VITAL SIGNS

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Building a culture of Care, Compassion & Life….

Canadian Physicians for *Life*

Inside this issue:

The Commercialization of Reproduction and Donor Anonymity in Canada

prepared by Brittney Sharp

This report was written by the Center for Bioethics and Culture and is reprinted with their permission. This is an abbreviated version of the report. The full report can be found here: http://www.cbc-network.org/2011/09/the-commercialization-of-reproduction-and-donor-anonymity-in-canada/

Advancements in reproductive technologies over the past two decades have prompted moral and ethical debates worldwide. Canada has approached this new ethical landscape and the development of new reproductive technologies by constructing a legislative framework to "protect the health and safety, rights and dignity of Canadians."[1] Canada boasts having created "one of the most comprehensive pieces of legislation in the world" to address the many issues that arise when individuals employ the use of reproductive technologies and engage in biological research to explore human reproduction.[2] Canada's *Assisted Human Reproduction Act (AHRA)* covers a wide range of topics involving all stages of assisted human reproduction, and Canada's case law covers a number of topics as well.

Prohibition on the Commercialization of Human Reproduction

According to Health Canada's website, as many as one out of eight Canadian couples will have problems with infertility.[3] Occasionally an individual's infertility situation cannot be remedied and the only opportunity available for a couple to have a child that is biologically-related to at least one of them is through the use of donated eggs or sperm or the services of a surrogate mother. In addition, a growing number of single women and homosexual couples have expressed a desire to have a child through nonconventional methods involving assisted reproductive technologies. These types of situations have created an increase in the demand for egg and sperm donors and surrogate mothers, and the increased demand has created an entire infertility industry in many countries. However, a number of ethical issues are involved in such commercialization of human reproduction. For example, some studies have revealed that the women who donate their eggs or relinquish their bodies to provide surrogacy services are often from lower socioeconomic groups while the women who receive donated eggs or a child born from a surrogate tend to be more "socially and economically advantaged."[4]

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The Assisted Human Reproduction Act

In 1989 the Canadian federal government created the Royal Commission on New Reproductive Technologies, known as the "Baird Commission," to study human reproduction technologies.[5] The Commission inquired into existing medical technologies as well as foreseeable scientific and medical advances and in 1993 released its final report entitled *Proceed With Care: Final Report of the Royal Commission on New Reproductive Technologies.*[6] The Commission was apprehensive and concerned about specific practices and "pressed the government to pass legislation to limit their use."[7] For example, it strongly recommended criminal prohibitions on "selling human eggs, sperm, zygotes, or fetal tissue; [and] advertising for, paying for, or acting as an intermediary for preconception (surrogacy) arrangements."[8] The Commission alleged that "to allow commercial exchanges of this type [buying and selling embryos, use of financial incentives, etc.] would undermine respect for human life and dignity and lead to the commodification of women and children."[9]

On March 3, 2004, the Senate adopted Bill C-6, An *Act Respecting Assisted Human Reproduction and Related Research*, also referred to as the *Assisted Human Reproduction Act*.[10] On March 29, 2004 the *Assisted Human Reproduction Act* received Royal Assent and became law.[11] The Canadian Ministry of Health had two objectives in drafting the bill: to ensure that Canadians do not compromise their health and safety through the use of reproductive technologies, and to regulate research on human reproductive material.[12] The specific language from the *AHRA* regarding the relevant sections includes the following:[13]

> **6**. (1) No person shall pay consideration to a female person to be a surrogate mother, offer to pay such consideration or advertise that it will be paid.
>
> (2) No person shall accept consideration for arranging for the services of a surrogate mother, offer to make such an arrangement for consideration or advertise the arranging of such services.
>
> (3) No person shall pay consideration to another person to arrange for the services of a surrogate mother, offer to pay such consideration or advertise the payment of it.
>
> **7.** (1) No person shall purchase, offer to purchase or advertise for the purchase of sperm or ova from a donor or a person acting on behalf of a donor.
>
> (2) No person shall purchase, offer to purchase or advertise for the purchase of an in vitro embryo; or sell, offer for sale or advertise for sale an in vitro embryo.
>
> (4) In this section, "purchase" or "sell" includes to acquire or dispose of in exchange for property or services.
>
> (5) **60.** A person who contravenes any of sections 5 to 9 is guilty of an offence and *(a)* is liable, on conviction on indictment, to a fine not exceeding $500,000 or to imprisonment for a term not exceeding ten years, or to both.

