

## Assisted human reproduction in Canada: it's a gnarly world out there

By Brian Seaman

### Cases Considered:

[Assisted Human Reproduction Act, S.C. 2004, c.2.](#)

When 60-year-old Ranjit Hayer of Calgary gave birth via caesarean section to twin boys at Calgary's Foothills Hospital in early February of 2009, the news spread quickly around the world. She became one of a small but growing number of women who, subsequent to having undergone assisted human reproductive treatments, successfully give birth at ages late in the menopausal cycle, or in a handful of even more extreme examples, after menopause has ended. Indeed, in what is probably the most extreme example of a successful post-menopausal pregnancy to date, a 70-year-old woman in India is reported to have given birth in July of 2008 to twins (see [here](#)).

The contemporary model for ethical patient care in Canada and throughout the democratic part of the world generally is based on that of informed consent; i.e. a patient makes her or his own decision as to therapeutic treatments or interventions based on the advice - if not outright recommendation, in practice - of a health care professional. However, when an older woman's womb becomes, essentially, a laboratory for fertility clinics or physicians to experiment with, one can only speculate as to the social, cultural, and / or familial pressures that could have been factors to influence, if not coerce in fact, a woman of Mrs. Hayer's age to contemplate pregnancy.

Advances in assisted human reproductive treatments such as in vitro fertilization (IVF) and fertility drugs have enabled women to have children late in their reproductive cycles, well beyond the years at which their reproductive systems are at their healthiest. However at what cost? After all, there are serious, attendant health risks. Not only are there elevated health risks to the babies of women of an advanced age; there is the high probability of premature birth, for one thing. There is also an elevated risk of giving birth to a child with Down syndrome or other serious genetic conditions; a link that was established long before the advances in genetic knowledge that have come to mark health science in the late 20th and early 21st centuries. However, women themselves have greater risks associated with pregnancy at a late menopausal phase, let alone after menopause. In Mrs. Hayer's case, her babies were delivered by way of an emergency c-section seven weeks before the due date. The placenta had attached itself to the bottom of Mrs. Hayer's uterus and covered part of her cervix, a condition which can cause severe

hemorrhaging. After she began hemorrhaging, an emergency c-section was performed to deliver the babies and the blood loss was so severe, that doctors had to remove the uterus. Mrs. Hayer had to spend several days in an intensive care unit following the delivery.

Unfortunately, physicians and clinics in Canada that offer assisted human reproductive services, including fertility treatments, work in a field where regulatory oversight is lacking. To the credit of these service providers, they at least draw the line at extending IVF treatments to women of Mrs. Hayer's age, with 45-50 being the age range beyond which women cannot obtain fertility treatments, on Canadian soil anyway. However, there are a number of countries, India included, where the only restriction on obtaining assisted reproductive services such as IVF is the ability to pay for them. Consequently, women who want to become pregnant but who are unable to get IVF or fertility drugs in Canada because of risk factors such as advanced age or other health issues, have been travelling to offshore locations - a practice that has been dubbed "reproductive tourism."

It is a given that stories like Mrs. Hayer's will occasionally surface to capture public imagination and prompt passionate, if not always informed, debates on blogs, on-line chat rooms, call-in shows and newspaper op-ed pages. However there are other pressing issues in the field of assisted human reproductive practices in the Canadian context. For one thing, there is no registry of sperm and egg donors. Secondly, physicians and clinics essentially are free to determine their own guidelines regarding whether information about donors should be released to the adult children of donor-assisted conceptions. Although many ova donors do agree to be known, the vast majority of sperm donors do not. Consequently, for the thousands of Canadians conceived from sperm donations, there is no way for them to know their full genetic history, i.e. they have no way of knowing whether they carry genes for future debilitating conditions such as Huntington's disease or cystic fibrosis. Nor do they have any way of knowing who their genetic siblings are. With some sperm donors making dozens or even hundreds of donations, the number of offspring emanating from a single donor can therefore number into the dozens or even hundreds of people.

To date, the practice of physicians and clinics offering assisted human reproductive services has been to assert a duty to maintain confidentiality over all donor information, not just personal identifying information but to the medical and social histories of the donors as well. This is surely an egregious misapplication of the ethical duty of patient confidentiality because, in accordance with canons of medical ethics and the common law itself, a duty of confidentiality is supposed to apply to patient records. This begs the question: in the case of a woman seeking to become pregnant through donated sperm or an egg, who is the patient? It is surely her, not "Sperm Donor Y" or "Egg Donor X." Furthermore, should not a prospective mother need to be fully informed of all health risks, including whether the donor of sperm or an egg has a history of a genetic condition in his or her genetic line? After all, a genetic predisposition to life-limiting conditions - such as cystic fibrosis, sickle cell anemia, Huntington's disease, or Tay-Sachs disease - is empirical reality, lurking in the genes on a chain of DNA in each cell of a carrier's body.

Then there is the issue of whether the children who have been conceived pursuant to sperm or egg donations should have a right themselves to access at least the genetic/medical history of their anonymous biological parents. Irrespective of how family these days may be a social construct, the immutable law of genetics is that we inherit half our genes from a biological father and half our genes from a biological mother. For physicians and fertility clinics to maintain secrecy over all donor information would appear to violate the equality rights of the thousands of Canadians conceived through assisted human reproduction. Although there is secrecy regarding the identities of biological parents in instances of adoption, adopted children may, in accordance with relevant provincial legislation governing adoptions (in Alberta, it is the *Child, Youth and Family Enhancement Act*, c. 12, RSA 2000) obtain access to their records when the health, safety or well-being of such children is at stake. To deny access in cases of donor-conceived children represents, it may be argued, discrimination by mode of conception and thus may very well constitute an analogous form of discrimination that offends the equality provision, section 15, of the *Canadian Charter of Rights and Freedoms*.

Sadly enough for the equality interests of women and donor-conceived children, law reform to address these matters was slow in coming. There were 15 years of lobbying by donor-conceived children and various women's groups who recognized the issues of equality and personal security that were at stake. There was considerable debate in Parliamentary committees at the House and Senate levels, a major study done by a parliamentary commission, and two bills that died on the Order Paper when governments fell at elections. Finally, Bill C-6, *An Act Respecting Assisted Human Reproduction and Related Research*, c. 2, S.C. 2004 ("AHR Act") was passed into law in 2004. Among other initiatives, the Act established a national registry of sperm and egg donor records under the management of a Health Canada agency. However, the federal government was dilatory in enacting the necessary regulations to get the registry established so the necessary reforms as promised by legislation merely had a paper existence.

Now, unfortunately, even that paper existence is in doubt because of a constitutional challenge. On June 19, 2008, in a reference by the Government of Quebec pursuant to the *Court of Appeal Reference Act*, R.S.Q., c. R-23, the Quebec Court of Appeal struck down sections 8-19, 40-53, 60, 61 and 68 of the *AHR Act*, including the provision applying to the creation of a registry of records, as *ultra vires* of federal jurisdiction because they were deemed to trench upon areas of exclusive provincial jurisdiction in health care. The Supreme Court of Canada will be hearing an appeal of this decision on April 24, 2009. The resulting decision will be of profound importance to physicians and clinics offering assisted human reproductive services, thousands of donor-conceived children, parents of such children, and women interested in assisted reproductive therapies alike. Clarity and legislative direction is sorely required in order to address the equality rights of women and children, and give direction to Canada's medical community.