning this technology are consistent, to make only internal comparisons within this area. External comparisons are also needed because reproduction technology is part of the larger "value and policy web" of both medicine and society. Consequently, it cannot be properly examined in isolation from these. That is, we need to look at the similarities and differences between different reproduction procedures, themselves, as well as those between these and other medical procedures. In particular, the rules of ethics or law which govern various...
medical procedures and the factors which determine these rules need to be re-examined in the light of reproduction technology. This could lead to new insights and perceptions in both areas. For instance, abortion or demand for purely contraceptive sterilization can be compared with cosmetic surgery, in that they are all non-therapeutic medical interventions. Whether most uses of "birth" technology should be characterized as being non-therapeutic, or as a treatment for infertility and, therefore, therapeutic, is debatable. But, to adopt the latter approach leads to the conclusion that one is prescribing a child as therapy. Further, as has been pointed out already, the rules applicable to therapeutic and non-therapeutic medical research differ. We must also carefully analyze the general legal-medical doctrine of informed consent, as well as its application in the context of "birth" technology. These are but examples of the wide range of situations where comparative analysis could prove fruitful.

5. Consistency of Attitudes Regarding Access to Anti-Reproduction and to Pro-Reproduction ("Birth") Technology

Access to sterilization and abortion can be compared with access to "birth" technology. An important question is whether there are any rights of access. Should we be concerned to ensure consistency of access to these technologies? If so, should there be consistency of access to all such technology? Or should consistency of access only be required within each discrete category that is, those of pro-reproduction and anti-reproduction technology? The provision of ready access for "birth" technology and anti-reproduction "birth" technology would indicate the implementation of a policy of giving persons control over their reproductive functions, whether this control is used to achieve pro-natal or to achieve anti-natal outcomes. On the other hand, providing access to only either pro-reproduction or anti-reproduction technology could indicate a pro-reproduction or an anti-reproduction policy, respectively. For instance, almost all governments in Europe support family planning. Does this indicate an anti-natal policy or a pro-control of reproduction approach? One indication that it could be the latter would be concurrent support by the government of "birth"

99. Supra section III(B)(5).
100. See infra section III(F)(4).

102. It is here to some common law lawyers to suggest that rights can be relative, because inherent to their definition of a right is that it is absolute. In comparison, civil law lawyers are much more comfortable with a concept of the relativity of at least some rights, which has been developed in the doctrine of "abus de droit" ("abuse of rights"). For a summary of the civil law doctrine of "abus de rights" and for a comprehensive bibliography on this topic, see J.-L. Baudouin, La responsabilité civile délictuelle, Les Presses de l'Université de Montréal, nos. 65-93, at 55-75 (1973).
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Persons having control over their reproduction can involve a spectrum of situations from exercising such control in order not to reproduce, as in abortion, contraception and sterilization; to control being exercised in order to limit family size or for sex selection; to a person's having control in the sense of having access to the technology or treatments which are necessary to enable that person to reproduce. Without judging the moral acceptability of these procedures either individually or as a whole, consistency with respect to a policy which promotes persons having the fullest possible control over their reproductive functions would allow, or even establish rights to have access to reproduction technology, regardless of whether this was being used to inhibit or to promote reproduction.

It is interesting to examine the law of any given jurisdiction, in order to determine whether that society has a pro-natal or anti-natal policy, or is simply neutral in this respect, or has a policy of "pro-control of reproduction by the individual concerned." In examining the nature of possible legal rights relating to reproduction, the following formulations can be compared:

(1) a right not to have one's reproductive capacity interfered with;
(2) a right not to have one's decisions concerning one's reproductive capacity interfered with;
(3) a right to control one's reproductive capacity;
(4) a right not to have one's decisions concerning reproduction overridden;
(5) a right to control one's reproduction; and
(6) a right to reproduce.

In comparing these different formulations of rights, all of which relate to the same basic situation of reproduction, two further factors should also be kept in mind. First, even if a right is recognized, is it relative or absolute? That is, is there a limited or relative right or an absolute right to control one's reproductive function? Second, is the right formulated with positive or negative content — is it a "right to . . . " or a "right not to . . . "

99. Supra section II(B)(5).
100. See infra section III(F)(4).
"right not to..."? Although attribution of a given right, in defined circumstances, may be independent of its positive or negative formulation, the ability to exercise a right can be very different depending on which of these two forms has been used in articulating it. This is particularly likely to be true, where the assistance of others is required to exercise the right. With this in mind, each of the rights listed above can be analyzed in terms of what they could encompass with respect to rights of access to reproduction technology, including "birth" technology.

The first right is negative in content and does not contemplate any right of access to pro-reproduction or anti-reproduction technology. It is, in effect, a statement of an inviolability principle (that is, the right not to be touched without one's consent), in relation to reproductive function. The second right is also negative in content as is the fourth. The difference between the second and fourth rights is that while both would encompass contraception and sterilization, the former, unlike the latter, would not contemplate any right to abortion. In all probability, neither of these rights creates any positive content obligation to provide access to either pro-reproduction or anti-reproduction technology. Rather, they would most likely be interpreted to the effect that access to this technology must not be inhibited, within the limits of the right, without justification. While the third right may not differ from the second, it is of more positive content and, consequently, is more likely than the second (although far from certain) to be held to contemplate access to "birth" technology as a right. In comparison, the fifth formulation contemplates an obligation to provide access to both pro-reproduction and anti-reproduction technology. Even more clearly, the sixth right could contemplate an obligation to provide access to "birth" technology, but, unlike the fifth right, does not encompass any right to prevent reproduction.

One can then examine American and Canadian law regulating reproduction, in the light of the formulation of legal rights set out above. First, there is no legally established right to reproduce, in either American or Canadian law.** Second, the legal systems in these jurisdictions do establish a right not to be subjected to unconsented to interfere with one's reproductive capacity.104 Third, in both the United States and Canada, contraception and sterilization are legal provided that there is "informed consent." This is one type of confirmation that there is a right to be free of interference in one's decisions to inhibit the exercise of one's reproductive capacity, at least by means of contraception and sterilization.

These two legal systems are not identical with respect to the fourth right, listed above, insofar as it is sought to use this to found a legal right to abortion. A right not to have one's decisions concerning reproduction interfered with is very similar to that of the constitutionally protected right of "reproductive privacy," relied upon by the Supreme Court of the United States in Roe v. Wade105 to strike down state statutes restricting access to abortion. This right is seen as overriding until the point at which the fetus achieves viability.106 In comparison, until very recently, Canadian law made abortion a criminal offense, unless such action was authorized by a therapeutic abortion committee or fell within a common law defense of necessity.107 Thus, in Canada, after a woman was pregnant, she did not have the same freedom to decide not to reproduce or, more accurately, not to allow reproduction to continue, as did a woman in the United States. This situation changed dramatically with the decision of the Supreme Court of Canada in the Morgentaler case.108 The Court struck down the entire abortion law as being unconstitutional. In Canada, there is now no law prohibiting abortion and new law may or may not be introduced. This means that a woman can legally have an abortion on demand at any time during her pregnancy. The defense of necessity has concurrently become irrelevant to law governing abortion in Canada because there is no need for a defense when the act itself is legal.

106. It is interesting to contemplate definitions of viability in relation to fetuses, in light of the developments in "birth" technology. Viability is usually defined as the ability of the fetus to live outside the body of its mother, with or without artificial support. See, e.g., Colautti v. Franklin, 439 U.S. 379 (1979). A frozen embryo fits this definition in literal terms. Should it, and will it, be classified as viable for the purposes of the law?
"right not to..."? Although *attribution* of a given right, in defined circumstances, may be independent of its positive or negative formulation, the ability to *exercise* a right can be very different depending on which of these two forms has been used in articulating it. This is particularly likely to be true, where the assistance of others is required to exercise the right. With this in mind, each of the rights listed above can be analyzed in terms of what they could encompass with respect to rights of access to reproduction technology, including "birth technology.

The first right is negative in content and does not contemplate any right of access to pro-reproduction or anti-reproduction technology. It is, in effect, a statement of an inviolability principle (that is, the right not to be touched without one's consent), in relation to reproductive function. The second right is also negative in content as is the fourth. The difference between the second and fourth rights is that while both would encompass contraception and sterilization, the former, unlike the latter, would not contemplate any right to abortion. In all probability, neither of these rights creates any positive content obligation to provide access to either pro-reproduction or anti-reproduction technology. Rather, they would most likely be interpreted to the effect that access to this technology must not be inhibited, within the limits of the right, without justification. While the third right may not differ from the second, it is of more positive content and, consequently, is more likely than the second (although far from certain) to be held to contemplate access to "birth" technology as a right. In comparison, the fifth formulation contemplates an obligation to provide access to both pro-reproduction and anti-reproduction technology. Even more clearly, the sixth right could contemplate an obligation to provide access to "birth" technology, but, unlike the fifth right, does not encompass any right to prevent reproduction.

One can then examine American and Canadian law regulating reproduction, in the light of the formulation of legal rights set out above. First, there is no legally established right to reproduce, in either American or Canadian law. Second, the legal systems in these jurisdictions do establish a right not to be subjected to unconsented to interference with one's reproductive capacity. Third, in both the United States and Canada, contraception and sterilization are legal provided that there is "informed consent." This is one type of confirmation that there is a right to be free of interference in one's decisions to inhibit the exercise of one's reproductive capacity, at least by means of contraception and sterilization.

These two legal systems are not identical with respect to the fourth right, listed above, insofar as it is sought to use this to found a legal right to abortion. A right not to have one's decisions concerning reproduction interfered with is very similar to that of the constitutionally protected right of "reproductive privacy," relied upon by the Supreme Court of the United States in * Roe v. Wade* to strike down state statutes restricting access to abortion. This right is seen as overriding until the point at which the fetus achieves viability. In comparison, until very recently, Canadian law made abortion a criminal offense, unless such action was authorized by a therapeutic abortion committee or fell within a common law defense of necessity. Thus, in Canada, after a woman was pregnant, she did not have the same freedom to decide not to reproduce or, more accurately, not to allow reproduction to continue, as did a woman in the United States. This situation changed dramatically with the decision of the Supreme Court of Canada in the * Morgentaler* case. The Court struck down the entire abortion law as being unconstitutional. In Canada, there is now no law prohibiting abortion and new law may or may not be introduced. This means that a woman can legally have an abortion on demand at any time during her pregnancy. The defense of necessity has concurrently become irrelevant to law governing abortion in Canada because there is no need for a defense when the act itself is legal.


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The defence of necessity is, however, relevant to American law governing abortion, because it can be used to render lawful an abortion carried out after viability of the fetus. After this time, a woman's right to privacy, and, consequently, any right not to be prevented from having an abortion based on this privacy right, are overridden by claims of the viable fetus to preservation of its "potential life," unless the woman's life or health is seriously threatened. That is, the basis on which an abortion would be legalized in such circumstances, would be the doctrine of necessity, which was recognized by the Supreme Court of the United States in Roe v. Wade. The difference between American and Canadian law in this respect, prior to the Morgentaler case, was that in Canada all legal "rights" to abortion, whether arising under statute or at common law, were based on a therapeutic criterion. Consequently, in Canada the legality of all abortions depended, to some extent, on necessity, whereas in the United States the doctrine of necessity would only be relevant to an abortion performed after the fetus becomes viable.\footnote{109} Now, in Canada, there is no need in law to show necessity in order to perform an abortion at any stage of the pregnancy. However, in practice, it is unlikely that physicians would perform an abortion after viability, unless a situation of necessity were present.