The AHRA not only prohibits the purchase of gametes or the services of a surrogate mother, it makes it a criminal offense to do so that is punishable by up to $500,000 or ten years in prison. However, altruistic surrogacy and egg or sperm donation is not prohibited, and according to Health Canada's website, donors and surrogate mothers can be reimbursed for the expenditures associated with donation and surrogacy, "provided that the expenditures are receipted, and that they meet licensing and regulatory

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Canadian Physicians for Life holds that reverence for every human life lies at the root of all medical tradition. Through the ages, this tradition has been expressed in the Oath of Hippocrates. It was rephrased in modern times in the Declaration of Geneva, which says in part, "I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity." We affirm this declaration.

Letters and submissions for publication are welcome. Membership is by donation. Tax receipts are issued for all donations.

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‘Deselecting’ our children

by Margaret Somerville

Here’s a recent Danish headline: “Plans to make Denmark a Down syndrome-free perfect society.” The Danes want to promote aborting fetuses with Down syndrome, so their society will be free of such people around 2030. One bioethicist describes it as a “fantastic achievement.”

At least the Danes are raising this issue. In North America, it’s estimated that more than 90 per cent of unborn babies with Down syndrome are aborted.

The ethics issues that prenatal screening raises will only increase as the range of tests expands, they’re safer for the woman, cheaper, easier to use and presented as routine medical precautions. But not all tests have medical goals. The latest – identification of a baby’s gender at seven weeks of pregnancy – raises fears of sex selection, which has resulted in millions of missing girls in India and China. These “deselection” decisions affect society itself. Many young men, for instance, can’t find a wife.

The British riots provide insight regarding actions by individuals that cumulatively threaten society: Unlawful assembly and rioting are such crimes. The same can be true of individuals “choosing” their children. So what limits should we place on their doing so in the interests of society?

Widespread, publicly endorsed and paid for prenatal screening to eliminate people with Down syndrome implicates values of respect for both individual human life and human life in general, and respect for disabled people. Collectively, these decisions implement negative eugenics regarding disabled people. It’s a “search and destroy” mission to wipe them out.

What kind of society might result from endorsing a belief that a society without disabled people is “perfect?” The use of science in the search for human perfection has been at the root of some of the greatest atrocities.

Offering routine prenatal screening sends a message that a woman is conditionally pregnant, until she’s told there’s “nothing wrong” with the baby – the fetus is certified as “normal” – or, even, is the “right sex.” This contravenes the value that parental love is unconditional – we love our children just because they’re our children.

A societal-level message is: “We don’t want you in our society unless you measure up to a certain standard. You’re only a potential member, until you’ve passed the admission test we’ll pay for with our tax dollars.”

And what about the “everyday ethics” of screening? Many physicians are not competent to obtain informed consent to all prenatal tests and carry out follow-up genetic counselling. Physicians also tend to be very pessimistic in predicting the impact, for instance, of Down syndrome on the child, and usually see no possible benefits from having such a child.

People who could inform them otherwise are often silenced. Audrey Cole, the mother of a 47-year-old man with Down syndrome, writes: “Our voice will, inevitably, be dismissed as the whinings of a ‘special interest’ group. I have never been able to understand why my feelings as a parent of a wonderful, caring, gentle man can be so easily dismissed as ‘special interest.’ I am frightened of the times that seem to be coming.”

And how will women who refuse screening be regarded? Will families who “choose” not to abort when “abnormalities” are discovered be seen as socially irresponsible?

In deciding about the ethics of prenatal screening, we should recall that, for all of us, “the well are only the undiagnosed sick.”

