

**THE POLITICS OF “CHOICE”:**

**Canadian Feminism and the Royal Commission on New Reproductive Technologies**

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## **Abstract**

### **THE POLITICS OF “CHOICE”: Canadian Feminism and the Royal Commission on New Reproductive Technologies**

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The Royal Commission on New Reproductive Technologies developed rapidly in Canada after the birth of world's first “test tube baby,” Louise Brown, in 1978. Canadian feminists, propelled by the women's health movement, perceived these technologies as a threat to women's control over their bodies, the gains made to redefine the identity “woman” against the biological tradition of “mother,” and against the safety and freedom of women based on race, disability and class. In response to the lobby efforts of the women's movement under the Canadian Coalition for a Royal Commission on New Reproductive Technologies, the Mulroney government established a commission in 1989 to study the medical, legal, and social implications these technologies would have on Canadian society.

Through a qualitative analysis of manuscript and printed sources, this thesis explores the debate surrounding new reproductive technologies (NRTs) before and after the mandate of the Royal Commission (1989 to 1993). It discusses the views and positions of some of the key stakeholders such as the National Action Committee on the Status of Women, the Canadian Medical Association, the DisAbled Women's Network, as well as adds the voice of infertile women through the Infertility Awareness Association of Canada.

This thesis also examines the controversy and discontent created by the Commission's dismissal of several members, by the management's style of its Chair, and by the final report's narrow scope. In the end, the reaction to the report was one of considerable disappointment amongst all major stakeholders, starting with NAC, which claimed that its voice had not been heard. At the same time, the debate over NRTs illustrates NAC's ongoing internal problems as it faced the challenge of “identity politics.”

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## Introduction

A major chapter in the history of the Canadian women's movement was its involvement with the Canadian Royal Commission on New Reproductive Technologies, which took place from 1989 to 1993. The movement's involvement was focused on the debates that arose over the issues of advances in reproductive medicine. A *new reproductive technology* (NRT) was the term used to describe any medical procedure that enhanced the process of conception and gestation. Technologies classified as NRTs ranged from commonplace procedures, such as the widely used ultrasound, to more invasive and risky procedures, such as in vitro fertilization (IVF) and genetic therapy. The rapid development of NRTs in Canada in the 80s and early 90s was a source of concern for various social groups, especially the women's movement, which called for a public debate over the safety, legality, and ethics of using NRTs, as well as the implications that these new technologies would have for Canadian women.

In 1978, following the birth of Louise Brown in Great Britain, the world's first successful IVF birth, Canada began the development of its own fertility industry. While NRTs became a source of hope for the involuntarily childless, the absence of government regulation over the still experimental technologies was a source of concern for the Canadian women's movement and, more specifically, its umbrella organization the National Action Committee on the Status of Women (NAC).

NAC's concerns, propelled by the historic subjection of women's bodies to control by the state and scientific ambition, encompassed a wide array of social, economic, and political issues. Among these issues were the exploitation of women

based on race, (dis)ability, and class, as well as the potential loss of autonomy over women's health and their bodies; rights that had been gained through the efforts of the women's health movement. Feminist activists feared that scientists and doctors, as the perceived traditional enforcers of women's reproductive roles, would increase their control over women's reproductive health unless the federal government took steps to set national standards over NRTs and impose restrictions on certain practices.<sup>1</sup>

Propelled by the women's health movement, a fragmented and still largely understudied component of the larger Canadian women's movement, NAC joined other concerned groups to form the Canadian Coalition for a Royal Commission on New Reproductive Technologies (hereafter referred to as the Royal Commission). This Coalition was concerned that previous studies by the UK and Australian governments, as well as a study by the Ontario Law Reform Commission, had not taken a feminist approach to understanding these new technologies and had failed to examine adequately the possible implications that NRTs would have on women's reproductive lives and freedoms. As a result, the Coalition lobbied for a Canadian study to address properly these important feminist issues. The Coalition was successful in its lobbying, and Brian Mulroney's Progressive Conservative government agreed to devote the resources of a royal commission to the study of the medical, social, legal and economic impact of the developing NRTs on women's bodies, and the health and well-being of their children. Thus in 1989, the Canadian Royal Commission on New Reproductive Technologies was established.

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<sup>1</sup>Ann Pappert, "Can Feminism Survive Test-Tube Revolution?" in *the Reproductive Revolution: Special Report by Ann Pappert*, (1989), Canadian Women's Movement Archives (CWMA), NAC file: 'New Reproductive Technologies 1990-1992,' box 731.

The women's health movement's primary goal was the emancipation of women's bodies, especially in relation to a woman's reproductive choices, from the "medicalization" of the body—the medical and scientific control of women's bodies. The movement expected that the Royal Commission would conduct research supporting the need for safeguards that would protect the rights of women to control their reproductive destinies. Women's health activists believed that unless regulations were established from a woman-centred approach, gains already made by the women's health movement would be jeopardized.

Interestingly, the same rhetoric used by the Canadian women's movement to gain control over women's bodies through access to birth control and abortion, was being used to defend NRTs. "Freedom of choice" was invoked by women who were infertile during their campaign as an argument for access to NRTs. This new "rhetoric of choice" would lead these infertile women and their supporters to challenge seriously NAC's position on NRTs.

As the main voice of the Canadian women's movement, NAC was facing difficulties in the late 1980s. During the debates over the adoption of the Canadian Charter of Rights and Freedoms in the early 80s, NAC had resorted to legal approaches which were successful in getting gender equality entrenched into the Constitution. But NAC's relationship with the federal government had greatly deteriorated by the time it began to push for a royal commission on NRTs. This deterioration occurred because the

Canadian state was run by a conservative party, while NAC's leadership was politically far more radical.<sup>2</sup>

The clash between the federal government and the women's movement was most clearly illustrated in the former's funding practices. Funding to women's groups was difficult to obtain or was denied because these groups were critical of the federal government's economic and social policies. Groups such as NAC, the Canadian Advisory Council on the Status of Women (CACSW), provincial advisory councils, and legal watchdogs like the National Association of Women and the Law (NAWL)<sup>3</sup> felt free to critique the government's policies, while receiving a significant portion of their funding from the very institution they sought to change.<sup>4</sup> Some groups began to realize that they were spending more time and effort applying for federal grants than they were on actually working towards their goals.<sup>5</sup> The government was in the position to undermine these pivotal bastions of the Canadian women's movement by withdrawing their funding, thus forcing some to downsize and others to dissolve.

In 1984, the Mulroney government attempted to silence the outspoken women's movement by cutting funding to special interest groups, especially women's groups such as NAC. The Mulroney government's neo-liberal agenda to decentralize federal fiscal

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<sup>2</sup> This was reflected by its choice of presidents: Lynn Kay (1988-90) a socialist; Judy Rebick (1990-1993) a Marxist and minority rights activist Sunera Thobani (1993-1996). Sunera Thobani, *Sunera Thobani: Anti-Racism and the Women's Movement*, [http://auto\\_sol.tao.ca/node/3013](http://auto_sol.tao.ca/node/3013). Accessed September 15, 2010.

<sup>3</sup> Nancy Adamson, Linda Briskin, and Margaret McPhail, *Feminist Organizing for Change: The Contemporary Women's Movement in Canada*, (Don Mills: Oxford University Press, 1988), 62.

<sup>4</sup> Marjorie Griffin Cohen, "The Canadian Women's Movement Documents," in *Canadian Women's Issues Volume 1: Strong Voices*, eds. Ruth Roach Pierson, Marjorie Griffin Cohen, Paula Bourne, and Philinda Masters (Toronto: James Lorimer & Company, 1993), 22.

<sup>5</sup> Cohen, 22.

responsibility included funding cuts to special interest groups,<sup>6</sup> especially those that opposed its pro-family, pro-business policies. By classifying NAC and other women's groups as special interest groups and identifying them as costly, the government was able to cut their funding. These funding cuts in 1984 gradually reduced the operations of NAC,<sup>7</sup> and were seen by the women's movement as the federal government's attempt to dismantle and silence the most powerful women's lobbying group in the country.<sup>8</sup>

Further illustrating the deteriorating relationship between NAC and the federal government was the Conservative Government's refusal to meet with NAC during their annual lobby sessions from 1987 to 1991. When confronted on this issue in the House of Commons by Liberal Senator Lorna Marsden, a former NAC president, Conservative Senator Lowell Murray stated that NAC had been "hijacked by extremists" and that meeting with them was "a waste of time."<sup>9</sup> Marsden then reported to the House of Commons that she had heard a Conservative member of the House of Commons tell reporters that the Progressive Conservatives would not meet with women's groups unless they were "grateful" for what the government had done for them.<sup>10</sup>

Despite this unfavourable context, NAC was eager to work with the government in establishing a royal commission that would educate the public on the nature and the

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<sup>6</sup> Neo-liberalism espouses free trade, the decentralization of decision making and markets, and focuses on private enterprise rather than public and social programs. Alexandra Z. Dobrowolsky, *The Politics of Pragmatism*, (Don Mills: Oxford University Press, 2000), 16-17.