The fifth formulation of a right articulated above contemplates positive rights of access to "birth" technology. Such rights are particularly important when a procedure can only be carried out with medical assistance, as is true for most abortions and many "birth" technology situations, which are therefore similar in this respect. There is no legal right to assistance in having an abortion, in either the United States or Canada, except in rare circumstances. In both countries, such a situation would occur where the life of the mother is in danger and there is no reasonable alternative except for the physician, with whom she is in a treatment relationship, to perform the abortion. However, the right involved here is that of the woman not to be abandoned by the physician, when that would endanger her life, which situation would, almost certainly, never arise in the context of a woman claiming access to "birth" technology. That is, no right of access to "birth" technology could be established by reliance on such rights. In Canada, there are also rights, under provincial law, to emergency medical treatment,\footnote{111} which might include abortion, or even other anti-reproduction technology, but almost certainly would never include "birth" technology.\footnote{118}

It may also be asked whether we should consider adopting a legal rule which reflects a policy of "pro-control of reproduction by the individual concerned," or perhaps a legal rule which contemplates rights to reproduce, as in the sixth formulation of possible legal rights delineated above. Both these rights could include correlative obligations either not arbitrarily or unreasonably to deny persons opportunities to reproduce,\footnote{116} or, even, to act affirmatively to provide opportunities in this respect. Such rights would not have been important in the past, when there was little medical science could do to assist infertile people, but this is no longer true. However, the creation of such legal rights could have other ramifications. For instance, if a right to reproduce were to be recognized, prisoners could allege that their rights in this respect were being contravened, if they were not allowed conjugal visits.\footnote{114} Such difficulties could be avoided by framing any legal right to be "assisted in reproduction," as one of access to health care, which would be defined as including access to "birth" technology where this was needed as a treatment for infertility. Consequently, persons who were not infertile would not be denied any right of access to necessary health care if they were denied access to "birth" technology, because the right only contemplates an obligation to provide such access when this is necessary as the only reasonable means of overcoming infertility. Likewise, any right to have assistance in not reproducing could depend on this being necessary as health care. This approach would not only make the regulation of rights of access to pro-reproduction and anti-reproduction technology consistent, but also, would avoid another difficulty. Establishing a legal right either of control over one's reproduction or of non-interference with one's decisions concerning reproduction would, almost certainly, be interpreted as creating a right to abortion
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109. Except as discussed in the following paragraph, there may be no right, as such, to abortion in either Canada or the United States. Rather, at any time during its pregnancy, in Canada, and up to a certain time, or, after that time, on certain conditions, in the United States, abortion is not a crime.

110. Somerville, supra note 88.
on demand. But, this is not the present law in those jurisdictions where only therapeutic abortion is legal, or the only legal justification for abortion after a certain period of gestation, is that it is required therapy for the mother. Such conflicts are avoided when all rights of access to reproductive technology depend upon such access being necessary as health care. It is recognized that such an approach invites precisely that some interventions are necessary health care when in fact they are not, in order to gain the desired access. However, it needs to be pointed out in this regard that the subject of discussion here is a right of access to reproduction technology and the basis on which this could be recognized. Further questions are involved in deciding whether, in the absence of any such right, the situation is either one in which access may be provided (that is, there is no obligation either to provide or not to provide access to reproduction technology) or one in which it ought not to be provided.


One also needs to consider, here, attitudes to reproduction by persons who comprise a group which can be called "non-traditional" parents and, in particular, the use by such persons of "birth" technology to facilitate reproduction. Included in this definition of a "non-traditional" parent would be anyone desiring to have children outside a heterosexual, married and cohabitation relationship. Should we allow, if there is a law prohibiting discrimination on the basis of sexual orientation, should and would this be applied to prohibit such discrimination on this ground in gaining access to "birth" technology? If homosexual or lesbian parents are awarded custody in divorce suits, does this indicate that there is no valid reason for, and there should be no policy of withholding "birth" technology from these persons? Or are the issues raised in these situations, which do not involve "birth" technology, different in kind from the issue of who should have access to "birth" technology, and, therefore, should not be used as a precedent in this latter respect?

If we do withhold "birth" technology from persons who desire to become "non-traditional" parents, are we doing so on moral grounds? Or are we doing this on the basis of the "best interests of the child," and because we are making a judgment that such people are unfit to parent, whether it be psychologically, socially, financially or even genetically? In this case, we can extend such reasoning and ask whether all applicants for "birth" technology should be screened for fitness to parent. Apart from extreme cases, can we and should we judge whether a person is "fit" to parent? What if it were shown that a child with one loving parent was better off than a child with two quarrelling, rejecting parents, should couples be assessed with respect to the "health" of their relationship before they are given access to "birth" technology in preference to a single, likely-to-be-loving person? Further, if single persons are denied access to "birth" technology on the grounds that a child needs a male and a female parent, should couples be assessed for the likelihood of the breakdown of their relationship? Perhaps, the major issue raised here is whether there should be an irrevocable presumption, or, even, an initial presumption, that single persons should not be given access to "birth" technology. Further, should any such presumption be so irrevocable that, for example, an "in vitro" embryo whose father was killed, would not be available to the mother? The Waller Report is ambivalent in this respect, because, as it states, it can be argued that it should not be public policy to provide technological assistance and scientific and medical help to ensure the birth of a child to a single parent. Given that there is a choice, it is difficult to maintain

115. See id.

116. For a comprehensive list of the relevant legislation in each province of Canada, see B.M. DICKENS, MEDICO-Legal ASPECTS OF FAMILY LAW, 5 n.12 (1979).

117. The use of the word "single" to describe a person's marital status can be confusing, because it can mean that a person is unmarried and not cohabitjng with a person of the opposite sex, or that the person is unmarried, but living in a "de facto" marriage relationship. On the whole, in this paper, the former sense is intended, except where it is made clear that this is not the case. Perhaps thought should be given to adopting tripartite terminology, namely: single, unmarried and married persons, where the second term would indicate that there is a "de facto" marriage relationship.

118. See, e.g., Charter of Human Rights and Freedoms (Quebec) supra note 111, sec. 10.

119. Somerville, supra note 114.

120. See, supra section II(A)(6).
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apy for the mother. Such conflicts are avoided when all rights of access to reproductive technology depend upon such access being necessary as health care. It is recognized that such an approach invites pretense that some interventions are necessary health care when in fact they are not, in order to gain the desired access. However, it needs to be pointed out in this regard that the subject of discussion here is a right of access to reproduction technology and the basis on which this could be recog-

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sence of any such right, the situation is either one in which access may be provided (that is, there is no obligation either to provide or not to provide access to reproduction technology) or one in which it ought at to be provided.

6. Consistency of Attitudes Towards and Rules Governing Ac-

cess to “Birth” Technology with Those Governing Custody of and Access to Children

One also needs to consider, here, attitudes to reproduction by pe-

sons who comprise a group which can be called “non-traditional” pa-

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ogy to facilitate reproduction. Included in this definition of a “non-

traditional” parent would be anyone desiring to have children outside a heterosexual, married and cohabitational relationship. Should we allow, be neutral towards, or prohibit the use of “birth” technology by persons who deviate from this norm? For example, if we allow a single person to adopt a child (as is possible on varying conditions in all provinces of Canada117), should we, likewise, allow single persons to have access to “birth” technology?118 If there is a law prohibiting discrimina-

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that the interests of a possible child are well served by bringing it into existence in such circumstances."

However, to give a woman, whose husband has died, access to his frozen semen (as happened in a French case)\(^{122}\) and to deny a woman similarly situated an embryo which is genetically hers, as well as her partner's, would be totally inconsistent. It is true that it is highly desirable for a child to have a male and female social parent, whether or not these persons are also the biological parents, and it is also true that in certain circumstances single persons may be unsuitable parents. But, this should not be an immutable presumption, any more than it should be presumed that couples will automatically be suitable parents. At worst, although it is not suggested that such an approach be adopted, the initial presumptions as to suitability to parent could differ in the two cases. Further, where "assisted reproduction" is not necessary, the issue of suitability to parent is moot. It is also relevant, in the context of this discussion, to look at the many children who are raised by a single parent as a result of divorce. Does it make a difference that single parenthood occurs in most of these cases by chance (or at least, one presumes, was not intended at the time of conception) rather than by choice?\(^{123}\)

Before deciding that approaches taken with respect to awarding custody of, or access to children, in situations of divorce or adoption, indicate policies which should be consistently carried through with respect to giving access to "birth" technology, the ramifications of this would need to be explored.\(^{124}\) If the law of a given jurisdiction provides

121. Waller Report, supra note 17, section 2.15, at 31.

122. The Purpahuis case (France) referred to in Friedrich, A Legal Moral Social Nightmare, TIME, Sept. 10, 1984, at 52. The rights of a woman to have access to a given man's semen after his death raises some interesting issues. If the man has left directions, provided they are not contrary to "public policy" or "public order and good morals," his wishes should govern. In the absence of directions, however, is there any less reason to give the sperm to a woman who had a relationship with the donor, and requests it, than to some woman to whom the donor was unknown? Is the reason for refusing the insemination of such a woman who requests the sperm, that she is single? Or could it be that it is not in the "best interests" of the child for his or her mother to know that she is carrying and will give birth to the child of a dead person, whereas the recipient of an anonymous donation of sperm is unaware of these circumstances?

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that couples with one child have priority to adopt a second child, in order not to have one-child families, should the same rule be applied in determining priority of access to “birth” technology? And, if treatment of prospective parents' infertility is seen as therapy,125 could this ever also be regarded as therapy for an only child? Or, could it be argued, for example, that the fact that a divorced father can be awarded sole custody of his children is support for proposals in favor of allowing surrogate motherhood? This follows because such a custody award recognizes a single man’s claim to raise his child, and unless surrogate motherhood is available there would be no means for a single man to have his own child and claim custody of it on birth. For the same reasons, it may be asked whether a policy of equality between the sexes indicates that surrogate motherhood should not be outlawed.126 Likewise, antidiscrimination legislation may indicate that we should at least start from an initial presumption that we should not discriminate on the basis of sex (gender), sexual orientation, marital status, or age

125. It is interesting to contemplate whether a single person can even be regarded as infertile, or only a couple and, consequently, an intervention can only be regarded as therapeutic if it is carried out in relation to a couple. In one sense, all single persons are infertile in that they cannot reproduce without access to the gametes of a person of the opposite sex (with the exception of cloning). But, clearly, what is contemplated by the notion of infertility is the inability to reproduce with either any person, or a given person, of the opposite sex. The two types of infertility could be described as extrinsic (that is, the person seeking to use “birth” technology to reproduce lacks an extrinsic factor in achieving this aim) and intrinsic (that is, there is an intrinsic impediment to reproduction for the person, or if a couple is involved, for the couple, including the likelihood of transmitting genetic disease. For instance, a man's sterility is intrinsic to him, and to the couple of which he is a partner, and hence to his wife as part of the couple, but not to her individually). To some extent the distinction between intrinsic and extrinsic infertility reflects that between therapeutic and non-therapeutic treatment of infertility, respectively. The distinction between ex- trinsic and intrinsic infertility is relevant to whether single persons, who are not intra-

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(within the limits of fertility) in providing access to "birth" technology. In short, if there are policies of non-discrimination operative in other areas of our society, implemented by law, and, in particular, if those policies are applied in determining rights to custody of, or of access to, children, it may be inconsistent not to apply them in governing access to "birth" technology. However, it is a separate and further question whether such inconsistency may be justified. The point being made here is that when inconsistency is present it always needs to be recognized and, sometimes, justified. Further, we must consider not only extrinsic consistency or inconsistency, but also intrinsic consistency or inconsistency with respect to the rules that we adopt to govern access to or use of "birth" technology. For instance, if we were to outlaw surrogate motherhood, but did not outlaw access of single women to artificial insemination by donor (AID), this would mean that a single woman would not be acting illegally by utilizing "birth" technology in parent a child, but a single man would be. We should at least consider whether such inconsistencies need justification. Just because we find, for example, surrogate motherhood, especially the idea of single men using it to found families, highly reprehensible, is not a sufficient reason to avoid articulating and examining the arguments for and against allowing or prohibiting this.

Three warnings are appropriate with respect to the above discussion. First, its emphasis is on the rights or the claims of potential parents against wrongful discrimination in the "birth" technology context. These are valid considerations, but they may often be outweighed by the "best interests" of the child, which must always be a priority. The most difficult issue raised by adopting this latter criterion to govern decisions on access to or use of "birth" technology is that it may involve saying that a child is better off not being conceived and born, than, for example, being born to a surrogate mother and given up in another person to be raised. Second, it focuses on rights to reproduce and to parent a child, when a more appropriate primary focus is on responsibilities in these respects. Third, even if a given course of action is justified on a micro-level (whether in terms of ethics, risk-benefit calculus or other factors) and it fulfills the wishes or claims of an individual, it could still have harmful repercussions on a macro-level. In short, protection of society from adverse social consequences could justify the prohibition of certain conduct that is desirable in terms of promoting personal satisfaction.339

We can examine the acceptability of surrogate motherhood with such warnings in mind. The Warnock Report is negative about the use of surrogate motherhood, including its use by a married couple:

Even in compelling medical circumstances the danger of exploitation of one human being by another appears to the majority of us far to outweigh the potential benefits [of surrogate motherhood], in almost every case. That people should treat others as a means to their own ends, however desirable the consequences, must always be liable to moral objection.340

However, it should be noted that the Report appears to object to other persons using the carrying function (the so-called biological function) of the surrogate mother in order to obtain a child, rather than to the genetic donation of the surrogate mother, that is the use of her gametes. In this respect, the Committee records that "[t]he Report expresses its concern about the use of AID and rejection of surrogate motherhood. Because it would ban surrogate motherhood for everyone, the Warnock Committee does not identify the use of a surrogate mother by a single man as a consideration or examine the issues involved in this. However, it does refer, in passing, to the use of AID by single women.341 That is, those living outside a heterosexual relationship, without commenting on it.342 It may be asked why this approach was taken. Was it based on the pragmatic reason that prohibition of access to AID by single women was simply not feasible? Or does it indicate that there is less disapproval of this use of AID than of any use of prospective motherhood? To the extent that the Warnock Committee did not disapprove of single women being given access to AID, it is in line with other jurisdictions where

128. [Note]: supra note 15 at 10.
131. As previously explained, there is confusion in use of the term single woman or man. See supra note 117. Traditionally, it means unmarried, but in the Warnock and Waller Reports, it means a person living outside a heterosexual couple relationship.