Margaret Somerville is the founding director of the Centre for Medicine, Ethics and Law at McGill University.

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Important Questions for Modern Times

by Will Johnston, MD

As a society we have largely conquered cold weather, hunger, disease and early death, so in our leisure we now busy ourselves arguing over who to kill. Are you young enough? Unwanted enough? Old enough? Depressed enough? Inconvenient enough? Does your Down syndrome leave you with too many 21st chromosomes to suit the 21st century?

Should you, a pregnant woman, kill your tiny baby now, before your belly swells and you start working hard at being pregnant? Should you wait a while? Should you wait until after birth, strangle the baby with your thong and throw him over the fence? A judge will understand. The judge will say that Canadians "...generally understand, accept and sympathize with the onerous demands pregnancy and childbirth exact from mothers....". Hmmm. Well, in any case, at least onerous demands which dwarf this judge's expectations of human decency in Canada.

Should you, an elderly man, kill yourself because you have lost interest in life? Before you are too weak to do it? Before you go and spend your children's inheritance on expensive "assisted living", should they help you arrange an "assisted suicide"? Do your children want to arrange this for you? Are you ambivalent about dying now? Do you need an assisted decision to stop dithering and get on with your assisted suicide?

What a clever species we are! Our barbarism adapts so well to the science of the moment. We can look back with relief that we no longer watch people being burned at the stake, but we must remember that their executioners were just doing their level best with the technology they had close at hand. Now we have suction curettes, RU 486, misoprostol, pentobarbital, helium death hoods. But lest we feel smug, imagine what the future might bring! How crude our methods will seem to posterity!

Women come to me with stories. Last week, one told me how she had tried for years and was finally pregnant, only to have a doctor suggest an abortion after hearing about some trivial adversities which the woman shared in conversation. Out of this doctor's shrivelled stores of compassion, the offer of abortion alone remained. It is but an illusion of professional neutrality to claim to endorse an uncertain woman's abortion plans as heartily as her hopes for motherhood. Motherhood fears for the child's safety, abortionhood fearfully rejects the child and wishes it dead. Should someone who expresses indifference between the two outcomes be trusted and taken seriously by an agonizing woman?

Another of my patients was marched into a medical abortionist's office by her abusive boyfriend. When she returned to the waiting room, she told the man that the abortion had happened, though she had actually refused it. He promptly abandoned her, to her relief, and I attended the delivery of a healthy little girl a few months later.

A university student feared that her strict father, who lived far away estranged from her mother, would reject her if she stayed pregnant. I had lost hope that she would come back to my office still pregnant when, at 15 weeks gestation, she returned. Her father was not told about the pregnancy. After her daughter was born she picked her father up at the airport and he pointed quizzically at the baby car seat. She began to cry. He understood at once, comforted her, and met his first grandchild with pleasure soon after. Years later the woman discovered an aggressive cancer and had extensive chemotherapy. She told me how grateful she was that I had encouraged her to go on with her only pregnancy, to love and hope for her only child.

Another woman was not as lucky. Her parents insisted on a late-term abortion which was performed in the U.S. Complications ensued and she needed a hysterectomy to save her life. Travelling from healthy motherhood to permanently childless grief required only the abortion mindset, a coerced woman, and a compliant medical profession.

And still our world asks who to kill next. So much new science, so little time. We really need help.

Will Johnston, MD, is a Vancouver family physician practicing a wide spectrum of practice and obstetrics. He is President of Canadian Physicians for Life, and Co-Chair of the Euthanasia Prevention Coalition of BC.

The Canadian Physicians for Life Editorial Board welcomes your commentaries and articles. To submit an article for possible inclusion in an upcoming edition of Vital Signs, send an electronic copy to info@physiciansforlife.ca. Please include the original publication information, if applicable.