<sup>7</sup> NAC was forced to meet fewer times per year, downsize staff, and find free office space. Even the president's honorarium was cut to only \$2000 per year, despite the fact that the position was a full-time commitment. Doris Anderson, "Why NAC is bound to survive," *Toronto Star*, (Jan 17, 1991), CWMA NAC fonds, Box 651, file 8.

<sup>8</sup> Lynn Kaye, "President's Report," *Annual Report NAC 1989-90*, CWMA, NAC fonds, box 649, file 11. Lynn Kaye said in her president's report (1989-90 Annual Report) that the federal government was "...attempt[ing] to silence the women's movement through funding cuts."

<sup>9</sup> Debates of the Senate Official Report, 2<sup>nd</sup> session, 34<sup>th</sup> Parliament, 33, no. 4 (May 15, 1990): 1625. CWMA NAC fonds, box 650, file 3. She responded with, "I would not hold my breath."

<sup>10</sup> *Ibid.* 1625.

potential outcomes of NRTs. This thesis will thus examine Canadian feminists' involvement in the debates surrounding NRTs, from the Royal Commission's establishment in 1989 until the release of its final report, *Proceed with Care*, in 1993. It will examine NAC's interaction with the Canadian state and with the commissioners, and compare the views of NAC with other key players in the debates, such as the Canadian Medical Association (CMA), the DisAbled Women's Network (DAWN), and the Infertility Awareness Association of Canada (IAAC).

This thesis will show how the rhetoric of choice was appropriated by NRT supporters, such as the IAAC, NAC, and women who formerly identified as part of the Canadian women's movement. The issue of infertility, or involuntary childlessness, is rarely discussed in the feminist literature devoted to this Royal Commission. It does, however, shed light on the tensions within NAC at this period. Infertile women were a marginalized group that withdrew representation in NAC in the early 1990s. Many of these women felt betrayed by the women's movement, and chose to leave NAC, fearing that their access to NRTs might be restricted if NAC's views prevailed.

### ***Historiography***

This thesis is informed by feminist scholarship devoted to the medicalization of motherhood and to the regulation of women's reproductive functions.<sup>11</sup> I have not included a discussion of the evolution of NRTs, however, but have focused on the

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<sup>11</sup> Cynthia Comacchio, *Nations are Built of Babies*, (Quebec City: McGill-Queen's University Press, 1993); Denyse Baillargeon, *Babies for the Nation: The Medicalization of Motherhood in Quebec, 1910 – 1970*, (Waterloo: Wilfred Laurier University Press, 2009); Wendy Mitchinson, *Giving Birth in Canada*, (Toronto: University of Toronto Press, 2002).

debate surrounding the technology.<sup>12</sup> While the Canadian historiography on NRTs is limited, a strong national and international body of scholarship exists on the history of the medicalization of motherhood and reproduction.

### *The Medicalization of the Body and Motherhood*

According to American sociologist Adele Clarke, the study of reproduction developed later than the studies devoted to the other major organ systems because it was a topic marginalized within the sciences until the beginning of the twenty-first century.<sup>13</sup> Clarke states that it was the eugenic and birth control movements that gave legitimacy to the study of reproductive organs and systems. She also describes how the specialization of medicine led to the medicalization of the body and its processes.<sup>14</sup> New medical interest in reproduction allowed questions of population control and public health to be discussed more thoroughly.

In Canada, it was the state's growing concern over the country's birthrate in the late nineteenth century that legitimized the increased medicalization of women's bodies. The term *medicalization* describes a process through which medical professionals reconstruct a natural process, such as birth and aging, by attaching pathological terms to the condition. The identification of a natural condition as a "disease" subjects it to the specialized knowledge of the medical practitioner. The practitioner then guards his/her jurisdiction over the condition through highly technical and specialized jargon, isolating

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<sup>12</sup> For an example, see Adele Clarke's monograph, *Disciplining Reproduction: Modernity, American life sciences, and "the problems of sex,"* (Berkeley: University of California Press, 1998), for a history of American reproductive technologies.

<sup>13</sup> Adele Clarke, *Disciplining Reproduction: Modernity, American life sciences, and "the problems of sex,"* (Berkeley: University of California Press, 1998), page 30 – 31. accessed online through Trent University Netlibrary at <http://www.netlibrary.com/Reader/>, April 16, 2011.

<sup>14</sup> *Ibid.*, 35.

knowledge of the condition from the patient. The patient feels a separation from his/her body through ignorance of medical knowledge and is thus disempowered.<sup>15</sup> The patient concedes control of her/his body to the medical profession and its practitioners. This control allows the medical profession to subject the body to technological procedures which it deems appropriate and therapeutic. The patient's exclusion from the knowledge necessary to understand the procedures prevents dissent in medical decisions, giving further power over the patient's body to the doctor. The emergence and growth of NRTs in society occurred in the context of the medicalization of reproduction and motherhood.

Since the state's priority was to ensure the production of healthy babies, the surveillance of mothers increased and was routinized. As Harriette Marshall and Anne Woollett argue, "medical discourses construct pregnancy as potentially risky or as pathology."<sup>16</sup> The linking of pregnancy to illness resulted in mothers making regular visits to the doctor, and improved hygiene. With advances in reproductive technologies, procedures which had been previously reserved for exceptional circumstances such as the ultrasound, became the norm in the prenatal care and delivery of infants by the 1970s.

Canadian historian Cynthia Comacchio uses a Marxist approach in her analysis of the state-enforced medicalization of motherhood and the weight medical advice carried in post-WWI Canada. She argues that the medicalization of motherhood points to the Canadian state's need to modernize and (re)produce its labour pool.<sup>17</sup> The state supported medically designed promotional material to educate mothers on pre- and post-

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<sup>15</sup> Nikolas Rose, "Beyond Medicalization." *The Lancet*, 369, (February, 2007), 701.

<sup>16</sup> Harriette Marshall and Anne Woollett, "Fit to Reproduce? The Regulative Role of Pregnancy Texts," *Feminism & Psychology*, 10, no. 3 (2000): 351.

<sup>17</sup> Cynthia Comacchio, *Nations are Built of Babies*, (Quebec city: McGill-Queen's University Press, 1993), 4-5.

natal care. This medical education of mothers, and their acceptance of the responsibility for their prenatal health, is a development which Comacchio calls *scientific motherhood*.<sup>18</sup>

Corroborating this interpretation is the work of Quebec historian Denyse Baillargeon, in her book *Babies for the Nation*. Baillargeon asserts that the growing concern for the labour force in post-war Canada, especially in Quebec, was the driving force behind the establishment of free children's welfare clinics. Like Comacchio, Baillargeon argues that the fight against mothers' ignorance of the medical problems associated with childbirth was the state's main strategy, while simultaneously ignoring the impact of race and class on child mortality.<sup>19</sup>

She found the state's effort to increase a doctor's involvement in the birthing process to be successful. Before 1960, when fertility was able to be controlled through the birth control pill, women were inconsistent in seeking the advice of a physician during pregnancy. A number of reasons contributed to this inconsistency in seeking medical advice during pregnancy: lack of money to pay the doctor, apathy, disappointment at being pregnant again after already having children, or feeling a visit to the doctor was unnecessary.<sup>20</sup> Between 1960 and 1970, however, Baillargeon found that more than 99% of Quebec women visited the doctor regularly during pregnancy and delivered in hospitals, partially because of the impact of the pill.<sup>21</sup>

Canadian historian Wendy Mitchinson, however, rejects the portrayal of women as victims of medicalized motherhood. Instead, she argues that women themselves opted

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<sup>18</sup> Ibid., 4.

<sup>19</sup> Denyse Baillargeon, *Babies for the Nation: The Medicalization of Motherhood in Quebec, 1910-1970*, (Waterloo: Wilfred Laurier University Press, 2009), 75.