127. See, Dunsan Report, supra note 15, section 8.2, at 80; see also supra section II(B)(1), and note 58.
Somerville: Weaving "Birth" Technology into the "Value and Policy Web" of Mod:

In short, if there are policies of non-discrimination operative in other areas of our society, it is possible to provide access to "birth" technology. However, it is a separate and further question whether such inconsistency may be justified. The point being made here is that when inconsistency is present, it always needs to be recognized and, sometimes, justified. Further, we must consider not only extrinsic consistency or inconsistency, but also intrinsic consistency or inconsistency with respect to the rules that we adopt to govern access to or use of "birth" technology. For instance, if we were to outlaw surrogacy, but did not outlaw access to single women to artificial insemination by donor (AID), this would mean that a single woman would not be acting illegally by utilizing "birth" technology to parent a child, but a single man would be. We should at least consider whether such inconsistencies need justification. Just because we find, for example, surrogate motherhood, especially the idea of single men using it to found families, highly reprehensible, is not a sufficient reason to avoid articulating and examining the arguments for and against allowing or prohibiting this.

Three warnings are appropriate with respect to the above discussion. First, its emphasis is on the rights or the claims of potential parents against wrongful discrimination in the "birth" technology context. These are valid considerations, but they may often be outweighed by the "best interests" of the child, which must always be a priority. The most difficult issue raised by adopting this latter criterion to govern decisions on access to or use of "birth" technology is that it may involve saying that a child is better off not being conceived and born than, for example, being born to a surrogate mother and given up to another person to be raised. Second, it focuses on rights to reproduce and to parent a child, when a more appropriate primary focus is on responsibilities in these respects. Third, even if a given course of action is justified on a micro-level (whether in terms of ethics, risk-benefit calculus or other factors) and it fulfills the wishes or claims of an individual, it could still have harmful repercussions on a macro-level. In short, protection of society from adverse social consequences could justify the prohibition of certain conduct that is desirable in terms of pro-

127. See, Dunstan Report, supra note 15, section 8.2, at 80; see also supra section H(B)(1) and note 54.

However, it should be noted that the Report appears to object to other persons using the carrying function (the so-called biological function) of the surrogate mother in order to obtain a child, rather than to the genetic donation of the surrogate mother, that is the use of her gametes. In this respect, the Committee records that "[i]t is argued ... that it is inconsistent with human dignity that a woman should use her uterus for financial profit and treat it as an incubator for someone else's child." This distinction might explain the concurrent acceptance of AID and rejection of surrogate motherhood. Because it would ban surrogacy, everyone, the Warnock Committee does not identify the use of a surrogate mother by a single man as a consideration or examine the issues involved in this. However, it does refer, in passing, to the use of AID by single women, that is, those living outside a heterosexual relationship, without commenting on it. It may be asked why this approach was taken. Was it based on the pragmatic reason that prohibition of access to AID by single women was simply not feasible? Or does it indicate that there is less disapproval of this use of AID than of any use of surrogate motherhood? To the extent that the Warnock Committee did not disapprove of single women being given access to AID, it is in line with other jurisdictions where

131. As previously explained, there is confusion in use of the term single women or man. See supra note 117. Traditionally, it means unmarried, but in the Warnock and Waller Reports, it means a person living outside a heterosexual couple relationship.
single women are given such access.133

Although there are many distinctions that immediately come to mind, it merits asking why we outlaw surrogate motherhood entirely, but not artificial insemination even when used by single women? At first glance, the prohibition of the use of animals as "surrogate car-
riers" may not seem particularly relevant to answering this question, but it serves two functions. First, it allows us to separate our concerns for the surrogate mother from our concerns for the child. Second, it indicates two important concerns in using human or animal surrogates: first, there is concern for the "best interests" of the child, and this obvi-
ously includes avoiding harm to the child; and, second, there is concern to avoid affronts to fundamental human values and the dehumanization of human reproduction through surrogate parenting.134 These points will be dealt with in order.

It is difficult to gauge the harm to a child that results from its being handed over by its surrogate mother. If the child has bonded psychologically to the mother during the pregnancy (and it has cer-
tainly bonded psychologically), breaking this bond is a source of harm.136 It may also be harmful for a person to learn, later in life, that he or she was handed over by his or her genetic and carrying mother, but this does not differ from the situation faced by all adoptees. The fact that the handing over was planned prior to conception does, how-
ever, distinguish surrogate motherhood from adoption. This "planning" could also give rise to a further distinction. It could indicate to the child of a surrogate mother that the anguish and socio-economic neces-
sity that are often present in giving up a child for adoption and which can later serve as an "explanation" for adopted children of why their mothers relinquished them, were not present. This could deprive chil-
dren of surrogate mothers of psychological coping mechanisms that are available to adopted children. There are also risks to the child if the surrogate mother refuses to hand it over, or if its biological father re-
uses to accept it. Other more long-term risks would need also to be

134. Warrock Report, supra note 15, section 12.9, at 72;
136. See supra note 15, section 8.18; and Waller Report, supra note 17, section 4.7, at 51. Both suggest that it should be a criminal offense to make a "commercial" surrogate motherhood contract.
137. See infra section III(B).
138. Somerville, supra note 114. The initial studies carried out in relation to motivation and attitudes of surrogate mothers include the following: P.J. Parker, Moti-
vation of Surrogate Mothers: Initial Findings, Am. J. Psychiatry 1983; 140: 117-118; P.J. Parker, Surrogate Motherhood: Psychiatric Screening and Informed Consent.
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“birth” technology, including surrogate motherhood, were much less prone to such risks than other children, and that couples who used “birth” technology to create their family had more stable and long-lasting relationships, we would need to weigh such positive factors in our decisions concerning the acceptability of “birth” technology, equally with the corresponding negative factors. It could also be that while the “best interests” of the child raise some similar issues with respect to the use of surrogate motherhood and the use of AID, surrogate motherhood may be prohibited because it derogates more from other values, than does the use of AID. For instance, surrogate motherhood involves the commercialization of reproduction, which has been compared with one form of commercialization of sex, namely prostitution. This same degree of commercialization, at least in an obvious form, is not present with artificial insemination. One way to address this problem would be to prohibit payment for surrogate motherhood, but not to prohibit the activity itself. However, this may be to allow the possibility of surrogate motherhood only in theory and not in practice, because in most cases, it would be difficult, if not impossible, to find an unpaid volunteer. Another reason why surrogate motherhood, but not AID, may be prohibited, is that the surrogate mother must overtly give up her child, but this is not true in relation to the sperm donor, the “surrogate father.” Consequently, any attempt to the value of family bonds, or to accepted concepts of parental responsibility, or to accepted beliefs concerning what constitutes appropriate feelings towards children, may not be as serious in relation to AID as in relation to surrogate motherhood. It is also true that current societal attitudes towards men who donate sperm differ from those towards women who act as surrogate mothers. In this respect, it is interesting to note that, at one time, the willingness to donate sperm for use in AID was sometimes regarded as symptomatic of a personality disorder. Similar attitudes may exist, today, with respect to surrogate mothers. It is a further question whether there is any factual evidence which could justify such attitudes. However,
adequate screening procedures should function to eliminate prospective
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psychopathology, which could mean that there may well be less psycho-
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pared with those who seek to do so) than among the general
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We can also ask whether surrogate motherhood should be opposed on
the grounds that it would involve too many unknown risks — cer-
tainly those to the mother and possibly some to the child. Although we
have some knowledge about the psychological risks run by a mother who
gives up her child for adoption, these risks may not be analogous to
those of giving up a child pursuant to a surrogate motherhood agree-
ment. Moreover, even if the risks were of the same nature and magni-
tude, those associated with surrogate motherhood would be encountered
intentionally, whereas those associated with adoption are not. Among
the most ancient of the legally protected interests of a society in its
individual members is that of the right of the society to prohibit con-
duct which would be detrimental to the health of members of that soci-
ey, when maintenance of this is necessary for the protection or, some-
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within the limits of not contravening fundamental human rights or con-
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persons engaging in that conduct to become a serious burden on the
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serious, psycho-pathological consequences and that women suffering
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Distinctions, such as that raised above, that there may be a differ-
ence in attitudes towards men, as compared with women, being in-
volved in certain aspects of "birth" technology leads to discussion of a

J.P. Parker, The Psychology of the Pregnant Surrogate Mother: A Newly Updated
Report of a Longitudinal Pilot Study," in materials prepared for "What About
the Children?" An International Conference on the Legal, Social and Ethical Implications
of New Reproductive and Parental Technologies, sponsored by American Society
of Law and Medicine, Boston, Mass. (Oct. 29th-30th, 1984).

184. The crime of maim (mayhem) is an example of such a prohibition. See
M.A. Somerville, Medical Interventions and the Criminal Law: Lawful or Excessive

185. If the woman is able to carry a child, but not to conceive, alternatives to
using surrogate motherhood would be either ovum donation with in vitro fertilization
with the husband's sperm and embryo transfer to the infertile wife, or uterine lavage,
after artificial insemination of the own donor, and embryo transfer to the wife.
adequate screening procedures should function to eliminate prospective sperm donors or surrogate mothers who have any obvious degree of psychopathology, which could mean that there may well be less psychopathology among those who actually participate in these roles (as compared with those who seek to do so) than among the general population.

We can also ask whether surrogate motherhood should be opposed on the grounds that it would involve too many unknown risks — certainly those to the mother and possibly some to the child. Although we have some knowledge about the psychological risks run by a mother who gives up her child for adoption, these risks may not be analogous to those of giving up a child pursuant to a surrogate motherhood agreement. Moreover, even if the risks were of the same nature and magnitude, those associated with surrogate motherhood would be encountered intentionally, whereas those associated with adoption are not. Among the most ancient of the legally protected interests of a society in its individual members is that of the right of the society to prohibit conduct which would be detrimental to the health of members of that society, when maintenance of this is necessary for the protection or, sometimes, the benefit of the society. 139 Rel ying on such basic concepts, within the limits of not contravening fundamental human rights or constitutional rights, or being able to justify any such contravention, a society could prohibit certain conduct when this would be likely to cause persons engaging in that conduct to become a serious burden on the society. It is possible that surrogate motherhood could have long-term, serious, psycho-pathological consequences and that women suffering from these could become a burden, from which society wishes to protect itself. However, the persons opposing surrogate motherhood have not, so far, relied upon such reasoning.

Distinctions, such as that raised above, that there may be a difference in attitudes towards men, as compared with women, being involved in certain aspects of "birth" technology leads to discussion of a further, related factor. There may still exist an attitude in society that men are not necessarily, and that it is acceptable for them not to be, attached to their genetic progeny, whereas neither of these propositions is thought to be true or acceptable with respect to women. In short, challenges to traditional notions of motherhood may be taken much more seriously than challenges to traditional views of fatherhood. This might be because the concept and value of family stability is transmitted through beliefs about motherhood, in that this stability depends upon maintaining a belief that a mother's bonding with her child is unassailable. In contrast, beliefs about a father's bonding with his child may not serve such a function and, as a result, may not be treated as unassailable and unbreakable. This is not to say that those beliefs, at least with respect to women's feelings about their children, do not present reality in an overwhelming majority of cases. But, we need to question whether they always necessarily reflect reality and we need to raise the issue of whether society may have its own reasons for both promoting these beliefs and not wanting them challenged. Further, we need to examine whether the concept of the "best interests of" the child is involved in the distinction between beliefs concerning men's and women's attitudes towards children. Traditionally, nurturance has been both associated with women and disassociated from men. The need of all children for physical and psychological nurturance and the traditional belief that only the mother could provide this might explain why greater emphasis is placed on the mother's bonding to the child, rather than on the father's.