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requirements."[14] The fact that it is the purchase and sale of human gametes and surrogacy services that is prohibited means that the AHRA reflects the Baird report's attitude toward the commodification of women and children and the commercialization of reproduction. The ethical concerns that the Canadian government has with assisted human reproduction focus on the treating of human reproduction as products on the open market, rather than on the technologies themselves. According to an article written by L. Bernier and D. Grégoire in the Journal for Medical Ethics, the prohibition on the purchase and sale of embryos reflects the Canadian government's belief that "since embryos contain the potential of eventually becoming human beings, they should not be treated as commodities or objects."[15] The Canadian government's position on the sale of human eggs and sperm also coheres with the idea that the human body and all of its parts are "inalienable."[16] Lastly, although the AHRA has been challenged by the province of Quebec (see below) the key portions of the law pertaining to the purchase of gametes and surrogacy services were conceded. Therefore, the notion that the commercialization of human reproductive materials is harmful and that the criminalization of such behavior is within the jurisdictional power of the federal government has been conceded by the Canadian provinces.

Quebec Challenges the Assisted Human Reproduction Act

After its passage, the *AHRA* was challenged on constitutional grounds by the Attorney General of the Province of Quebec. According to an article from CBC News, in 2008 the Quebec Court of Appeal ruled that parts of the *AHRA* were unconstitutional because they violated the right of the provinces to regulate health care.[17] The Canadian government appealed the appellate court's decision and the case went before the Supreme Court of Canada on April 24, 2009.[18] On December 22, 2010 the Supreme Court released a split decision which enforced the right of the provinces to regulate health care, but also upheld the federal ban on compensation for egg or sperm donation.[19] In fact, the portions of the act which criminalize commercial payments to egg and sperm donors and surrogate mothers were not part of the constitutional challenge made by Quebec.[20] The Supreme Court explained that Sections 5 through 7 were conceded by Quebec to be valid criminal law.[21] As mentioned above, the province recognized that the criminalization of the sale of human gametes and surrogacy services was a valid exercise of the power of the federal government.

In the Supreme Court's written opinion, it continually referenced the moral values which are reflected in the *AHRA*. For example, it explained that the "dominant purpose and effect of the legislative scheme is to prohibit practice that would undercut moral values, produce public health evils, and threaten the security of donors, donees, and persons conceived by assisted reproduction."[22] In fact, the court explained that the dominant purpose of the prohibitions listed in Sections 5 through 7 is to "criminalize conduct that Parliament has found to be fundamentally immoral, a public health evil, a threat to personal security, or some combination of these factors."[23] Lastly, the Supreme Court made the following observation about morality as reflected through the *AHRA*:[24]

> The creation of human life and the processes by which it is altered and extinguished, as well as the impact this may have on affected parties, lie at the heart of morality. Parliament has a strong interest in ensuring that basic moral standards govern the creation and destruction of life, as well as their impact on persons like donors and mothers. Taken as a whole, the Act seeks to avert serious damage to the fabric of our society by prohibiting practices that tend to devalue human life and degrade participants.

Although Quebec challenged the constitutionality of portions of the *AHRA* before the Supreme Court, it accepted those sections prohibiting the sale of human gametes and surrogacy services. The Supreme Court has also made it clear that the criminalization of this type of behavior reflects the Canadian government's position that allowing such practices would undermine basic moral standards and degrade its citizens.

Notes

1. Introduction to Assisted Human Reproduction, HEALTH CANADA, Jan. 2, 2008, http://www.hc-sc.gc.ca/hlvs/ reprod/hc-sc/index-eng.php.

2. Id.

3. Id.

4. Id.

5. Reference re Assisted Human Reproduction Act, 2010 SCC 61, [2010] 3 S.C.R. 457 (Can.) [Assisted].

6. Id. at para. 160.

7. Id. Para. 5

8. Nancy Miller Chenier, Reproductive Technologies: Royal Commission Final Report, CANADA DEPOSITORY SERVICES PROGRAM, Apr. 22, 1994, http://dsp-psd.pwgsc.gc.ca/Collection- R/LoPBdP/MR/mr124-e.htm.