<sup>20</sup> Ibid., 195-196.

<sup>21</sup> Ibid., 191.

for increased medical involvement in their reproductive lives between 1900 and 1950.<sup>22</sup> Despite the authority held by the medical profession, women still decided when and how often they would see a doctor, and they could choose to follow his advice or not.<sup>23</sup>

### Feminism and NRTs

The social context of NRTs is shaped by the biological and social meanings attached to motherhood. In her classic book, *The Dialectic of Sex* radical feminist Shulamith Firestone argues that “motherhood” is the symbolic shackle that relegates women to inferiority. Biology, she argues, is used as a rationalization for women’s oppressed status and solidifies the gendered division of labour, especially reproduction, as a main feature of capitalism.<sup>24</sup> By producing children outside the womb, the difference in both sex and gender would be eliminated. Firestone believes that by removing the responsibility of childbirth from women, they would be relieved of the lower social caste of “mother” and would be truly equal to men.

Along with Firestone and other early feminist theorists who recognized NRTs’ liberating potential, Canadian feminist scholar Pamela Courtenay Hall also defines motherhood as a westernized myth developed to confine women to their constructed “natural” role.<sup>25</sup> This myth of motherhood, however, is problematic as the meaning of *mother* differs according to race, culture, religion, and time period.<sup>26</sup> If the imbalance

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<sup>22</sup> Wendy Mitchinson, *Giving Birth in Canada*, (Toronto: University of Toronto Press, 2002), 6.

<sup>23</sup> *Ibid.*, 7.

<sup>24</sup> Shulamith Firestone, *The Dialectic of Sex: The Case for Feminist Revolution*, (New York: Morrow, 1970).

<sup>25</sup> Pamela Courtenay Hall, “Mothering in the Late Twentieth Century: Science, Gender Lore, and Celebratory Narrative,” in *Canadian Woman Studies: an Introductory Reader*, eds. Andrea Medovarski and Brenda Cranney (Toronto: Inanna Publications and Education Inc., 1999), 337.

<sup>26</sup> *Ibid.*, 339.

of power between women and men is the result of biological difference, then taking away this difference—removing the function of childbirth from women’s bodies—is the only way to achieve true equality.

Many feminists, however, do not embrace NRTs as instruments of liberation.<sup>27</sup> Counter to Firestone’s argument are the works of the international feminist network on NRTS called FINNRAGE (Feminist International Network of Resistance to Reproductive and Genetic Engineering). This network consists of NRT critics Gena Corea, Janice Raymond, Renate Klein, Robyn Rowland, Patricia Spallone, Deborah Steinberg, and others, representing thirty countries from all continents.<sup>28</sup> FINNRAGE organized international conferences on the development, use, and regulation of NRTs in 1985 and 1986, and produced essays exposing the reproductive industry as a patriarchal bid for control over reproduction, and as a result, lowering women’s social status even further.

In her 1985 book *The Mother Machine*, journalist Gena Corea exposed the reproduction industry to which women were subject; it had originally been designed for the production of cattle and was being transposed into human delivery rooms. Her investigation depicted a perverse attitude, shared by both male farmers and physicians, of cheating nature and creating life. She conjures fear through her comparison of

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<sup>27</sup> Anne Donchin, “Feminist critiques of new fertility technologies: Implications for social policy,” *Journal of Medicine & Philosophy*, 21, no. 5 (1996): 475 ; Christine Overall, “L’ éthique de la reproduction: Les approches féministes et non féministes,” *Canadian Journal of Women & the Law*, 9, no. 1 (1997): 138-47;

<sup>28</sup> Corea et al. “The Struggle Over New Reproductive Technology,” *FINNRAGE*, [http://www.finrrage.org/pdf\\_files/History%20of%20Finrrage/FINRRAGE.pdf](http://www.finrrage.org/pdf_files/History%20of%20Finrrage/FINRRAGE.pdf) accessed Sept 17, 2010.

pregnant mother to heifers, reducing women to the social status of a breeder under the cloak of medical treatment and therapy.<sup>29</sup>

FINNRAGE's analysis also paints a portrait of the commercialization and commodification of women and children through the trade of reproductive material and services. Canadian philosopher Christine Overall concurs as she applies two economic models to FINNRAGE's interpretation of surrogate motherhood. The first is a free market model, where "...[reproductive] services that uncoerced women may offer for purchase by childless but fertile men and their infertile wives."<sup>30</sup> The second model is the prostitution model, where surrogate mothers are subjected to a deliberate exploitation in a way that mirrors sexual prostitution.<sup>31</sup>

Finally, the concept of "choice" becomes problematic when used to justify the development of NRTs. The argument that a woman had the right to choose her reproductive destiny was used to secure the legal right to abortion, and the social right to not have children. With the development of NRTs, the rhetoric of choice was reversed to include the right to have children through the use of technologies. This reversal implied that "choice" could be exercised in any situation involving human reproduction: the choice to abort fetuses known to be disabled or have "undesirable traits," implying racial features; the choice to force sterilization on women of colour or with disabilities; or the choice to hire surrogate mothers if a woman did not desire to experience pregnancy herself.

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<sup>29</sup> Gena Corea, *The Mother Machine*, (New York: Harper & Row, 1985).

<sup>30</sup> Christine Overall, *Ethics and Human Reproduction: A Feminist Analysis*, (Winchester, MA: Allen & Unwin, Inc, 1987), 113.

<sup>31</sup> *Ibid.*, 116, 117.

The choice of which fetuses to keep, who would carry fetuses, and how to get pregnant, were consequential discussions surrounding the promotion of NRTs as a means to give women the right to choose. This rhetorical position had the dangerous potential of giving one woman's right to choose priority over other women's right to reproductive freedom through exploitation based on race, class, and ability. This exploitation could lead to the marginalization or eradication of "undesirables," again based on class, race, and ability.<sup>32</sup>

The legal implications of practices such as artificial insemination and in vitro fertilization were only beginning to be examined in the late 80s. In 1986, Somer Brodribb argued that a perceived threat to fatherhood, and thus a threat to patriarchy, was behind the government's push for regulation of NRTs at that time. The courts, she predicted, would be presented with cases of ownership and custody of reproductive material and progeny, which could affect a father's right to progeny, but could also affect the legal rights of gay and lesbian parents who use NRTs, undermining this group's struggle for the legal recognition of same-sex parented families.<sup>33</sup> Furthermore, legal scholar Catherine Tolton feared that awarding rights to the fetus would logically follow the government's decision to regulate NRTs: "To what extent will our society respect the right of a woman to make fundamental decisions, and who has the right to determine the values that govern those decisions?"<sup>34</sup> For many feminists, the possibility

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<sup>32</sup> Immigrant Women of Saskatchewan. Brief presented to the Royal Commission on New Reproductive Technologies by Nayyar Javed, Anne Marie Dilella, and Bonnie Loewen. Saskatoon: Presented October 25, 1990. National Library and Archives of Canada, accession no. RG33-154, file no. PH-2-SAS

<sup>33</sup> Somer Brodribb, "Off the Pedestal and Onto the Block? Motherhood, Reproductive Technologies, and the Canadian State," *Canadian Journal of Women and the Law*, 1, no. 2 (1986).

<sup>34</sup> Catharine Tolton, "Fetal Rights: Ruling that a Fetus is a Person Raises a Host of Issues," *The Globe and Mail*, (4 Aug. 1989).

of granting rights to the fetus threatened the future of women's rights over their bodies, including the right to abortion.

### ***Identity Politics***

Critiques of NRTs take a different shape if we consider the intersectionality of race, class, sexual identity, and ability.<sup>35</sup> In the early stages, the women's health movement, in both the United States and Canada, articulated universalizing views on women's experiences. Starting in the late 1980s, women of colour and women from diverse religions, cultures, and abilities began to question the dominant voices of the liberal, middle class, white feminists within the Canadian women's movement and began to express their own views on NRTs. They feared that these technologies would generate further exploitation of vulnerable women by women of a higher socio-economic status, while they would be excluded from these practices due to their high cost. At the same time, the negative impact of NRTs had not been fully studied. For example, children 'designed' through genetic technology would intensify the devaluation of people and groups deemed 'undesirable,' such as racial minorities and the disabled.<sup>36</sup>

### ***Methodology***

This thesis consists of a qualitative analysis based on the consultation of manuscript and printed sources, primarily the submissions made during public hearings

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<sup>35</sup> Vanaja Dhruvarajart, "Feminism, Reproduction, and Reproductive Technologies," in *Gender, Race, and Nation: A Global Perspective*, (Toronto: University of Toronto Press, 2002).