7. Consistency of Attitudes Towards Men's as Compared with Women's Involvement in or Use of "Birth" Technology

If we not only tolerate, but the state pays for artificial insemination, as in Canada, in order to enable a fertile woman in an infertile couple, to bear children and form a family unit, should not we allow likewise the use of surrogate mothers to remedy the like situations, where the man is fertile but the woman is unable to conceive or to carry a child? Stated another way, to allow artificial insemination by donor, but not allow surrogate motherhood, is to discriminate against a

139. The crime of maim (mayhem) is an example of such a prohibition. See M.A. Somerville, Medical Interventions and the Criminal Law: Lawful or Excusable Wounding?, 36 McGill L.J. 82 (1981).

140. If the woman is able to carry a child, but not to conceive, alternatives to using surrogate motherhood would be either ovum donation with in vitro fertilization with the husband's sperm and embryo transfer to the infertile wife, or uterine lavage, after artificial insemination of the ovum donor, and embryo transfer to the wife.
married fertile man having his own genetic progeny when his wife is unable to reproduce, as compared with a married fertile woman having her own genetic progeny when her husband is unable to reproduce. Looked at from yet another perspective, one could say that we are discriminating against an infertile woman when we prohibit her husband from using a surrogate mother to produce a child for their family, but at the same time we allow the wife of an infertile man access to "birth" technology in order to have a child who, even legally, becomes the child of them both.\textsuperscript{143}

While raising the above arguments, it is recognized that there are many extremely problematic ramifications of surrogate motherhood that are not presented by artificial insemination. But, in terms purely of the "conception issue," that is, in terms of allowing the fertile person to have an infertile partner, to realize his or her reproductive potential in order to create a family, there may be a lack of consistency in the way that fertile men, as compared with fertile women, are treated.

Another, perhaps more mundane, example of the same type of inconsistency, is that while payment for sperm donation has, in general, been widely accepted, there has been much more reticence regarding payment of surrogate mothers, and it has been proposed, for example in Australia, that such payment should constitute a criminal offence.\textsuperscript{144} This discriminates between both men and women "recipients" and "donors." When payment to surrogate mothers is prohibited, but payment to sperm donors is allowed, men have less access to a surrogate mother than women have to a sperm donor, that is, men are discriminated against as "recipients," correlative, in the same circumstances women have less opportunity to earn money as compared with men, that is, women are discriminated against as "donors." Further, there is an interesting comparison which can be made between artificial insemination and surrogate motherhood, with respect to payment. It has been felt, on the whole, that paying sperm donors for their services, rather than for their sperm, reduces the ethical and legal problems inherent in the situation. The contrary seems to be true with respect to surrogate motherhood. In this case, it is payment for the woman's services in carrying the child which is regarded as more problematic than the payment for her genetic contribution, which could even be eliminated as a feature of the transaction if a donated embryo or ovum were to be used.

This same phenomenon of a discrepancy of approach with respect to men and women in relation to "birth" technology is reflected in yet another way: the screening of prospective surrogate mothers is much more rigorous than that of sperm donors. Again, there is some basis for this distinction in that the woman will carry and affect the child for nine months, whereas the man has only a "genetic contact." But this does not explain discrepancies in genetic screening between surrogate progenitors, depending upon whether that person is a man or woman, even in relation to simple and basic measures such as taking a detailed family history and carrying out a physical examination. It would be extremely rare for these not to be undertaken on a surrogate mother, but this is not true in relation to donors of sperm for artificial insemination.

8. Consistency of Attitudes Between Various Societal Groups With Respect to "Birth" Technology

The issue of who should formulate law or policy or be a decision-maker in a given "birth" technology situation has already been raised.\textsuperscript{145} This is particularly important when relevant attitudes may vary between different groups. For instance, a higher percentage of persons who were infertile or whose relatives had had problems involving infertility approved of artificial insemination than those who were not similarly situated.\textsuperscript{146} Related to this issue of who should make the rules, is the issue of what weight should be given to public opinion polls, which are frequently cited in relation to attitudes to reproduction technology. Likewise, what weight is and should be given to perhaps an even more relevant source of opinion in the "birth" technology context, the recommendations of high-level committees, often set up by government, to advise on the approach that should be taken vis-à-vis "birth" technology, and which often conduct extensive public consultation? The Waller Committee, in the Australian state of Victoria, is one example of such a committee, and it is relevant to note again here that its rec-

\textsuperscript{143} See, e.g., Civil Code of the Province of Quebec, articles 386 and 588(2).
\textsuperscript{144} Supra note 136. Some members of the Waller Committee (Waller Report, supra note 17, section 4.7, at 51) considered that payment of surrogate mothers should be a criminal offense.
\textsuperscript{145} G. Rawson, Human Artificial Insemination by Donor — Some Australian Perspectives, A Report Prepared for "The Advisory Committee on Human Artificial Insemination," established by the Minister of Youth and Community Services for New South Wales (Australia) (March, 1982), Sydney (1983-84) section 1.6 at 18.
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142. Supra note 136. Some members of the Waller Committee (Waller Report, supra note 17, section 4.7, at 51) considered that payment of surrogate mothers should be a criminal offence.

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ommendations regarding disposal of the frozen embryos, whose parents had died without expressing their wishes as to what should happen to the embryos, were overruled by the Victorian Parliament. Is it possible to develop a policy on these issues through national consensus, as has been called for in the United States? Or will the battle continue to be waged on any available front, particularly on the legislative one, as has occurred in both Australia and England and is beginning in Canada? In Australia, a bill was introduced into the federal Parliament which would prohibit entirely research on human embryos and would be very likely to restrict some clinical applications of "birth" technology. A bill presented in the British House of Commons, with the aim of achieving a similar outcome to that sought in the Australian bill, provoked angry outbursts by some parliamentarians.

Two sets of questions are relevant with respect to the influence of public opinion on decision-making regarding "birth" technology. First, do public opinion polls reflect people's views and what are the "real" views of people — what they practice or would practice, in this regard, if they were in a situation of having to decide, or what they preach? Likewise, whose views do committees' reports reflect? Second, assuming that both the views and the persons or groups holding them can be identified, when should they be followed and what priorities should be adopted in situations of conflict? Diagonetically opposed approaches with respect to whether public opinion polls on reproduction technology issues should be followed, can be seen by comparing Pope John Paul II's stance in this regard with that of many politicians. If a Quebec poll is indicative of a general trend, the majority of Catholics do not agree with the Church's stance on reproductive technology.

145. See supra note III(A)(5).
148. I am indebted to Dr. Alan Trounson, Director, Research Centre for Early Human Development, Monash University, Victoria, for personal communication on this matter and for providing copies of submissions made regarding this Bill.
151. See Waters, Few Quebec Catholics Support Pope's Anti-Birth Control

However, the Pope totally rejects that such opinions should influence religious doctrine. In comparison, many, if not most, politicians feel that they can only disregard such polls at their peril, because such disregard can constitute a major detraction from their political viability. This difference in approach between the Church and politicians can be seen in giving rise to another example of an inconsistency in "conception policy." This is an inconsistency between the religious and political views — the private and public views, respectively — of some individuals in our community, whose views may have effect on persons other than themselves. For example, it may be that a politician would follow the opinion polls in the legislature, whereas, in private life, he may follow the Pope's directives. Thus, it would be possible for a person to belong to two different groups, which can have conflicting attitudes regarding reproduction technology. This gives rise to the possibility that an individual could have personal, internal inconsistency in relation to his or her attitudes towards reproduction technology. Likewise, attitudes towards reproduction technology, for example, in some areas of the United States, may be fundamentalist as a political reality, and this conservative view may well be adopted by researchers. But such adoption may not arise from conviction that the fundamentalist approach is the proper one, but in order not to endanger funding, for both "birth" technology and other medical research projects. The latter is a relevant and necessary consideration, because, often, funding of medical research in general is made contingent on complying with regulations governing conduct other than the research funded. That is, funding of general medical research could be made to depend on compliance with regulations governing "birth" technology research, whether or not the funding for this "birth" technology research was also provided by the same sponsor.

In summary, to determine whether or not there are consistent attitudes towards any given situation involving reproduction technology, including "birth" technology, it is important to distinguish between public and private attitudes (which could be regarded as another exam-

152. See, e.g., Protection of Human Subjects: HEW Support of Human In Vivo Fertilization and Embryo Transfer, Report of the Ethics Advisory Board, 44 Fed. Reg. 35033, 35047 (1979). "[T]he Department interprets the National Research Act as authorizing (if not requiring) IRB review of human research not funded by HEW at any institution which receives a grant or contract involving human subjects under the Public Health Service Act."
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145. See supra section II(A)(5).
147. A Bill for An Act to prohibit experiments involving the use of human embryos created by in vitro fertilization (Human Embryo Experimentation Bill 1985).
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In summary, to determine whether or not there are consistent attitudes towards a given situation involving reproduction technology, including "birth" technology, it is important to distinguish between public and private attitudes (which could be regarded as another exam-
C. Consistency of Genetic Heritage and the Use of "Birth" Technology

One also needs to look at the issue of consistency in relation to family genetic heritage. For instance, if we look at the situation where both a husband and wife carry a harmful gene, are adamantly opposed to abortion and want to avoid conceiving a defective fetus, it may be asked whether IVF and embryo transfer should be used for one pregnancy, using a donated ovum and the man's sperm, and then for a second pregnancy, whether AID should be used. This would mean that the couple would have one child who was the genetic child of only one of the parents, but who would be able to have children with the other partner, and then the other parent would become the genetic child of only the other parent. This would create a problem of identity of the birth parents, as one would be the genetic child of only one of the parents, while the other would be the other parent, and both would be genetically related to each other. One should ask, "What about the children?" Have we concentrated too much on parental-child "genetic bonding" and the importance of this, and not enough, for instance, on sibling "genetic bonding," which could be extremely important. One will always have genetic forebears, and increasing, with the development of "birth" technology, one can choose whether to have genetically related descendants. The one thing which is often out of our control is whether we have genetically related generational equals, that is, brothers and sisters, or even half-genetically related generational equals, half-brothers and half-sisters. This latter outcome could be achieved in, for example, the family situation described above, where both parents carry a deleterious gene, by using either AID, or, alternatively, the husband's sperm combined with ova donation, IVF and embryo transfer, to achieve all pregnancies. In terms of simplicity and cost, the use of AID would seem preferable. But, is this to discriminate unfairly against the man having his genetic children? Should the couple be encouraged to draw lots if they cannot agree or both feel ambivalent as to whose genetic heritage should form the basis of the family? Or should the couple consider accepting a group of donated embryos (those for future use could be kept frozen), which are full-sibs to each other, but unrelated to either prospective parent? In comparing ovum donation with AID, it has been said that

135. See supra note 138, for reference to the conference "What About the Children?"
ple of overt and latent values, respectively). One indicator that these might not be consistent would be the presence of any potential conflict of interest for a person in adopting, publicly, certain attitudes or values.

B. Consistency in Theory in Comparison with Consistency in Practice in Relation to "Birth" Technology

It is also necessary to consider whether there is real or only apparent consistency between some of the approaches taken to the use of "birth" technology. That is, is there consistency in practice or only in theory? For example, legislation may allow an unmarried couple both to have access to "birth" technology and on the same conditions as married couples (for instance, as was initially proposed, but subsequently overruled, in the Bill, which became the Infertility (Medical Procedures) Act 1984 of the State of Victoria in Australia). But, even were such access allowed in theory (that is, it is not prohibited by statute, as it is now in Victoria153), in practice, ethics committees or other relevant decision-makers, at each of the institutions which have the technology, may block such use or apply more stringent conditions to infertile unmarried couples than to married couples. In order to determine the consistency of legislative policy in such a respect, comparisons could be made between legislation governing "birth" technology and that regulating adoption. For example, legislation which prohibits access to "birth" technology by unmarried couples could be compared with adoption legislation which allows such a couple to adopt. However, even if unmarried couples are not legislatively denied access to "birth" technology and are eligible as adoptive parents, in practice, there may be no consistency between the two situations. Unmarried couples may actually be able to adopt a child, whereas they may not be given access to "birth" technology.

153. Statutes of Victoria, 1984, c. 123.

154. Access to "birth" technology by unmarried couples is prohibited by the Act, as finally passed, through indirect means. This occurs because the Act prohibits all "relevant procedures" except those carried out in accordance with the Act and the Act defines the persons who may have access as limited to married couples. It is interesting that the proposal to allow unmarried cohabiting couples to have access to "relevant procedures" proved to be a major source of conflict, both when the Act was debated in the Legislature and in the public forum, in general.