9. Assisted, supra note 6 at para. 111 (citing Canada, Royal Commission on New Reproductive Technologies, Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies, Ottawa: Minister of Government Services Canada, 1993 at 718).

10. A Chronology of the Assisted Human Reproduction Act, HEALTH CANADA, Jan. 02, 2008, http://www.hcsc. gc.ca/hl-vs/reprod/hc-sc/general/chronolog-eng.php.

11. Id.

12. L. Bernier & D. Grégoire, Reproductive and Therapeutic Cloning, Germline Therapy, and Purchase of Gametes and Embryos: Comments on Canadian Legislation Governing Reproductive Technologies, 30 J. MED ETHICS 527, 527 (2004).

13. Assisted Human Reproduction Act, S.C. 2004.

14. Healthy Living Frequently Asked Questions, HEALTH CANADA, http://www.hc-sc.gc.ca/hl-vs/reprod/hcsc/faq/index-eng.php

15. Bernier & Grégoire, supra note 14, at 530.

16. Id.

17. Regulating and treating conception problems, CBC NEWS, Dec. 22, 2010, http://www.cbc.ca/news/health/story/2009/02/05/f-reprotech.html.

18. Id.

19. Id.

20. Tom Blackwell, Blackwell on Health: Supreme Court Keeps Fertility-Donor Payments in Feds' Hands, NATIONAL POST, Dec. 22, 2010, http://news.nationalpost.com/2010/12/22/blackwell-on-health-supremecourt- keeps-fertility-donor-payments-in-feds-hands/#more-39105.

21. Assisted, supra note 6.

22. Id.

23. Id. at para. 88

24. Id. at para. 61

Announcing the

2011 MEDICAL STUDENTS FORUM

November 11 - 13, 2011
Lord Elgin Hotel
Ottawa, ON

Canadian Physicians for Life will be co-hosting this year's Medical Students Forum with the University of Ottawa's Medical Students for Life club, November 11-13, in Ottawa, ON.

We offer to pro-life medical students a broad range of seminars and workshops designed to not only inform them with regards to sensitive and emerging issues, but to equip them with the confidence to 'make their case' when interacting with colleagues and the public who may question their stance on life issues. Pro-life medical students and residents are encouraged to apply for a scholarship to attend.

We also encourage our physician and retired physician members to attend the forum. This is a great opportunity to network with pro-life colleagues, and interact with some exceptional medical students from across Canada.

Advance registration is required. Contact KC McLean - D'Août at info@physiciansforlife.ca or 613.728.5433 for more information.

List of Confirmed Speakers

(in alphabetical order)

Thomas Bouchard, MD, Canadian Physicians for Life board member and medical resident, University of Calgary

- "*Thriving, Not Just Surviving Medical School as a Pro-Life Student"*

Stephen Genuis, MD, FRCSC, DABOG, Associate Clinical Professor, Department of Obstetrics and Gynecology, University of Alberta

- "*End of Life Decisions"* and *"Dismembering the Ethical Physician"*

Stephanie Gray, Executive Director of the Canadian Centre for Bioethical Reform

- *"The Abortion Debate: Equipped to Engage"*

Will Johnston, MD, President of Canadian Physicians for Life and Family Physician, Vancouver

- *"Fetal Pain"*

René Leiva, MD, CM, CCFP, Family Physician, Ottawa

- *"Reproductive Technology"*

Andrea Mrozek & Brigitte Pellerin, ProWomanProLife (www.prowomanprolife.ca)

John Robson, PhD, Parliamentary bureau columnist and commentator, Sun Media

John Scott, MD, M.DiV., Assoc. Prof, Faculty of Medicine, University of Ottawa, Palliative Care Physician, Ottawa Hospital

- *"Euthanasia/Palliative Care"*

Theresa Zimmermann & Pat Errey, Canadian Association of Pregnancy Support Services (CAPSS)

- *Interactive role-play session*

University of Ottawa medical students launch pro-life club

Congratulations to students at the University of Ottawa for launching Medical Students for Life, this term. CPL Board member David D'Souza (class of 2013) and classmates prepared a display for the annual medical school interest group club fest.