<sup>36</sup> John A. Robertson, *Children of Choice: Freedom and the New Reproductive Technologies*, (New Jersey: Princeton University Press, 1994), 156, 163-164.

from 1991 to 1992 to the Royal Commission, as well as the final report, *Proceed with Care*, which was released in November 1993. This thesis will not include interviews due to the constraints and the methodological challenges linked to the conduct of interviews.

While Mitchinson suggests that medicine is the result of a social agenda, science and technology scholar Steven Epstein similarly states that by seeking out the motives of patient groups and social health movements, one can better understand the development of a technology in its social context as a response to a social problem.<sup>37</sup> To do so, I identified patient groups based on a collective medical condition or experience.<sup>38</sup> One of these groups, the involuntarily childless, had formed a network of infertility support groups. I chose the Infertility Awareness Association of Canada (IAAC) as the voice of this patient group because they had a national network which was held together through a national newsletter and yearly conferences. These people shared the experience of being confirmed sterile, miscarrying, not having success at conceiving, or not being able to conceive after one successful birth (a condition called secondary childlessness).

The second identified patient group shared the experience of having a disability. I chose the DisAbled Women's Network as the voice of disabled patients because they approached the subject from a woman-centred point of view. DAWN Canada published a national newsletter, *Thriving*, and participated in the public hearings as did their provincial chapters. They were also vocal in the debates within NAC, which proved insightful when considering the dynamics within the women's movement.

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<sup>37</sup> Steven Epstein, "Patient Groups and Health Movements," chapter 21 in *The Handbook of Science and Technology Studies*, 3<sup>rd</sup> edition. Edward Hackett et al., eds. (Massachusetts: MIT Press, 2008), 503.

<sup>38</sup> *Ibid.*, 511

NAC presented their research to the Royal Commission and networked with provincial associations and smaller women's groups across the country. They spearheaded a massive campaign to present the same research at every public hearing to enforce the importance of the women's movement's concerns. I focused primarily on their presentations, letters, communiqués, resolutions, and national publications as being the main position of the women's movement. I also consulted NAC affiliated magazines such as *Herizons*, to reinforce NAC's official communiqués and press releases on NRTs.

I also considered the Women Healthsharing Collective, a small but determined group of women who published a nationally circulated women's health journal called *Healthsharing*, another important effort to inform the public on women's health issues and NRTs. This group had lobbied, through NAC, to establish a Canadian women's health network. I therefore chose this group's journal as the official voice of the women's health movement. Though operating independently from NAC, this journal's membership closely followed the debate and reported the position of the women's health movement on NRTs with diligent regularity. I put as much weight on the writing and opinions shared in this journal as I did on official NAC views because their membership overlapped, and because *Healthsharing* supplemented the much less detailed material found in the files of NAC's special committees on health and NRTs.

The methodological goal in collecting these articles and letters was to describe women's accounts of their lived experiences with their reproductive health and/or infertility, while explaining the historical context that led to the development, and the push for regulation, of NRTs. The women who contributed to *Healthsharing* and the IAAC newsletter were eloquent in their accounts of childbirth, their fertility treatments, and their feelings of loss for children that would never be born. The Royal

Commission's work, and some of the NRTs developed, would be driven by the experiences of women—white and non-white, abled and disabled, poor and middle-class—with their own health issues.

I performed an exhaustive search through the IAAC newsletter and *Healthsharing* magazine from 1989 to 1994, looking for three types of articles: those relating directly to the Royal Commission, those specifically reporting on NRTs, and those discussing reproductive health issues or problems. In my search, I also included letters to the editor if they addressed or mentioned the Royal Commission; the federal government; NAC's views regarding NRTs; as well as the implications NRTs could have for women, their access, funding, and regulation, and the dissent on either side of the debate. What I found was a poignant fear of NRTs—both of their use and their prohibition—from women who used to find themselves on the same side of the fight for women's reproductive rights. I use these articles and letters as representations of the general consensus of those organizations' membership.

Newspapers are used to gauge the response of political and social groups to the Report, along with various newsletters and publications from national representative organizations such as DAWN, the IAAC, and the CMA.<sup>39</sup>

Archival material was collected at the Library and Archives Canada and the Canadian Women's Movement Archives at the University of Ottawa. The fond of the Royal Commission on New Reproductive Technology, RG33-154, contains transcripts and submissions, as well as some correspondence, from all special interest groups,

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<sup>39</sup> This thesis focuses on national organizations only. It should be noted that many regional, provincial and professional women's associations, such as provincial and territorial committees on the status of women and nurses associations, presented important feminist research on NRTs to the Royal Commission but are not included in this analysis.

individuals and research firms that made submissions to the Commission. It also contains the minutes from the Commissioners' meetings, as well as information kits that were produced for the Commission. Of further value were the newsletters from the Infertility Awareness Association of Canada which are found at this same location.

This fond does not help unravel the internal conflicts that occurred within the Commission, as tapes from meetings have been destroyed, and there are no written transcripts. For further study on this topic, information on the internal relations of the Royal Commission and supporting documents can be found at the Federal Court by requesting Statement of Claim T-3035-91. The Statement of Claim contains correspondence between the Commissioners, the Secretary General of the Privy Council, and lawyers that were hired to deal with the internal conflict and divisions of power.

The Canadian Women's Movement Archives contain the NAC fonds as well as files regarding the establishment of the Canadian Women's Health Network. The archives also house some of the feminist and women's health periodicals that are no longer in print, such as *Kinesis* and *Healthsharing*, in addition to a few newsletters from DAWN Canada.

Finally, I performed an exhaustive search through the *Canadian Medical Association Journal* (CMAJ) from 1989 to 1993, and then selected articles from 1994 to 2004. I used the same research strategy as I did in searching the other magazines by identifying articles that dealt specifically with the Royal Commission, NRTs, and women's reproductive health. Since the Canadian Medical Association (CMA) is Canada's largest and most influential professional association of physicians, I consider the CMAJ as the representative voice of Canadian doctors.

***Organization***

This thesis is divided into five chapters. Chapter one focuses on the medicalization of the body, childbirth, and the perceived problem of infertility in Canadian society. Chapter two outlines the views of the women's health movement and of NAC on NRTs, while chapter three focuses on those of the Canadian medical profession as outlined in the CMAJ. Chapter four highlights some of the key arguments made by feminist groups, infertile women, other women's groups, and the medical profession, in their submissions to the Royal Commission. Finally, chapter five discusses the Commission's final report and its reception by the main stakeholders discussed in this thesis.

## Chapter 1

### *Medicalizing Childbirth and Childlessness*

Nicknamed *Superbabe* by the media, Louise Brown, born in the UK on July 25, 1978, was the first child successfully conceived in a petri dish. Several years later, on December 25, 1983, Robert John Saunders Reid became Canada's first test tube baby. The birth of these children held antonymous meanings for Canadians. On one hand, this technology was an attractive option for those who could not have children. On the other hand, it raised the spectre of reproductive commerce and a reduction in the role of a woman's body to that of a breeder.

NRTs promised a "cure" for the problem of infertility after the births of Brown and Reid, but they also created new ethical, legal, social, and economic problems in a global economy. For instance, the technology responsible for "test tube babies," in vitro fertilization (IVF), was a new and experimental procedure which gave hope to infertile couples that they would one day sire, conceive and gestate to term a genetic baby of their own. IVF, however, was also problematic because it had an extremely low success rate of bringing a fetus to full term. Furthermore, the cost and availability of IVF raised the potential for the globalization of these technologies through reproductive tourism and the exploitation of the poor. This chapter locates IVF, and other NRTs, in their historical context by examining the medicalization of women's bodies and of mothering, as well as the growing public discussions about infertility and the perceived problems of NRTs.

### *The Medicalization of the Body and Motherhood*

Medical knowledge of the human body increased dramatically over the course of the twentieth century, creating a greater concern for public health. The Canadian state's interest in the health of the nation increased after WWI for several reasons. First, the recruitment of soldiers during WWI had revealed the poor health of Canadian males. Second, the spread of venereal disease among soldiers threatened to negatively impact the Canadian birthrate after the war. Third, Canada suffered massive loss of life to the war, tuberculosis, and the Spanish influenza epidemic from 1918 to 1919.<sup>40</sup> Finally, the push to increase the successful birthrate of white middle class babies was also pushed by the eugenics movement.<sup>41</sup> The resulting drive to better understand the body and to improve the health of the general population led to the public health movement and the increased medicalization of the human body.