C. Consistency of Genetic Heritage and the Use of "Birth" Technology

One also needs to look at the issue of consistency in relation to family genetic heritage. For instance, if we look at the situation where both a husband and wife carry a harmful gene, are adamantly opposed to abortion and want to avoid conceiving a defective fetus, it may be asked whether IVF and embryo transfer should be used for one pregnancy, using a donated ovum and the man's sperm, and then for a second pregnancy, whether AID should be used. This would mean that the couple would have one child who was the genetic child of only the man, but who would be carried by the woman, and another child who would be the genetic child of only the woman. This would result in a two-child family, in which each of the children would be the genetic child of one or other of the parents, but the children would not be related genetically to each other. One should ask, "What about the children?" Have we concentrated too much on parental-child "genetic bonding" and the importance of this, and not enough, for instance, on sibling "genetic bonding," which could be extremely important. One will always have genetic forebears, and increasingly, with the development of "birth" technology, one can choose whether to have genetically related descendants. The one thing which is often out of our control is whether we have genetically related generational equals, that is, brothers and sisters, or even half-genetically related generational equals, half-brothers and half-sisters. This latter outcome could be achieved in, for example, the family situation described above, where both parents carry a deleterious gene, by using either AID, or, alternatively, the husband's sperm combined with ova donation, IVF and embryo transfer, to achieve all pregnancies. In terms of simplicity and cost, the use of AID would seem preferable. But, is this to discriminate unfairly against the man having his genetic children? Should the couple be encouraged to draw lots if they cannot agree or both feel ambivalent as to whose genetic heritage should form the basis of the family? Or should the couple consider accepting a group of donated embryos (those for future use could be kept frozen), which are full-sibs to each other, but unrelated to either prospective parent? In comparing ovum donation with AID, it has been said that

155. See supra note 138, for reference to the conference "What About the Children?"
there are differences, and [in the former case] the [IVF] mode of conception coupled with the donor factor may compound to have serious adverse influences on the future psychological development of the child. Such influences centring on confusion of genetic descent and one's parents would be even more marked in the situation of the donor embryo. The biologist-philosopher Leon Kass in his submission to the Ethics Advisory Board of the US Department of Health, Education and Welfare, expresses his grave concern on this IVF application, suggesting that "clarity about who your parents are, clarity in the lines of generation, clarity about who is whose, are the indispensable foundations of a sound family life, itself the sound foundation of civilised community. Clarity about your origins is crucial for self-identity, itself important for self-respect. It would be . . . deplorable public policy further to erode such fundamental beliefs, values, institutions and practice."

This raises the issue of deceiving children born through the use of "birth" technology, about their genetic origins when donated gametes are used, or if not deceiving them, then letting them remain uncertain in this respect. This will happen unless some standardized form of record keeping and disclosure of information about gamete donors is established. Moreover, it is not only such children who might be deceived; other family members, such as grandparents, might also be unaware that a child is not their genetic descendant or be intentionally misled in this respect. It is not unlikely that the presence of such deception will be psychologically and emotionally harmful to individual family members, especially the child, who is both the subject and the object of the concealment. Further, such deception could be destructive of the stability of the family, although the source of such harm may be unidentified. But, the ramifications of such deception may be even wider. It has been suggested that "[o]penness and lack of secrecy within the family are . . . one of the foundations of trust within the wider society."156 Perhaps the real concern here is not so much with specific incidents of deception with respect to a child's genetic origins, as with institutionalized deception regarding biological heritage. For example, if legislation were passed to regulate "birth" technology and it made no provision for children born through use of such technology to have access to information that in their cases this technology was used, or, even, it prohibited such access, this could be regarded as institutionalizing known and planned deception and is probably unjustified from several perspectives. On the other hand, failure to provide identifying information concerning gamete donors who were involved, or even to provide non-identifying information about them, may be justified in certain circumstances. This leaves open the question of whether, when there is a record that "birth" technology was used, it is acceptable to fail to record the use of a gamete donor or donors and, if only one, of which gender. It is proposed that the intentional omission of this information is not justifiable, because it would leave all children born through the use of "birth" technology in doubt as to their genetic origins, and even for those for whom gamete donors were used, such a state of doubt could be more harmful than knowledge of the facts. Psychologically, a state of continuing, unresolvable doubt can be one of the most difficult with which to cope.

Other possibilities for achieving genetic consistency among siblings when "birth" technology is employed, have been provided by the use of sperm banks and the advent of embryo freezing. When IVF is used with donor sperm, additional ova from the genetic and carrying mother can be fertilized and frozen for use in subsequent pregnancies. Similarly, when both male and female donor gametes are used, additional embryos can be created and frozen for later use. It may even be possible to split an embryo and freeze one half for later use (although, it is proposed, this would be unethical because, among other reasons, this would be to create a situation — identical "twins" of different ages which would never occur naturally), or an attempt could be made to create artificially an identical twin pregnancy (which raises the issue of whether it would be unethical to attempt to produce identical twins). Likewise, donor sperm or, now that it is possible to freeze ova, donor ova, could be frozen for later use by the same woman, or the same surrogate mother could be employed for a subsequent pregnancy in order to achieve genetic consistency between siblings, when she has already had one or more children for the couple by being inseminated with the husband's sperm. This latter approach to achieving genetic consistency between siblings is, of course, subject to many more human, although not scientific, vagaries and uncertainties than the other methods mentioned. With respect to AID and surrogate motherhood, it should be remembered that a child born through use of these techniques may well have half-brothers and half-sisters — other children of the sperm donor or surrogate mother — outside his or her im-

157. See supra section II(B)(3).
158. Duxton Report, supra note 15, section 5.3, at 47.
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157. See supra section II(B)(3).
158. Donnan Report, supra note 15, section 5.3, at 47.
mediate family. The usual concern with respect to such relationships is that requirements of confidentiality regarding the use of "birth" technology could result in incestuous reproduction among these genetically related, generational equals, which, apart from other problems, increases the likelihood that the resulting children will suffer from genetic disease. Another possible scenario is of such persons seeking their genetic half-sibs, as some adopted or AID children now seek their parents.

The above considerations can be collectively referred to as the issue of genetic consistency in the family. But would it be wrong to give any weight to such consistency as a value or priority to achieving it, when we have many instances in our modern societies where it does not exist, for example, in blended families established through divorce and re-marriage, and families composed of adopted children, who are not genetically related to each other? We need to ask whether it makes a difference when the lack of a genetic relationship between the children in a family is entirely a matter of choice, as it would be in the hypothetical situation considered at the beginning of this section, as compared with when it has occurred through chance, which is usually the case when there has been adoption or blended families have been formed because of divorce.

D. Consistency and Inconsistency in Relation to "Birth" Technology as "Masculine" and "Feminine" Characteristics or Values

Could it be that aiming to achieve genetic consistency in a family, as described above, is not in itself an acceptable goal? Could the pursuit of seeking it be the result of what, for want of a better word, could be called a "masculine" model supposedly based on reason and logic, rather than a "feminine" approach, which is purportedly more tolerant of inconsistency? Are we facing, in a new context, an ancient concern of a society dominated by male models of organization and institutions, namely that a man's heirs should be his genetic progeny? It should be pointed out that here the words "masculine" and "feminine" are used to describe groups of characteristics traditionally associated with one gender or the other and not, necessarily, as attributes of any given person, simply on the basis of his or her gender. Similar divisions are those between cognitive and emotional mental functioning, or between logic and intuition.

In the same vein, because the concepts of equity and equality can be respectively related to "feminine" and "masculine" approaches, should we look more to being consistent in terms of equity (need), than being consistent in terms of equality (rights) when we are establishing and governing "conception policy"? For instance, should we be more concerned with establishing consistency in fulfilling equal degrees of need, rather than consistency in terms of recognition of equal rights with respect to access to "birth" technology?

To define those factors which may validly be taken into account in determining the extent of a person's need to have access to "birth" technology would involve a value judgment, to some degree. For instance, should a couple's need be regarded as augmented and great where they have tried unsuccessfully all other available means of achieving pregnancy prior to resorting to "birth" technology, particularly when they require expensive forms of this, which are in short supply, such as in vitro fertilization? Furthermore, how would we deal with allocating "birth" technology on the basis of need when, for instance, greater psychological suffering was experienced by one person than another because of childlessness, yet, in all other respects they had equal claims? Moreover, how would we even judge the degree of such suffering? How would we correlate need with the age of the woman or, even, that of the man? Should older persons be regarded as being in greater need than younger ones, because their time remaining for childbearing and child-rearing is shorter? Or does the fact that younger persons are more likely than older ones to have success in using "birth" technology, because of their statistically higher degrees of fertility and their statistically fewer problems in pregnancy, all other factors being equal, indicate that any greater need of older persons should not be a determining factor? To what extent should a belief that children are better off with younger parents be taken into account to justify a simi-

159. supra section II(A)(4).
160. see B. Bratasiu, Neo-Feminism and the Next Revolution in Consciousness, 27 J. Med. Ind. & Ethics L. J. 1 (1982), is the one adopted here. That is, the term equity is used in the sense of ordering responses according to degrees of need, rather than in the sense of fairness in terms of equality, which is more in the nature of a rights approach. In this latter respect, see H.T. Engelhardt, Jr., Shattuck Lecture Allocating Scarce Medical Resources and the Availability of Organ Transplantation: Some Moral Presuppositions, 16 N. Engl. J. Med., 1984, 311: 68-71, who speaks of decision outcomes which are fair, but unfortunate, as compared with those which are both unfortunate and unfair. Engelhardt considers that it is only the latter which must be remedied.
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159. supra section II(A)(4).

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lar conclusion? At the other end of the scale of need, the use of "birth" technology simply for convenience (for example, a husband and wife conceive a child naturally, then use uterine flushing with embryo transfer and the services of a carrying mother), if acceptable at all, would probably have the lowest priority, in terms of need, to have access to "birth" technology. The word "probably" is used in the previous sentence, because the degree of need of the couple for such access would almost certainly be considered to be very low. But one could simultaneously consider the degree of need of the embryo to be high in such circumstances. For instance, if the couple would only accept the options of having access to "birth" technology or abortion, the embryo's only chance of survival is through the use of such technology.

In comparing feminine and masculine approaches to the regulation of "birth" technology, we also need to consider whether or not we should have consistency with respect to the way in which we govern relationships between intimates, as compared with the way in which we govern relationships between strangers. To raise such a consideration is to propose that relationships can be characterized as "feminine" and "masculine", respectively, in the sense in which those terms are defined above. One of the problems may be that, at least with respect to legal regulation, we have tended to treat all relationships consistently, whereas we may need to be inconsistent in our approaches. For instance, when we use the law to govern relationships, such as family relationships, which have "network" aspects, which should be both taken into account and protected, we may need to utilize different procedural mechanisms or substantive principles, than when we use the law to govern purely arms-length transactions. This distinction has not always been made. Moreover, such an approach only becomes relevant when we consider that the law has a proper role, not only as an instrument for the protection of individual rights, such as autonomy, individual liberty, and inviolability, but also as an instrument for the protection of network and relational interests, such as those found in the

family and which may be the fundamental element of which the family is comprised.

It is interesting to consider legal regulation of "birth" technology from this perspective. That is, if we are to use different forms of substantive or procedural law to govern different types of contacts or relationships, which form of law would be most appropriate to apply to "birth" technology? One of the criticisms of the use of this technology is that it depersonalizes and dehumanizes some of our most intimate, personal and human contacts. Does this mean that the contact involved in its use constitutes a relationship between strangers and should be regulated accordingly? Or, could it be that if we view "birth" technology as promoting the ability to create network and relational interests by creating a family, and, therefore, as promoting the right to fulfill the human need for intimacy, then "birth" technology should be treated under "intimate relationship" rules to some degree? This might recently there has been no suggestion of any legal right of a grandparent to have access to a grandchild. This one-sided rights situation has almost certainly arisen because, traditionally, parental rights have been formulated as the correlative of the parent's obligation to the child, rather than vice versa, and the child has no similar obligation to the parent, at least while still a minor, and hence no correlative right. Possible reasons why the law has not given wider protection to relational interests could include that any damage resulting from trespassing on a relational interest is, usually, somewhat intangible, non-physical and emotional or psychological — all of which factors have tended, historically, to indicate the withholding of a legal remedy. The fact that some relational interests, namely, those of a master with respect to a servant and a husband with respect to a wife, were protected through the writ of per quod servitum amisit (which, it is worth noting was a trespass writ and therefore requires, unless the trespass is to the person of the plaintiff himself or herself, that the plaintiff be in possession of the real or personal property [in this case, a person] with respect to which the wrong is done, in order for the plaintiff to have " locus standi" to sue), because they were deemed to be of a proprietary character, also indicate the presence of such reasoning. (See J.G. Flemming, THE LAW OF TORTS, 645-49 (6th ed. 1983). Other reasons for denying damages for injury to relational interests could be fears of opening up a floodgate of litigation, fears of creating irreconcilable conflicts with rights protecting non-relational interests, and unduly infringing on personal liberty. In this latter respect, it should be noted that both relational and non-relational rights are rights of an individual, it is just that in the former case the content of the individual right involves other persons. (I am indebted to my colleague, Professor Jane Glenn of the Faculty of Law, McGill University, for discussion on this point.)