Thanks to the generosity of our members and donors, CPL is pleased to support medical student pro-life clubs on campuses across Canada. Club members volunteer their time to engage classmates in thoughtful discussions about a range of topics through guest speakers, debates, and film nights. Some groups also corporately volunteer at local pregnancy care centres.

For more information about pro-life medical student groups, visit www.cplstudents.ca or contact info@physiciansforlife.ca.

Announcing CPL's 2011 Annual General Meeting

You are invited to attend CPL's 2011 Annual General Meeting in Ottawa this November.

Friday, November 11, 2011

5:30 p.m.

Lord Elgin Hotel

100 Elgin St. Ottawa, ON

Please RSVP:
Email: info@physiciansforlife.ca
Phone/Fax: 613.728.5433

We welcome you to join us after the meeting for the opening session of the 2011 Medical Students Forum. This session will be a debate featuring Stephanie Gray from the Canadian Centre for Bioethical Reform. The debate will be held on the University of Ottawa campus. It is a free event and will be open to the public.

Vital Signs will be running a series of cases for reflection on a relevant topic related to medical ethics or challenging scenarios with colleagues in order to spark discussion among our readers and members.

Pro-Life Case File #1: Prenatal screening

Background

It is mandated in many provinces that pregnant women should be offered prenatal screening early in pregnancy to detect if there are any abnormalities with the developing fetus. The undercurrent to this practice is that when abnormalities arise, women would also be "offered" to terminate the life of their fetus. The case below examines a response to this difficult situation.

Case

Amanda is a 25 year old in your practice who has been trying to conceive with her husband since they were married 2 years ago. She has just had a positive pregnancy test in your office and is asking when she needs to go for an ultrasound. She was told by some friends that the first ultrasound usually occurs around 12 weeks.

Context

The SOGC guideline on Prenatal Screening (#187, Feb 2007) states that "All pregnant women in Canada, regardless of age, should be offered, through an informed consent process, a prenatal screening test for the most common clinically significant aneuploidies" and that "Maternal age screening is a poor minimum standard for prenatal screening for aneuploidy."

The expectation is that prenatal screening should have a minimum "75% detection rate with no more than a 5% false positive rate for Down syndrome." A positive nuchal translucency is followed up with an amniocentesis for a more definitive diagnosis, should the patient choose this more invasive procedure that carries a 1/200 risk of miscarriage.

Response

To find out where a patient's knowledge and impressions are, ask the patient questions around the issue of prenatal screening.

Some helpful questions may include:

What do you know about prenatal testing?

The 12 week ultrasound for nuchal translucency is done in order to give women in enough time to have an abortion should they choose to if they receive a positive test result. It is also argued that some women may not consider an abortion but would want the test to prepare for a child with high needs if the test were positive.

What would you do with the results of prenatal testing?

Needless to say, a positive test result leads to significant anxiety even in those who are at fairly low risk. It also puts couples in a difficult position to choose amniocentesis for the definitive diagnosis which carries a risk of miscarriage.

Do you know anyone with Down's syndrome? What do you feel about people with Down's syndrome? Would the information help you to prepare for a special needs child?

If a woman would not abort her child but would find the information useful to prepare for a child with Down's syndrome, resources could then be provided. Families could be linked to other parents who have been through the same situation. In addition, if a trisomy 13 or 18 were discovered with a poorer prognosis, then the family could be put in touch with perinatal hospice or a physician who takes care of babies with fatal anomalies.

Would you end the pregnancy if there was a positive test result?

If a woman would not want to abort her child if she had a positive test result, I would not recommend the 12 week nuchal translucency screen.

If a woman would abort her child if she found out it had Down's syndrome, I would respond by saying that I would continue to care for her up to and after her decision, but I could not participate in an abortion process. If she chooses to do the genetic screen, and the test were positive, I would not be willing to refer her for an abortion.

Thomas Bouchard and Larry Reynolds are board members for Canadian Physicians for Life