In the case of women, medicalization of the body constructed natural processes, such as aging, menopause and childbirth, in pathological terms, associating them with illness. As a result, these processes were considered relevant for study among medical professionals who came to understand the body in terms of disease. This attempt to understand the body through a pathological lens, sometimes led to harmful medical and pharmaceutical treatment of non-pathological (natural) processes in the body. For example, the prescription of the drug Thalidomide to alleviate morning sickness during

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<sup>40</sup> Janice Dickin McGinnis, "From Salvarsan to Penicillin: Medical Science and VD Control in Canada," in *Essays in the History of Canadian Medicine*. Wendy Mitchinson and Janice Dickin McGinnis eds. (Toronto: McClelland and Stewart, 1988), 127. See also Janice P. Dickin McGinnis's paper "The Impact of Epidemic Influenza: Canada, 1918-1919," *Historical Papers*, 12, no. 1 (1977), Canadian Historical Association, 120 – 140. As the government was recruiting for WWI, they were appalled at the poor health of their young men. Many were rejected for service because of poor health.

<sup>41</sup> McLaren. *Our Own Master Race*, (McClelland & Stewart Inc.: Toronto, 1990).

childbirth, a natural but unpleasant effect of pregnancy, led to severe birth defects in babies during the 1960s.<sup>42</sup>

Between the two World Wars, medical attention turned to the health and mortality of infants. Despite the improvement of living conditions, due to better sanitation and medical breakthroughs such as the development of bacteriology, infant mortality rates continued to climb.<sup>43</sup> To foster a strong labour force, public health and the prevention of disease were considered vital to the economic stability of the post-war society.<sup>44</sup> It was also believed that the best way to ensure a healthy population was to focus medical intervention on prenatal and infant care. Historian Cynthia Comacchio argues: “The result would be a modern Canada worthy of the most favourable implications of modernity: progress, efficiency, productivity, and the triumph of reason that was signified by advances in science and technology.”<sup>45</sup> The medical profession worked to ensure the survival and care of infants through prenatal care.

The Canadian government identified the mother as the key to the health of the child and, therefore, the nation.<sup>46</sup> The government’s educational material promoted a close contact between mother and physician before and after birth, encouraging women to seek more pre- and postnatal care from doctors. Regular prenatal visits to the doctor meant fewer surprises during delivery by ensuring that preparations were made for every expected complication. There was an increase in hospital births during the inter-war

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<sup>42</sup> Marina Morrow, “‘Our Bodies, Our Selves’ in Context: Reflections on the Women’s Health Movement in Canada,” in *Women’s Health in Canada: Critical Perspectives on Theory and Policy*, Marina Morrow, Olena Hankivsky, Colleen Varcoe eds. (London: University of Toronto Press, 2007), 43.

<sup>43</sup> Katherine Arnup, “Educating mothers: Government Advice for Women in the Inter-War Years,” In *Delivering Motherhood*, eds. Katherine Arnup, Andrée Lévesque, and Ruth Roach Pierson (New York: Routledge, 1990), 190.

<sup>44</sup> Comacchio, 9.

<sup>45</sup> Comacchio, 4.

<sup>46</sup> Earnest Couture, *The Canadian Mother and Child*, (Ottawa: King’s Printer, 1949), 6.

years as women accepted, and sought, a closer proximity to technology in case of complications during delivery.<sup>47</sup>

The medical profession's advocacy of technology and of its role in childbirth was clearly articulated in *The Canadian Mother and Child*, issued by the Canadian government in 1949:

Here, we are face to face with one of those prejudices which must be overcome. A common opinion is that it is unnecessary to see a doctor, and this is based on the fallacy that, in the past, results were equally satisfactory when a doctor had not been consulted for pregnancy nor even for childbirth. Many have ignored the necessity of having recourse to competent medical assistance unless special complications occurred, but experience has definitely proved that this is a gross error, and that better results are obtained where close medical supervision is exercised.

Everybody is quite familiar with the remarkable advances of science in many fields, such as the development of the radio, the growing facilities of transportation, etc. One cannot but be aware of this progress because it plays an important part in our daily life. Medical science displays an equally striking advance, but unfortunately for the public, in many instances, achievements in this field are not sufficiently appreciated.<sup>48</sup>

After WWII, the federal state increased its funding toward biomedical research, thus increasing the status and influence of the medical and science professions.<sup>49</sup> This new status created the need for doctors to protect their authority over the body. As the science and medical professions gained more respect, they also became more specialized, causing a knowledge gap between medical practitioner and patient. As a

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<sup>47</sup> Comacchio, 89.

<sup>48</sup> Couture, 6.

<sup>49</sup> H.E. MacDermot. *One Hundred Years of Medicine in Canada*. (Toronto: McClelland and Stewart Ltd., 1967), 81.

result, patients started to become removed from the decision-making process concerning issues that directly affected their own bodies and health. While this removal of the patient from the decision-making process was not unique to reproduction, women tended to have less power than male patients in negotiating with physicians, especially with respect to their bodies in pregnancy and childbirth.<sup>50</sup>

Comacchio further argues that gender, race, and class shaped medical concern for child welfare and the intrusion of the state in the private sphere. The state's position was that white, middle-class women who did not reproduce contributed to the decline of people of good moral quality.<sup>51</sup> Neglecting to address the health issues associated with race and poverty, the government put the responsibility for the health of infants entirely in mothers' hands.<sup>52</sup> "[F]ar too many mothers mar this period [pregnancy] of their lives by unnecessary mishaps...because they neglect their health...Today, all Canadian mothers, without exception, can obtain the benefit of proper guidance during and after pregnancy, if they are willing to seek it."<sup>53</sup> The mothers, white, middle class Canadian women, were able to afford the cost of physicians' care but neglected to do so. Poor women, immigrant women, and women of colour who were unable to seek proper care during pregnancy were therefore believed to be at fault for the poor health, or death, of their infants because they neglected their own prenatal health.<sup>54</sup> Poor mothers' inability to seek prenatal care decreased their babies' chances of survival while care provided to

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<sup>50</sup> Mitchinson, 7.

<sup>51</sup> Comacchio, 18.

<sup>52</sup> Comacchio, 14 and Arnup, 192.

<sup>53</sup> Couture, 3.

<sup>54</sup> See Angus McLaren and Arlene Tigar McLaren, *The Bedroom and the State: the Changing Practices and Politics of Contraception and Abortion in Canada, 1880-1997*, (Toronto: Oxford University Press, 1997), 148; and Cheryl Krasnick Warsh, *Prescribed Norms: Women and Health in Canada and the United States since 1800*, (Toronto: University of Toronto Press, 2010), 160.

middle class women ensured that the survival of infants born to couples of “good moral quality” increased.

### ***Women’s Control of their Bodies: Birth Control and Abortion***

While technologies were developed to ensure the survival of babies, some women were seeking these same technologies in an attempt to limit and control pregnancy. Until the Canadian Criminal Code was amended to decriminalize access to birth control methods in 1969, women had to rely on clandestine methods of gaining access to contraception, often without knowing if they were effective or safe.<sup>55</sup>

After WWII, several factors led women to strive for more control over their reproductive lives. Large families were an economic strain in an increasingly urban context. Canada developed a consumer culture that required two incomes in order to maintain the quality of life that new consumer technologies provided. As a result, many women chose to remain in the workplace after marriage.<sup>56</sup> This new trend in women’s lives, coupled with the financial burden of large families, further compelled them to monitor their fertility through birth control. In 1968, students from McGill University published *The Birth Control Handbook*, which triggered the creation of the Montreal Health Press.<sup>57</sup> The handbook and other publications such as *Our Bodies, Our Selves* (1972), an informational booklet from the Boston Women’s Health Care Collective, became bestsellers with Canadian women, who were seeking comprehensive

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<sup>55</sup> Andrea Tone, *Devices and Desires*, (Hiss and Wang: New York, 2001), 154-155.

<sup>56</sup> Adamson et al., *Feminists Organizing for Change*, 37. In the 1980s, the percentage of women in the workforce was up to 39%. Also, Alison Prentice et al., *Canadian women: A History*. (Scarborough: Thomson Nelson, 1996), 289, 338.