It may be that only some aspects of "birth" technology should be regulated under intimate relationship rules. For example, physicians should be subject to the usual rules governing professional liability (which are rules governing relationships between strangers), but a sperm donor or surrogate mother should not be subject to the rules governing products liability, which, likewise, are rules governing relationships between strangers.
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162. Warnock Report, supra note 15, section 8.17, at 46, expressly rejects as "totally unrealistic" the use of birth technology, in particular, surrogate motherhood, for convenience alone. See also supra note 125.


164. It is interesting to contemplate what the law has protected in this respect and why it has not given wider protection. For instance, fathers, and in modern law mothers as well, have had legal rights of custody and access to their children, but a child has no right, as such, to "custody" of or access to a parent. Likewise, until very
mean that it should be more loosely governed in some respects. On the other hand, if, as is sometimes the case, the use of "birth" technology is a commercial proposition, should it be characterized as involving relationships between strangers and governed accordingly? This could mean that the focus should be solely or principally on protection of the individuals involved, whether they be the parents or the resulting children, and arguments, for example, for allowing a substantial degree of risk to be taken in using "birth" technology, because this use is likely to promote relational interests, should be rejected. Anti-reproduction technology, especially the anti-natal forms of this, could be similarly analyzed, although this might prove to be an even more complex and value-laden undertaking.

Within this same context, it is worth mentioning that we should not undervalue or decry the worth of intuitive decision-making. While this may not constitute a sufficient decision-making mechanism, it may be a necessary one, and in fact, may often be present in a latent form. It could be that it is only when our reasoned decisions conflict with those which we would make intuitively, or we have no well-developed or well-accepted, reason-based approach which we can use in a particular situation, that we become aware of our often present, latent, intuitive decision-making. Both the Waller and Warnock Reports are again of interest in this respect. In a dissenting opinion, one member of the Waller Committee states,

"Intuitively we do not equate a fertilized [human] egg with a hamster or a piece of mouse tissue." (Professor Ian Kennedy in The Times, 26 June 1984). Intuitive that reaction may be, but it does not lose any of its force for that reason since in any moral judgment in the area of basic human values there is a certain preeminent and instinctive component which cannot be totally reflected in analytical discourse or legally accountable terms but which is nonetheless real. 166

Likewise, the Warnock Committee notes that "many people feel an instinctive opposition to research which they see as tampering with the creation of human life." In contrast, the Dunstan Report, in relation
to surrogate motherhood, states: "It is important that the legal responses to such developments should be based upon rational grounds. It is easy to form an instinctive and emotional hostility towards such procedures and to condemn them out of hand as undesirable practices." 167

E. Consistency of Approaches to Economic Aspects of Reproduction Technology

The topic of the economics of health care is a vast and a complex one. It becomes even more complex when the ethical and legal concerns pertinent to this field are examined. When one superimposes on these factors the issues raised by a controversial new medical advance, such as "birth" technology, it becomes unnecessary to explain why the treatment of this topic, here, amounts to little more than raising the issue as a passing reference.

There are many economic aspects of reproduction technology which could be examined for consistency or inconsistency both within the reproduction technology context itself and within a more general context. For instance, the allocation of funds for medical research on contraception can be examined with respect to consistency with principles requiring equal treatment of men and women. Could it be that there has been a bias towards developing methods of female contraception, rather than male contraception? Was this purely fortuitous, in that male contraceptives are more difficult to develop and possibly less safe? If true, was this bias meant to, and does it, benefit men or women or both? What are the relative benefits and relative harms to men and women of the development only of female contraceptives? Or can it be asked whether it is consistent to be allocating funds to contraceptive research and also funds to "birth" technology research. The answer is yes, if we are promoting choice and control, which are connected factors. This is because often if control is not possible, there is no choice available.

The issue of internal inconsistency in terms of economic support in relation to the development or use of "birth" technology occurring apparently by chance, or at least not by design, has already been raised in "the Australian Story." But what about deliberate inconsistency in relation to funding? For example, in a socialized medical system is it acceptable for a government to support an IVF program, but to refuse

167. Supra section 1(B).
mean that it should be more loosely governed in some respects. On the other hand, if, as is sometimes the case, the use of "birth" technology is a commercial proposition, should it be characterized as involving relationships between strangers and governed accordingly? This could mean that the focus should be solely or principally on protection of the individuals involved, whether they be the parents or the resulting children, and arguments, for example, for allowing a substantial degree of risk to be taken in using "birth" technology, because this use is likely to promote relational interests, should be rejected. Anti-reproduction technology, especially the anti-natal forms of this, could be similarly analyzed, although this might prove to be an even more complex and value-laden undertaking.

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166. For discussion of the risk/benefit calculus and justification of risk-taking conduct, see supra section II(B)(5).
167. Waller Reports, supra note 17, section A.2.2.1, at 63-64.

170. Supra section (B).
to pay for reversal of voluntary sterilization? Or, even, ought a government to refuse to pay in the latter case, taking into account the serious shortage of all health care dollars and, in order to achieve consistency, likewise refuse to pay for IVF when it is being employed to overcome voluntary sterility? This is a matter that has been under consideration in at least one province of Canada. The issue is whether the cause of the infertility should be looked at and, if it was voluntary sterilization (or even due to "carelessness," for instance, due to complications from several prior abortions which were undertaken simply as an alternative to contraception), whether such persons should have less priority of access to "birth" technology than others whose infertility is involuntary. If such a distinction is adopted, should persons who want reversal of voluntary sterilization be given access to the necessary treatment if they pay for it themselves? Or would this be an unfair discrimination against those who could not afford to pay? Although this may seem a meaningless question to persons accustomed to living in a society with a non-socialized medical system, such as the United States, the point is that different issues are raised by imposing such a condition, selectively, in relation to a particular treatment or a particular group of people, than when a like condition forms part of the basic and generally applicable philosophy and policy which govern most persons' access to medical care in general. Further, is such an approach inconsistent with that taken with respect to the provision of other forms of medical care and any legal rights to such care? For example, to deny medical care on the basis that a person had voluntarily induced the cirrhosis of the liver from which he or she suffers, by over-indulgence in alcohol, would not be accepted as ethical or legal conduct in Canada; and, yet, it should be noted that the same person may be refused a liver transplant on this basis, or be given a lower priority than other persons needing like transplants in whom the cause of the organ failure was not self-induced, although the true reason for the refusal may be hidden behind criteria of medical suitability for transplantation. Consequently, the notion that it is relevant, in determining rights of access to medical care, to take into account whether or not a disease for which treatment is sought was self-inflicted, is not rejected absolutely. One of the difficulties of allowing such decision-making factors to be taken into ac-

count in determining access to medical technology is that criteria of this type are open to both abuse and to the imposition of the value judgments of the person who has the technology, on the person who requires it.

Finally, the issue of whether scarce health care dollars ought to be spent on "birth" technology must be faced. While there can be no universal or permanent response to this question, some of the factors relevant to reaching an answer in any given situation have been addressed earlier in this paper. However, it is well to be aware of the fact that the persons making this decision may have a vested interest. Such persons can include medical researchers who need funding if they are to continue their research, whose funding may be contingent on the research giving rise to clinical applications and its being implemented as therapy. Consequently, clinician researchers may have a conflict of interest in promoting, for instance, an IVF unit in preference to some other form of health care. Moreover, the decision-makers with respect to the funding of "birth" technology may identify with those persons most likely to use it, for instance, where the latter are well-educated and middle class. But, if funding "birth" technology means, for example, that poor women may receive inadequate ante-natal care, we need to seriously question any such decision. It may even be that showing that funding "birth" technology does not take money away, at least directly, from pre-natal care, still does not make its funding acceptable. Rather, the provision of adequate pre-natal care for all pregnant women might be a condition precedent to setting up "birth" technology units. This argument could be extended to the effect that "birth" technology should not be funded unless it is shown that this does not detract from meeting any other health care needs of equal or greater priority. Such an approach has been suggested to govern the funding of new forms of organ transplantation (18) (it has advantages and disadvantages (19)), but this will not be discussed here. However, it is suggested that the more


173. This approach has been criticized as placing an unfair burden of proof on persons wishing to introduce new medical technology and as unjustifiably inhibiting this process. Such an approach is to adopt, in effect, a rebuttable presumption that new medical technology should not be introduced, unless it can be shown that it ought to be funded in preference to all currently offered health care services. On the other hand, if such a presumption can be rebutted, there should be no argument that funding the new technology is unjustifiable, which provides a very strong case to support its introduction. See also Somerville, supra note 77.
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171. The fact that a facade of different reasons from the operative ones is felt to be necessary indicates that the real reasons for the decision are not entirely acceptable or are, at least, the source of either discomfort or concern about opening up dangerous precedents.

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restricted version of this approach — namely, that a condition precedent to setting up "birth" technology units is the offer of adequate prenatal care to all pregnant women — is justified on a policy basis and from a psycho-social perspective, because these two areas of provision of medical care are so intimately related. To fail to appreciate this could well raise the same dilemmas that we are currently facing with respect to intra-uterine, pre-natal surgery being carried out on fetuses at the same stage of gestation as others are aborted. There are some emotional and intuitive links between such situations that require that they be treated in like manner and the presentation of arguments to the contrary, based simply on logic, does not dispel this perception which needs to be heeded.

The allocation of medical resources raises extraordinarily difficult decision-making issues, because in all cases we are allocating (at least, in the sense of failing to relieve) pain and suffering, whether these be physical or psychological. While this is unavoidable, we do need to take care that the poorest, least powerful, most-in-need members of our societies do not have allocated to them more of the burdens and less of the benefits, in these respects, than do other persons. Further, not to do harm is a stronger moral imperative than to do good, which could indicate that, for example, in certain circumstances, a newborn child care program should take priority over an IVF unit.

F. Consistency of Laws Governing and the Application of Law to "Birth" Technology

Both an internal and external locus is needed to address the issue of the consistency of the laws governing, and the application of law to, "birth" technology. In this section, the internal consistency of the laws governing "birth" technology, and the consistency of these laws with those governing anti-reproductive technology, are first considered. Then the consistency of "birth" technology practices with the law governing medicine and then with more general law — in particular, the law concerned with the protection of human rights, family law and the law governing privacy — are explored, briefly.

1. Consistency of Legislation Regulating "Birth" Technology

It may be asked whether state legislation governing "birth" technology, in a federal system where residents of one state have access to health care in another state, should be consistent. Just one example will be given in this respect, which is that the actual or proposed legal regulation of "birth" technology in two states of Australia, namely Victoria and New South Wales, is not consistent. For instance, a provision in the Victorian Infertility (Medical Procedures) Act 1984[174] could be interpreted as mandating that only one sperm donor is allowed to be used for artificial insemination of a given woman, at least during any one ovulatory cycle, whereas there is no such requirement in New South Wales law,[175] or proposed for enactment.[176] In all likelihood, the Victorian law is intended to allow tracing of genetic heritage, although whether this will be possible under the record-keeping provisions applicable under the Act to artificial insemination performed outside an "approved hospital" is far from certain.[177] If the adoption situation is any precedent, being able to trace their genetic heritage could be a very important factor for some children born as a result of the use of "birth" technology. And yet, children of the same nationality and living in more or less identical circumstances and societal conditions will have widely differing opportunities to do this, depending on the state of Australia in which they are conceived through use of "birth" technology. Such a difference is interesting because it reflects the fact that confidentiality of information relating to genetic heritage is an issue which has important risks and benefits on both sides. When this is true, there is no clearly "right" course to follow, and it becomes a value judgment which approach should be adopted.