<sup>57</sup>Morrow, 42. See also Christabelle Sethna “The Evolution of the Birth Control Handbook: From student peer education manual to feminist self-empowerment text, 1968-1975”, *Canadian Bulletin of Medical History/Bulletin canadien d'histoire de la médecine*, 23, no. 1 (2006), 90, 94-95.

information about their health and their bodies.<sup>58</sup> It wasn't until 1969, that sexual behaviour, specifically reproduction, stopped being criminalized.<sup>59</sup>

Abortion was another reality in women's reproductive lives. The 1969 change to section 251 of the Criminal code which decriminalized birth control also made an amendment to the abortion law.<sup>60</sup> Thereafter, abortion in Canada could be performed if the patient could successfully make her case to a Therapeutic Abortion Committee (TAC) comprised of doctors who would decide if an abortion was justified. This law continued the practice of leaving the fate of women's lives in the hands of predominantly white, middle-class medical men, who did not consider the socio-economic background of their patients, or consider what kind of impact a child would have on the parents' lives. Doris Powers, a single mother, thus recalled in 1970:

I was interviewed by two psychiatrists, and one medical doctor...Social or economic factors are not considered – only the mother's physical and mental health. These doctors are hopelessly ignorant of the pressures and strains involved in maintaining a family on an income lower than the poverty level...

When I was refused the abortion, the doctor asked if I would obtain an illegal abortion...He then said, "Well, take your rosary and get the Hell out of here."<sup>61</sup>

Hospitals were not required to set up TACs so many women had no access to safe, legal abortions in their communities. Furthermore, it would take up to a month for a case to be deliberated by a TAC, despite the crucial time line of pregnancy (an abortion is easier

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<sup>58</sup> Morrow, 42; Sethna, 90-91.

<sup>59</sup> Jacquetta Newman and Linda White, *Women, Politics, and Public Policy: The Political Struggles of Canadian Women*. (Toronto: Oxford University Press, 2006), 267.

<sup>60</sup> McLaren and McLaren, 136-137.

<sup>61</sup> Doris Powers, "Statement to Abortion Caravan Rally, Toronto, May 1970," in Pierson et al., 124.

to perform earlier in the pregnancy).<sup>62</sup> TACs did not stop women from seeking illegal abortions, risking their lives and their reproductive future as a result.

Feminists launched a campaign to oppose the new law. On February 14, 1970, the Abortion Caravan set out from Vancouver and marched to Parliament Hill in Ottawa, declaring war on the Canadian Government if the abortion law was not repealed by May 11.<sup>63</sup> These women marched to Parliament Hill with a coffin, symbolizing all the women who had died due to illegal abortions. With slogans such as “This Uterus does not belong to the State,”<sup>64</sup> the protesters reached Parliament and chained themselves to the gallery in the House of Commons. Abortion activist Kathryn Keate wrote, “Chaining ourselves is the symbol of what their lives are, and of what our lives as women are. The only way we can ensure that we get heard is by chaining ourselves to the seats in the public galleries – that’s what democracy is in this shitty society.”<sup>65</sup> This is but one example of how women involved in the health movement, and in the broader women’s movement, came together to oppose state control over their bodies. The Supreme Court deemed the abortion law unconstitutional in 1988.<sup>66</sup>

For Canadian feminists, the abortion debate amply demonstrated the power the state, and the medical profession, had over women’s reproductive freedom. After the Supreme Court’s decision to strike down the abortion law, Section 251 of the Criminal Code, the Mulroney government tried to pass an abortion bill which would send doctors

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<sup>62</sup> Alice Van Wart, “‘Abortion: A Woman’s Right’ Fredericton, New Brunswick, November 1975,” in Pierson et al., 127. (This is a primary document as re-printed by the editors. They footnote the text as having been printed in a publication called *Equal Times* which is available at the CWMA.)

<sup>63</sup> CARAL, “‘Abortion Caravan Demands’ Ottawa, 1970,” In Pierson et al., 125.

<sup>64</sup> Adamson et al., 46.

<sup>65</sup> Kathryn Keate, “‘The Great Chain Debate’ Ottawa, 1970,” in Pierson et al., 126.

<sup>66</sup> Catharine Dunphy, *Morgentaler: A Difficult Hero*, (Toronto: Random House, 1996), 303-307.

to jail for performing abortions on women whose health was not in danger.<sup>67</sup> The government's attempts failed, however, as the bill died in the Senate.<sup>68</sup>

### *Infertile Women*

The rhetoric of choice used by feminists in the abortion campaign took on a different meaning for women who could not get pregnant. Infertility was discussed in the medical literature throughout the twentieth century; physicians sought to find various remedies, based on their conviction that it was the result of an illness.<sup>69</sup> There was a perception by society that infertility was on the rise in the 70s and 80s. This trend, however, could not be corroborated, as there was no reliable data at the time.<sup>70</sup> Infertility awareness support groups were formed in the 70s and 80s to bring the issue of involuntary childlessness into the public arena.

Studies conducted by the Royal Commission on NRTs found that existing surveys on infertility did not adequately consider involuntary childlessness, since they focused instead on birth control trends among Canadians.<sup>71</sup> U.S. data reported that 14%

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<sup>67</sup> Ibid. All of this debate centred on the lengthy Henry Morgentaler case and the Chantal Daigle (1989) and Barbara Dodd (1989) cases where ex-boyfriends tried to legally prevent the women from having abortions.

<sup>68</sup> Robert Campbell and Leslie A. Pal, *The Real World of Canadian Politics: Cases in Process and Policy*, (2<sup>nd</sup> edition), (Ontario: Broadview Press, 1991), 33. It did, however, mean that provincial governments could regulate abortions through Medicare and where they could be performed.

<sup>69</sup> Mitchinson, "Historical Overview of Medical Perceptions of Infertility," 12.

<sup>70</sup> The only indicator of fertility the Canadian historian can use is population growth, which has declined steadily from 1957 on.

<sup>71</sup> T.R. Balakrishnan and Rajulton Fernando, "Infertility Among Canadians: An Analysis of Data from the Canadian Fertility Survey (1984) and the General Social Survey (1990)," in *The Prevalence of Infertility in Canada*, Research Studies of the Royal Commission on New Reproductive Technologies, vol 6. (Ottawa: Minister of Supply and Services, 1993), 107-162. The researchers had to compare the 1984 Canadian Fertility Survey with the General Social Survey (1990) and, since the original survey questions were designed to study something different, the researchers had to interpret the information in a different context. Another difficulty in comparing the surveys was that the definition of infertility is complicated. It can be perceived or inferred and is based on self-assessment. Furthermore, at the time of the Royal Commission, infertility only took into account married, heterosexual couples who had been not using

of married U.S. couples suffered from infertility.<sup>72</sup> Whatever the situation was in Canada, the increased discussion on infertility and its impact created new reproductive challenges for the medical community; conquering infertility by artificial methods, just as science had learned to regulate other bodily organs and systems such as the regulation of kidney failure through dialysis.

Several factors contributed to the perception of increased infertility rates in Canada. First, there was a growing awareness of some of the commonly identified causes of infertility. Causes such as workplace environmental hazards and the link with untreated sexually transmitted infections (STIs) were being discussed in feminist publications on women's health issues.<sup>73</sup> Feminists called for more public education and for more frequent testing of women for Chlamydia and other bacteria which provoked pelvic inflammatory disease (PID), a leading cause of infertility in women.

A second factor that contributed to the perception of increased infertility was the expectation of complete control over reproduction with the widespread use of oral contraceptives.<sup>74</sup> The first cohorts of women on the pill, who grew up with the means to postpone starting families in order to establish themselves professionally, were now facing an unforeseen loss of control over their reproductive lives. The apparent choice to delay reproduction, perhaps until the onset of age-related infertility, could have

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contraception for 12, 24, or 36 months. Finally, many women who took these surveys and who were using birth control may have been infertile but were unaware due to not having ever tried to get pregnant.

<sup>72</sup> Anne Martin Matthews and Ralph Matthews, "Beyond the Mechanics of Infertility: Perspectives on the Social Psychology of Infertility and Involuntary Childlessness," *Family Relations*, 35, no. 4 (October, 1986): 479.

<sup>73</sup> The term has since changed from STDs, sexually transmitted diseases to sexually transmitted infections (STIs) in the early 2000s since some of the illnesses transmitted are not diseases in the traditional sense of the word and can be treated effectively.

<sup>74</sup> Matthews and Matthews, 479.

adverse consequences.<sup>75</sup> Women who did not take the pill appeared to get pregnant faster than women who had taken it and stopped. In Canada, a couple was considered infertile after 12 consecutive months of unsuccessfully being able to achieve pregnancy and give birth.<sup>76</sup> It was therefore possible for a couple to be diagnosed as infertile while waiting for hormone levels to regulate.

According to American sociologist Shirley Scritchfield, the perception of infertility as a problem is the result of a social reconstruction of fertility rather than a biological dysfunction. She argues that the increased use of technology to control the body, more specifically the ability to decide whether or not to have children, when to have them and how to space their births out, gave Americans the impression that fertility could be controlled in the same manner.<sup>77</sup> Women who felt they had control over their body, but who could not get pregnant as planned, were inclined to conclude that they were infertile much sooner than women would have some twenty or thirty years earlier.<sup>78</sup> Scritchfield writes, “Along with the sadness they face as individuals, those who are infertile must also cope with the social consequences of their condition.”<sup>79</sup>

Remnants of traditional cultural attitudes toward marriage persisted. According to Western Christian tradition, there is no point in marrying unless there is intent of

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<sup>75</sup> Shirley A. Scritchfield, “The Social Construction of Infertility: From Private Matter to Social Concern,” in *Images of Issues: Typifying Contemporary Social Problems*, ed. Joel Best (New York: Walter and Gruyer Inc, 1995), 136. See also Matthews and Matthews, 481.

<sup>76</sup> Royal Commission on New Reproductive Technologies, *Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies – Summary & Highlights*, (Ottawa: Ministry of Supply and Services Canada, 1993), 9.

<sup>77</sup> Scritchfield, 135.

<sup>78</sup> Scritchfield, 135 – 136.

<sup>79</sup> Infertility Awareness Association of Canada (IAAC). *Submission to the Royal Commission on New Reproductive Technologies, April 30, 1992*, 1. Library and Archives Canada (LAC), box 7, file PH-9-OT.

having a child.<sup>80</sup> It is, therefore, stigmatizing not to be able to fulfill what is perceived as a societal function linked to one's sense of self and family.<sup>81</sup> An infertile woman also had to deal with a potential moral stain caused by suggestions that a past indiscretion, or the selfishness of putting her career before her family, was the reason for her childlessness.<sup>82</sup> Such attitudes can have severe emotional repercussions on both individuals and their families.<sup>83</sup>

Involuntary childlessness is often coupled with isolation and marginalization, stated the Infertility Awareness Association of Canada in 1990:

The infertile often feel alone and alienated in what appears to be an abundantly fertile society. Diaper commercials, local playgrounds, grocery store baby sections, strollers on the street, and pregnant friends and family members become painful daily reminders of one's infertility. Family events such as Christmas and christenings are often avoided by the infertile, thus increasing their sense of isolation.<sup>84</sup>

In 1985, Canadian sociologist Charlene E. Miall described the "stigma of involuntary childlessness" as the exclusion from a pronatal mainstream, or "in group" of mothers.<sup>85</sup> She reported that childless women were patronized by mainstream society, given advice that implied that their infertility was their own fault, and subjected to jokes about their infertility. Women reported isolation from their families and friends with children. One

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<sup>80</sup> Mitchinson, "Historical Overview," 9.

<sup>81</sup> Trish Maynard and Paulla Timmons, "The Experience of Infertility," 1. Library and Archives Canada (LAC). RG 33-154 Box 7, file PH-9-OT.

<sup>82</sup> Charlene E. Miall, "Community constructs of involuntary childlessness: Sympathy, stigma, and social support." *Canadian Review of Sociology and Anthropology*, 31, no. 4, (1994): 394-95.

<sup>83</sup> IAAC., 2.

<sup>84</sup> Trish Maynard and Paulla Timmons, *The experience of infertility*, included in the Infertility Awareness Association of Canada submission folder. LAC RG33 1993-94/531, box 7, file PH-9-OT, 2-3.

<sup>85</sup> Charlene E. Miall, "Perceptions of informal sanctioning and the stigma of involuntary childlessness," *Deviant Behavior*, 6 (1985). 389-90.

woman even explained how her in-laws tried to pressure her to divorce her husband because they felt he deserved his own child. Even mothers of adopted children were dismissed by biological mothers because they had not physically experienced childbirth.<sup>86</sup>

In Canada, infertile women felt marginalized through their exclusion from the health care system. In a 1978 roundtable discussion on CBC's *Newsmagazine*, one infertile woman named Sabina Erlich claimed that Canadian doctors were indifferent her plight. "The response has been unsympathetic. It's been, 'Go home and stop worrying about it; go back to work then you'll conceive; stop working; your working too hard; adopt and you'll conceive; wait another year...'"<sup>87</sup> In its submission to the Royal Commission on NRTs, the Infertility Awareness Association of Canada argued that fertile Canadians discounted the problems of infertile women and felt that having children was a privilege, not a right. This led to the belief that couples seeking fertility treatments were being selfish, because it was presumed that their real ambition was to have "designer babies."<sup>88</sup> The reality for the infertile was that they were living in a crisis situation. By taking control of their infertility, they ceased to be victims of the crisis.<sup>89</sup>

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<sup>86</sup> Ibid., 390.

<sup>87</sup> Sabina Erlich, interview on "Fighting for in vitro fertilization in Canada," *CBC Newsmagazine*, host Don McNeill. Broadcast date: July 31, 1978.

[http://archives.cbc.ca/health/reproductive\\_issues/clips/3381/](http://archives.cbc.ca/health/reproductive_issues/clips/3381/)

<sup>88</sup> IAAC., 2.

<sup>89</sup> Naomi Pfeffer and Anne Woollett, *The Experience of Infertility*, (London: Virago Press, 1983), 138.

*NRTs and Globalization, Ethics, and a Fertility Industry*

In the context of the abortion debate and the apparent rise in infertility, discussions about NRTs raised a host of ethical, moral, and economic issues. Furthermore, these issues were not isolated within Canadian society but would be consequential to the rest of the world. The impact of these new technologies led to discussions on globalization, discrimination, commercialization, eugenics, safety, and the changing definitions of the family. A global organization of feminists initiated research and critiques of NRTs, assembling and disseminating information and studies to activists around the world in an effort to spark public debate on the various implications of NRTs.

Allied with the abortion debate, the use and development of NRTs was an increasingly problematic issue among doctors, feminists, lawyers, and religious groups. For example, the legal and ethical discussions surrounding the use and treatment of fertilized embryos brought the notion of fetal rights into question. NRTs' potential ability to gestate embryos outside the human body called for the need for a discussion on the ethical treatment of fertilized zygotes. Without guidelines, these "potential babies," either embryos or ova and sperm, could be used for experimental research, may be sold or given to other couples, or may be frozen and kept for later use, even after the death of one or both parents. However, awarding fetal rights to a fertilized embryo in cryogenic stasis, or growing outside a woman's womb, would directly impact the 1988 Supreme Court ruling on abortion because those same rights would apply to the fetus developing

inside the womb. Therefore, awarding a fetus rights would take away a woman's right to control her body.<sup>90</sup>

Of further ethical concern was the property right over reproductive material and potential offspring. The U.S. divorce case *Davis v. Davis* (1989), involved a custody dispute over seven frozen, fertilized embryos produced during an IVF procedure the couple had undergone in 1988.<sup>91</sup> Though not the first court case involving the ethical and legal implications of NRTs, it raised considerable questions about the reproductive rights of the mother, the value of men's role in reproduction, and the definition of the embryo. Was it property or a person?<sup>92</sup>

Feminists examined the global economic threat posed by NRTs, commodifying women and children by constructing them as "property." The commodification of women, children, and reproductive material, and the commercialization of NRTs meant the threat to women of potentially losing the right to control their bodies, as the result of commercial development.<sup>93</sup> The treatment of women as producers, and their children as products, implied a need for commercial control over the body, control over the lifestyle choices and day-to-day activities of women, in order to ensure the best product. It was feared that the potential market created around the purchase of children would coerce poor women, non-white women and those living with disabilities, into allowing their bodies to be used for profit through surrogacy or egg donation, exploiting themselves so white, middle class couples might be able to have children. Feminists highlighted the

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<sup>90</sup> Overall, 69.