We need, also, to compare values found in policies or legislation dealing with "birth" technology, with values found in the community and to consider whether these are consistent or inconsistent. The results

174. Infertility (Medical Procedures) Act, 1984, supra note 153, section 19, forbids the use of semen produced by more than one man "in a procedure of artificial insemination," making such conduct a criminal offense.
175. Artificial Conception Act, 1984 No. 5 of New South Wales, sec. 5(4), provides that a reference to a "fertilization procedure" includes a procedure where the semen used for the artificial insemination of a woman "was a mixture of semen, part of which was produced by a man other than . . . [the woman's] husband and part of which was produced by her husband." The Act does not expressly prohibit the mixing of semen from more than one donor (although the reference to "a man" could be interpreted as constituting a restriction to this effect), so long as one of the men donating the semen for mixing is the husband. But, more importantly, there is no indication that the same donor must be used throughout any given ovulatory cycle.
177. See, SOMERVILLE, supra note 50, for a detailed discussion of the provisions of this Act.
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can represent, respectively, the difference between the use of legislation for value-reflection on the one hand, and for value-creation and promotion on the other. In the latter case, it needs to be determined whether the values being created or promoted are in conflict with community values or whether there is simply a void in which new values can operate. When the values found in existing legislation are not consistent with values in the community, there are two possible explanations. The legislation may be being used to try to establish new values, but these have not yet been accepted; or community values may have changed since the legislation was enacted, and it now represents "old" values. Both possibilities need to be kept in mind. Although the former is the more likely explanation when new medical technology is involved, this may not always be the case. For example, it is probably true to say that the medical and legal professions grossly over-estimated the degree of public resistance to the acceptance of the concept of "brain death" that would result from its introduction; any such resistance quickly dissipated. The same could be true for some aspects of "birth" technology. It could well be asked what the handling of the previously mentioned situation, regarding the two frozen embryos whose "parents" were killed, that arose in the Australian state of Victoria, demonstrates with respect to value reflection or creation or conflict. Was either the Waller Report's recommendation in this regard, or the legislation which rejected this, intended to be value-reflecting or value-creating? In each case, whose values and which values were being promoted? It would be a lengthy and hypothetical exercise (unless empirical research were possible) to explore this issue fully. But this is the type of analysis that needs to be undertaken if we are to articulate more fully and precisely the conflicts which we need to take into account in legal regulation of "birth" technology.

2. Consistency of Laws Regulating “Birth” Technology with Laws Regulating Anti-Reproduction Technology

If, through the application of the common law or legislation, the approach taken in governing pre-reproduction ("birth") technology is more stringent and restrictive than that taken in governing anti-reproduction technology, the reasons for this need to be considered. For instance, in comparing the law applicable to "birth" technology and to anti-reproduction technology, it makes a difference that IVF is an experimental medical procedure and that sterilization and abortion are non-experimental medical procedures. That is, IVF will be subject to different rules once it is no longer regarded as research, but it still may be more stringently controlled than anti-reproduction technology. The reason for this is also relevant to the research situation. There may be greater freedom to undertake standard medical procedures or to conduct medical research in other areas of medicine, including in anti-reproduction technology, as compared to "birth" technology. This is because in the latter case a child is intended to or could result and therefore is subject to the risks of the procedure or research, whereas, in the former case, the aim is to avoid conception and hence the birth of a child. On the other hand, if one wanted to promote the value of sanctity of life, it could be argued that some "birth" technology procedures or research deserve less stringent legal regulation than some anti-reproduction ones.

Finally, it may seem paradoxical, but it could be that if we examine the ethical and legal problems raised by population control, particularly the use of law to regulate this area, we would expose one side of a coin, the other side of which is constituted by the ethical and legal problems raised by "birth" technology. If this proves true, it is likely that there are common lessons to be found in both areas and that investigation, analysis and solutions in one will offer insights in relation to the other.

3. Consistency of the Application of Laws Regulating Medicine to Reproduction Technology

Laws, other than those specifically enacted to regulate reproduction technology (that is, other legislation or common law rules, in particular, those governing the practice of medicine), are also applicable to reproduction technology. It is a worthwhile exercise to explore the basis of any apparent inconsistencies, or even consistencies, in the application of these laws to various forms of reproduction technology, or to reproduction technology as compared with other medical procedures.

One cornerstone doctrine of medical law which deserves in-depth consideration in relation to the use of reproduction technology, including "birth" technology, is that of "informed consent." The issue of

178. Supra section II(A)(5).
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Laws, other than those specifically enacted to regulate reproduction technology (that is, other legislation or common law rules, in particular, those governing the practice of medicine), are also applicable to reproduction technology. It is a worthwhile exercise to explore the basis of any apparent inconsistencies, or even consistencies, in the application of these laws to various forms of reproduction technology, or to reproduction technology as compared with other medical procedures.

One cornerstone doctrine of medical law which deserves in-depth consideration in relation to the use of reproduction technology, including "birth" technology, is that of "informed consent." The issue of

178. Supra section II(A)(5).
179. See supra section II(B)(1).
consent to the use of anti-reproduction technology, such as abortion or sterilization, particularly in the context of minors or mentally handicapped persons, but even in general, has been a vexed one. This area will not be considered here. Rather, some issues raised by consent in the context of "birth" technology will be identified. For instance, difficult problems arise when research on those unable to consent for themselves, such as embryos, is involved. Is infertility, in itself, a coercive factor, such that the consent of a person who suffers from it, especially consent to some forms of novel and risky treatment, should be regarded as suspect, or even, invalid? Can a woman who has never borne a child, or one who has never relinquished one, give an informed (in the sense of an understanding) consent, to the relinquishment of a child under a surrogate motherhood contract? There is a fine balance to be struck in applying the doctrine of informed consent in the "birth" technology context, with respect to the degree of stringency of its application, if the aims sought by such application are to be achieved. On the one hand, in order to promote individual liberty, it is necessary to insist that the doctrine's requirements be fulfilled, but, on the other hand, it must not be applied so exactly that the difficulties of fulfilling these requirements give rise to exactly the opposite result, in that persons' wishes are not implemented on the grounds that there is no informed consent to the risks involved. Further, the doctrine could play a role in regulating the degree to which certain persons may pursue what they see as a benefit to themselves (for instance, reproducing) at risk of harm to others (for example, harm or risks of harm to the embryo or, even, to societal values). This would occur where, rather than prohibiting certain conduct directly, as being contrary to "public policy" or "public order and good morals," certain "birth" technology activities were restricted on the basis that they involved either serious risks of such a degree of probability or major unknown risks, that informed

181. See Somerville, supra note 139 at 87-96; Kouri & Somerville, supra note 104 at 599-628.

182. This argument is similar to that raised against "living wills." That is, that it is not possible to give an "informed refusal" of treatment in advance, because the person is not able to anticipate how he or she would feel when faced with the actual, rather than the hypothetical, situation. However, the latter is impossible, because "living wills" only apply to terminally ill persons who, at the relevant time, are incompetent to decide on treatment for themselves. A similar impossibility applies in the case of all "first time" surrogate mothers; if informed consent is impossible the first time, and it is cause to prohibit surrogacy, no woman would ever be in a position to consent to giving up a child, whereas having given one up for adoption were considered relevant...
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technology in conjunction with law governing organ transplantation, even when, as with artificial insemination by donor, the nature of the tissues donated and the procedures used to effectuate this could have been envisioned when such legislation was enacted. The situation is more complex again when the donated material is an embryo, which may not be able to be classified as a tissue or an organ, but may be a "sui generis" entity, and is being donated by a means—such as "embryo flushing"—which was never anticipated at the time at which most organ transplantation laws were enacted.

Finally, as several well-publicized incidents have indicated, the organ transplantation issue may not die with the donor, as most other transplantation concerns do when transplantation related to "birth" technology is involved. The case of the two frozen embryos in Melbourne, Australia, whose "parents" were killed in South America, which has been referred to more than once in this paper, as well as the case of the widow whose right to her dead husband's frozen semen, was upheld by a French court, were matters that attracted international interest. At one level, some of the issues raised by each of these two situations are those that could be characterized as involving transplantation: that of rights to be transplanted in the case of the embryos and that of rights to transplantable tissue in the case of the widow. Perhaps an even more extreme concern is that cadaver donor gametes could be harvested under present "contracting in" laws governing organ procurement, with the consent of a specified relative of the deceased, or, even, without this if "contracting out" legislation were introduced to govern organ procurement.

4. Consistency of the Application of Other Areas of Law to Reproduction Technology

Consideration of the consistency, on the one hand, of approaches and conduct relating to reproduction technology and laws governing this, with, on the other hand, other, more generally applicable, laws, should also be undertaken. Many areas of law could be relevant in this respect, including criminal law, administrative law, constitutional law, and even contract law, for example, where a surrogate mother is involved. But, among these other laws, the most likely to be relevant are those concerning human rights (some of which have already been mentioned), family law and the law governing privacy.

a. Human Rights Law

First, international human rights law could be relevant to reproduction technology situations, including "birth" technology ones. For instance, the Universal Declaration of Human Rights, Article 16, provides that "[m]en and women of full age . . . have the right to marry and to found a family." Human rights claims can also be based on national law. For example, respect for individual rights of self-determination could be examined by looking for the presence of its antithesis, that is, coercion, for instance, in relation to sexual sterilization. Moreover, maximizing self-determination would indicate not only that the law should protect against coercive, anti-natalist policy, but that there should be reasonable access to "birth" technology. In this latter respect, it is interesting to note that we rarely identify omissions, as compared with commissions, as being coercive. And yet, it could be argued that, in different sets of gives circumstances, both sterilization and failure to give access to "birth" technology can constitute coercive anti-natalist policies.

Respect for a right to health, or, more accurately, for a right of access to adequate health care, can be defined to include the requirement that women have access to abortion services, especially when health is defined to include mental health. If abortion is allowed for health reasons, and these reasons include protection of a woman's mental health, and allowing a woman to use the means necessary to protect her health in this way, is regarded as respecting one of her human rights, should access to "birth" technology be treated similarly? Could it even be argued that a right of access to adequate health care requires access to "birth" technology in order to protect physical health? For instance, could a woman who has a family history of breast cancer and who is unable to conceive without the use of "birth" technology, argue that she has a right to such access, because, statistically,

191. Supra section II(A)(5).
192. See supra note 122.
193. Somervile, supra note 50 and note 77.
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Rights against wrongful discrimination also figure prominently in human rights law. Discrimination on the basis of sex, sexual orientation and marital status, in relation to access to “birth” technology, have already been considered. But discrimination on the basis of handicap could also be relevant. Is infertility a handicap or a disease and, therefore, could discrimination on this basis be prohibited in the distribution of medical resources? For instance, could a government’s decision not to fund any “birth” technology unit, be challenged on the grounds of wrongful discrimination? Further, and perhaps more to the point, could infertile persons ever constitute a group, with respect to whom “affirmative action” might be indicated as appropriate?

Depending on the nature of the right involved, respect for human rights may require provision of the necessary services by a government in order to ensure not just the recognition, but also the fulfillment of these rights. Attribution of rights is not enough; their exercise must also be possible. This is to argue that human rights sometimes need to be of positive (that is, “rights to”) and not only negative (that is, “rights against”) content. However, the former type of right, while not more difficult to establish in theory, may be harder to realize in practice.

199. See E.W. KEYHLERLING, THE UNBORN CHILD’S RIGHT TO PRENATAL CARE (McGill Legal Studies No. 5, Quebec Research Centre of Private and Comparative Law, 1984).
200. Supra sections IIIA(6) and (7).
201. “Affirmative action” means that there is recognition, not only of a right not to be wrongfully discriminated against, but also, of a claim of entitlement to conferred of greater than equal benefits in order to remedy, adequately, the situation brought about by prior discrimination.

The degree to which “birth” technology has made possible the fragmentation of parenting in terms of time, place, genetic heritage, biological function, psychological, and social aspects, would have seemed like science fiction little more than a decade ago. This is to observe the now-possible situation from the perspective of the range of potential parents. But this same observation can also be stated from the perspective of the child: namely, the degree to which it is possible for a child to be disconnected from its “parents” in any of the sensess listed, and because of this to have “multiple parents,” was undreamed of previously. For example, now a child could be born ten years after it was conceived, having been carried in the uterus of a woman genetically unrelated to it, and then handed over to “other parents” to be raised. Such possibilities have played havoc with family law with respect to the status of “birth” technology children in relation to their “parents.” The fundamental nature of the relationship which gives rise to legal rights and obligations between parents and children; legitimacy; rights and obligations regarding maintenance; adoption; “vital statistics” in the form of statutorily required “true and accurate” official records of births; and, even, divorce. For instance, in the last respect, who would “own” or have the right to determine what happens to a frozen embryo, when the man and woman who donated the gametes which form it decide to divorce? Moreover, to ask whether an embryo is property, is to raise yet another area of law which could sometimes be relevant to “birth” technology, that of property law.

The issues just raised, as well as related matters not mentioned, could, and without doubt will, be the subject of several books, which is an indirect way of explaining why there, just some of them are merely identified and not even a comprehensive list is provided.

c. Law Governing Privacy

The development of the law of privacy is a recent phenomenon.
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199. See E.W. Keeryn, The Unborn Child’s Right to Pre-Natal Care (McGill Legal Studies No. 5, Quebec Research Centre of Private and Comparative Law, 1984).
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which has a range of manifestations. In relation to privacy of information, this law has been generated, in part, by reactions of concern to the possibilities for invasion of privacy presented by the emergence of sophisticated information technology. There is wide-spread concern to provide persons with the means of protecting, in the sense of ensuring the confidentiality of, those aspects of themselves that they wish to remain private. These include aspects of their personalities and private relationships. This is the "negative content" aspect of privacy law as applied to information — that is, the right against disclosure. The "positive content" aspect of such privacy law is a person's right to ensure that any information, the collection and continued holding of which is not illegal, is correct. Implementation of this right requires that persons have access to records, such as their medical records and some public or government records. Access to both these types of records can be regulated by legislation, the former, for instance, under "Hospitals Acts" or "Health Services and Social Services Acts," and the latter by "Freedom of Information" legislation.

Both the positive and negative aspects of privacy law are important in the context of "birth" technology, where they may need different treatment than in the law in general. This is particularly true in undertaking to strike a balance between honoring one or another aspect of the right to privacy when these are in irreconcilable conflict. There are serious, but different, harms involved in every available option.

For instance, failure to respect the negative aspects of privacy law, such as the right to confidentiality, may affect the existence of "birth" technology itself, in the sense of its being available for use. For example, it could be that men would not be willing to donate sperm unless they were assured of absolute rights of confidentiality concerning their identity.

But, honoring positive aspects of privacy law, which could mean failure to respect negative aspects, could be equally as problematic. The issue of whether children should have a right to non-identifying, or even identifying information, concerning their genetic origins has already been raised. The converse situation, although perhaps less likely, also needs to be considered. Should gamete donors have any right to non-identifying or even identifying information concerning their progeny? Apart from situations where the appearance of a genetic defect would constitute information that should be given to the donor in order to allow him or her to make decisions concerning further reproduction, should a person be allowed to trace a child either for psychological reasons (for example, as some parents are attempting to trace children given up for adoption) or for medical reasons (for instance, in the converse situation to that where the child needs to identify the genetic parent for purposes of organ or tissue donation, the genetic parent could seek to identify the child for the same reasons)? The balance struck in this regard in the Australian State of Victoria, the only jurisdiction so far to have passed comprehensive legislation to govern the use of "birth" technology, is to make identifying information available to all participants in the "birth" technology process — gamete donors, parents, children — but to provide that non-identifying information about gamete donors can only be disclosed with their consent. There is no provision which would allow a child to give permission for a gamete donor to have identifying information regarding him or her. Consequently, although mutual identification of gamete donors and "birth" technology children depends on an initial decision of the gamete donor, with respect to giving or refusing consent to disclosure of identifying information, whether or not this identification occurs is under the control of the child, which is as it should be.

Finally, a right to privacy can be viewed as one form of human rights law and in this respect, it can also be considered within a discussion of human rights aspects of "birth" technology. Moreover, as explained earlier in this text in relation to abortion, a right to privacy can encompass a right not to have interference with one's decisions concerning reproduction. This could give rise to an examination of whether the screening requirements imposed by "birth" technology units, as a condition of giving access to their services, interfere with rights of personal or family privacy, and so, whether such interfer-

204. See e.g., the Health Services and Social Services Act, R.S.Q. c. S-5, sec. 7.

205. One American organization which has been established to assist such parents in this undertaking is CUB (Concerned United Birth-Parents).


207. Supra section III(B)(4)(1).

208. Supra section III(A)(5).

209. One can postulate three levels of privacy. At a first level, the privacy protected is entirely personal and individual. An extension of this, which can be regarded as a second level, is protection of reproductive privacy, because this necessarily, in one form or another, involves a second person. And, on a third level, a right of privacy can be postulated which encompasses both the individual, his or her partner in reproduction, and the result of that reproduction, namely the children — that is, the family unit — within the sphere of its protection.
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IV. Consistency And "Conception Policy" — Do We Need To Take Some Form Of Global View?

In one sense law and medicine reflect two competing world views, that of a national, as compared with a global, approach, respectively. Law operates jurisdictionally and, usually, this is territorially. This can be contrasted with medicine, which has universal application, although it is often only available within certain territories. One of the issues which "birth" technology raises is whether we need to take some form of global view in terms of achieving consistency of "conception policy" and here, this term is used in the broadest sense to include all methods for creating or limiting a family. While this is a simple question to ask, it is extremely difficult to address in that it raises, at various levels, an almost infinite number of complex and, often, inter-related issues, including medical, ethical and legal ones. Despite this, the question needs to be articulated; to do so is not meant to imply that "birth" technology ought not to be developed, or that people should not have access to it. Rather, it is to propose that this may not be the single valid solution for all persons who want to bring up children and would need to use "birth" technology in order to have any chance of achieving this aim because, for instance, adoption through the usual channels was unavailable. Likewise, the use of anti-reproduction technology may not be the single valid solution for a person who wants to avoid having to raise a child. Could, for example, a scheme be organized, which was more humane than inhumane, which would allow "unwanted" or orphaned or destitute children from one country to be adopted in another country where there was a shortage of children? Obviously, safeguards would be needed to protect the children and to prevent exploitation of their natural parents and prospective adoptive parents, but these should not be impossible to devise.

Then, if we accept surrogate motherhood, could we consider supporting a woman in order to allow her to avoid an abortion which she does not want (especially if it constituted a risk to her health because only very inadequate abortion facilities were available, making the risk of septic abortion very high, as in some Third World countries) and agree to adopt the child when it is born? Or would this be extremely and unavoidably coercive, because the woman has no real alternative to giving up the child, although she may not want to do this? Would the harms of any such schemes necessarily and always outweigh any benefi

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IV. Consistency And “Conception Policy” — Do We Need To Take Some Form Of Global View?

In one sense law and medicine reflect two competing world views, that of a national, as compared with a global, approach, respectively. Law operates jurisdictionally and, usually, this is territorially. This can be contrasted with medicine, which has universal application, although it is often only available within certain territories. One of the issues which “birth” technology raises is whether it is necessary to take some form of global view in terms of achieving consistency of “conception policy” and here, this term is used in the broadest sense to include all methods for creating or limiting a family. While this is a simple question to ask, it is extremely difficult to address in that it raises, at various levels, an almost infinite number of complex and, often, inter-related issues, including medical, ethical and legal ones. Despite this, the question needs to be articulated; to do so is not meant to imply that “birth” technology ought not to be developed, or that people should not have access to it. Rather, it is to propose that this may not be the single valid solution for all persons who want to bring up children and would need to use “birth” technology in order to have any chance of achieving this aim because, for instance, adoption through the usual channels was unavailable. Likewise, the use of anti-reproduction technology may not be the single valid solution for a person who wants to avoid having to raise a child. Could, for example, a scheme be organized, which was more humane than inhumane, which would allow “unwanted” or orphaned or destitute children from one country to be adopted in another country where there was a shortage of children? Obviously, safeguards would be needed to protect the children and to prevent exploitation of their natural parents and prospective adoptive parents, but these should not be impossible to devise. Then, if we accept surrogate motherhood, could we consider supporting a woman in order to allow her to avoid an abortion which she does not want (especially if it constituted a risk to her health because only very inadequate abortion facilities were available, making the risk of septic abortion very high, as in some Third World countries) and agree to adopt the child when it is born? Or would this be extremely and unavoidably coercive, because the woman has no real alternative to giving up the child, although she may not want to do this? Would the harms of any such schemes necessarily and always outweigh any bene-
assessment and may, indeed, prove to be unacceptable. But such possibilities should be canvassed and with honesty, insight and compassion for all concerned. We need to be careful that we are not shocked by some suggestions, just because either we fear them or have some hidden prejudice, or because they are controversial or even, unfashionable. This section was included with hesitation because I was concerned about how readers might react. In particular, I feared that they would be alienated by these suggestions. Yet, I believe that this is a chance that must be taken, with the risk of being considered naive, simplistic, idealistic, and simply wrong, or, worse yet, evil.

V. Conclusion

Searching the social, scientific, legal, psychological, and personal contexts of "birth" technology for values and policies, and consistencies and inconsistencies, is a fascinating activity. It is a two-way enterprise and two-way insights result: what we find in "birth" technology can throw light on some other areas; what we discover in other areas, including other areas of reproduction technology, may help us to identify otherwise hidden factors in the "birth" technology context. This is the methodology used in this text. But the results are far from comprehensive. Furthermore, often, value judgments have been involved in deciding, for instance, on the causes of, or interpretation to be given to, certain facts. But, these are not fatal flaws. In fact, they are probably unavoidable outcomes. Moreover, recognition that this is the situation indicates the need to set up a structure in which we can explore the issues raised by "birth" technology, both internally within that context and within the reproduction technology context in general, and externally in relation to other values, policies and laws. This probably represents the most important point that could be made in this text, and it is what has been attempted in writing it. That is, the table of contents published at the beginning of this paper, can be regarded as an attempt to identify, articulate, and delineate such a structure.

Such a structure is needed, also, because we are not dealing with a static situation in terms of either attitudes, values, policies, laws, or science, or the interrelationship between these. As science changes so do values, policies, ethics, and law. To take an example from the "birth" technology context: cryopreservation of human ova has now become possible, but is still at an experimental stage, whereas cryopreservation of eight or sixteen cell embryos is well-established. Some of our ethical and legal problems regarding freezing and storing embryos will be solved now that we can freeze ova. This is an interesting example, because it shows that scientific advancement, and with it the possibility of greater control — that is, creating more scope for choice and less for chance — does not always augment our ethical and legal problems, as some of us may be inclined to think. Such advances may also solve problems, although they are often ones which we have created through a previous scientific advance. In short, the question, already asked once, "What about the Children?" was the title of a symposium held in Boston that dealt with the effects of "birth" technology on children produced through its use, could sometimes become irrelevant. This would be the case where, as in the above example, there would be no "child."

In this same vein of thought as to why we need a structure for dealing with issues raised by "birth" technology, it may be not only that we are unable to draw permanent lines — that is those that will persist into the future — between acceptable and unacceptable conduct, but also that we are unable to draw clear lines in the present. For instance, there may not be a clear line between pre-reproduction and anti-reproduction technology research (as compared with the application of such techniques), because an advance in "birth" technology may indicate a means of developing a better method of contraception. This realization could take us the full circle back to the story with which this paper commenced — "the Chinese Story" — and offer another explanation for the apparent inconsistency described. It contains also an important lesson for the sleuth on the trail of consistencies and inconsistencies in this area: while these are important to detect and consider in depth for the lessons this activity has to offer, we need to be open-minded and flexible about having any final answers as to the rights or wrongness of certain consistencies or inconsistencies discovered in the process. It is yet another example that society is an extraordinary and complex entity. It could be a test of any given society's viability and sophistication whether it can both live with some inconsistencies and accept change regarding others, whether this change is in the direction of greater consistency or greater inconsistency. The scenarios raised by some of the situations investigated in this text will test that viability and sophistication at a very fundamental level, because they touch on some of our most important individual and collective values, attitudes and beliefs. In this respect, it seems perfectly consistent...
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210. Supra section III(C).
to free associate the thought that we have survived 1984, but the year 2001 is fast approaching.

Normative Regulation of Reproductive Technologies in Israel*

Amos Shapira**

I. Introduction

The novel reproductive technologies raise problems — ranging from the pragmatic to the olympian — which cut across national frontiers and transcend cultural boundaries. Communities in the modern world promoting such technologies are bound to face common dilemmas of ethical, socio-political, and normative-regulatory dimensions. Yet these underlying similarities are qualified, sometimes substantially, by the inherent differences — in cultural heritage, religious tradition, social organization and form of government — marking the various nations of the world community. It might, therefore, be instructive — and occasionally puzzling — for an informed American observer to cast a comparative glance at a regulatory scheme devised elsewhere for the exercise of societal control over the novel reproductive technologies.

Despite profound disparities between the United States and Israel — in history, size, population make-up, socio-economic ethos and system of government — there is a striking resemblance in the essentially secularist, liberal and permissive individual life-style led by many (if not most) Americans and Israelis. But Israel, unlike the United States, has never subscribed to the principle of separation of religion and state. Cultural-religious values, institutions, practices, and injunctions are formally woven into the Israeli communal fabric. The ongoing debate on the proper role of religious tradition in the life of the nation generates heightened cultural tensions and heated political divisions, sometimes throwing society into turmoil. Also, unlike the United States, Israel has not yet adopted a formal written constitution complete with a super-law model of a bill of rights. Consequently, in the Israeli normative reality, the precepts of privacy, autonomy and self-determination are not anchored to any entrenched constitutional text backed by

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