<sup>91</sup> Thomas C. Shevory, "Through a Glass, Darkly: Law, Politics, and Frozen Human Embryos," in *Issues in Reproductive Technology: An Anthology*. Eds. Helen Bequaert Holmes (New York: Garland Publishing Inc, 1992), 232, 234-235.

<sup>92</sup> *Ibid.*, 238.

<sup>93</sup> Corea., *The Mother Machine*.

potential for the globalization of an NRT industry to lead to the exploitation of “Third World” women, through buying and selling of eggs and embryos, as well recruiting surrogate mothers from the developing world.

Canadian anthropologist Sari Tudiver highlights the effect a globalized economy has had on women and children.<sup>94</sup> Due to the ever widening gap between rich and poor, and the increase in poverty levels in the developing world, children were being sold into adoption, people sold organs for transplants, and women and children were being kidnapped and killed for their organs and tissues.<sup>95</sup> Women were already being used as surrogate wombs for wealthier women. The development of NRTs in this context would further increase the exploitation of these women and children—embryos could be harvested for organs and tissues, and women could be sold into reproductive slavery—to meet the demands of an ever increasing reproductive market.<sup>96</sup> Furthermore, the development of NRT industries in the developing world could present couples willing to travel with the opportunity of taking advantage of cheaper fertility treatments, or by benefiting from less restrictive services such as sex pre-selection.<sup>97</sup>

In Canada, Sociologist Margrit Eichler recognized the potential for reproductive tourism. Domestically, NRTs were not covered under most provincial health care plans which could create inter-provincial relocation of infertile women in order to be able to afford access to NRTs, similar to the when women travelled to Ontario and Quebec to

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<sup>94</sup> Sari Tudiver, “Canada and the Global Context of the New Reproductive Technologies: A Cautionary Essay,” in *Misconceptions: The Social Construction of Choice and the New Reproductive and Genetic Technologies*. Eds. Gwynne Basen, Margrit Eichler, and Abby Lipman (Hull, Quebec: Voyageur Publishing, 1993), 67.

<sup>95</sup> Tudiver., 69-70.

<sup>96</sup> Gena Corea, “The Reproductive Brothel,” in *Man Made Women: How new reproductive technologies affect women*. Eds. Corea et al. (Indianapolis: Indiana University Press, 1987), 43.

<sup>97</sup> Maura A. Ryan, “The Introduction of Assisted Reproductive Technologies in the “Developing World”: A Test Case for Evolving Methodologies in Feminist Bioethics,” *Signs*, 34, no. 4 (Summer 2009), 813.

obtain abortions before the changes to the Criminal Code. She further argued that NRTs' economic impact would be felt abroad. Globally, reproductive tourism presented a potentially dangerous and exploitive scenario for third world women and children. She concluded that Canadian regulation of NRTs must be done responsibly bearing in mind the effects a Canadian reproductive market would have globally.<sup>98</sup>

Feminists were obviously examining the potential repercussions of the new technologies on their fight to give women complete control over their bodies. The firm grip state and science had historically exerted on the reproductive freedom of women was threatening to tighten, as NRTs presented the potential to exploit women for their genetic material and wombs, regulating and restricting their lives in the process. Meanwhile, the problem of white middle-class infertility drove the development of a reproductive technology industry, which remained unregulated. The next chapter will discuss the response of the Canadian women's movement to the development, and regulation of, NRTs in Canada.

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<sup>98</sup> Statement by Margrit Eichler in *New reproductive technologies*. (Library of parliament :Ottawa, 1989), 2.

## Chapter 2

### *Canadian Feminism and NRTs: A Technological Handmaid's Tale*

The National Advisory Committee on the Status of Women (NAC) had been lobbying for a federally supported study on NRTs since 1987.<sup>99</sup> The subject of NRTs had been a focus of its women's health committee since the early 1980s, as demonstrated in the resolutions on health adopted during its Annual General Meetings. Feminist resistance to NRTs stemmed from the movement's struggle for control over women's bodies, and the danger and pain women had endured at the hands of those who held this control. NAC gradually built a strong case outlining the dangers of NRTs, drawing from multiple domains such as law, philosophy, health, and also from women's experiences, in order to convince the federal government that this issue was worth the money and resources of a royal commission.

This chapter will first outline the development of a Canadian feminist critique of traditional medical practice and of the feminist struggle to demedicalize women's bodies and reproductive functions through the grassroots efforts of the Canadian women's health movement. It will then examine feminist views on new reproductive technologies and the evolving "politics" of pregnancy and infertility. NAC's arguments against NRTs tended to be alarmist. They conjured images from literary classics such as Aldous Huxley's *Brave New World* and Margaret Atwood's *The Handmaid's Tale*, and invoked

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<sup>99</sup> NAC, resolution 500.30.15/87, *Index of Abridged Resolutions 1972-1995*, Canadian Women's Movement Archives (CWMA) NAC fond X10-1, box 62, file NAC – Constitution index to resolutions and related material 1993-1995 (1of2).

the infamous medical experiments conducted by the Nazis illustrate the technology's eugenic and commercial dimensions. Additionally, NAC faced an appropriation of the feminist discourse, labeled the "rhetoric of choice," by those who opposed their position on NRTs. Finally, the internal conflict between NAC and feminists who identified as infertile is discussed at the end of this chapter. Supporters of infertility within the women's movement were marginalized as dissenters against NAC; this created tension within the organization. This conflict also gave NAC's opposition ammunition against their campaign against NRTs.

### ***The Canadian Women's Health Movement: Educating Women About their Bodies***

The Canadian women's health movement was the product of regional grassroots efforts to educate women about their health and their bodies. It began in the same manner as the larger women's movement, through consciousness-raising groups in which women shared their experiences with the health care system, childbirth, mental health, addiction, and contraception.<sup>100</sup> These groups of women formed regional activist groups, which took on a wide range of issues, some of which overlapped with those of the larger women's movement, such as abortion, safe workplaces, and violence against women. The women's health movement, however, carried its activism further, by lobbying for women's health research centres, women's bureaus in research centres, and for an increase in women's participation in health care.<sup>101</sup>

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<sup>100</sup> Marina Morrow, "Our Bodies, Our Selves," 33.

<sup>101</sup> Madeline Boscoe, Gwynne Basen, Ghislaine Alleyne, Barbara Bourrier-LaCroix and Susan White, "The Canadian Women's Health Movement: Looking Back and Moving Forward," *Canadian Woman Studies/Les cahiers de la femme*, 24, no.1 (2004): 8

Canadian women's health activists tasked themselves with pointing out the systemic discrimination in the relationship between women and doctors, and the socio-economic realities that rendered women passive in decisions that affected their health. Women's health activist Maggie Burston declared that the movement provided women with a "critical examination of the concepts which shape our understanding of disease and the way this understanding is institutionalized in our present health care system,"<sup>102</sup> giving them the tools to secure agency over their bodies. The movement was focused on sharing information, such as symptoms, experience, battles, and research, to encourage women to take control of the decisions made about their health.

The Canadian women's health movement remained fragmented and its efforts largely undocumented until the creation of the Women's Health Network in 1993.<sup>103</sup> In the absence of a national unifying body prior to 1993, the Women's Health Collective's journal, *Healthsharing*, served as the means through which regional efforts and accomplishments were shared among other activists. As the Women's Health Collective stated in the first issue of *Healthsharing*, published in 1979: "But we in Canada are still, to a large extent, working in isolation or in small groups. A women's health movement exists but it is scattered and disjointed and, all too often, invisible."<sup>104</sup> Canadian women's health activists organized themselves to form the Committee for a Canadian Women's Health Network in 1982.<sup>105</sup>

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<sup>102</sup> Maggie Burston, "Sick but Not Silenced," *Healthsharing*, 10, no.2 (Spring 1989): 10.

<sup>103</sup> Morrow, 33.

<sup>104</sup> Women's Healthsharing Collective, "Notes from the Collective," *Healthsharing*, 1, no. 1 (November, 1979): 2.

<sup>105</sup> Canadian Women's Health Network (CWHN), "The Canadian Women's Health Network Project: Origins of the Project," <http://www.cwhn.ca/ARCHIVE/strength/index.html#TOC>. The information on the CWHN is taken from this source as it is the only documented account of the efforts of the nationally organized women's health movement.

Though this initiative failed in creating a network at that time, the women's health movement did not abandon its efforts to unify. In 1989, the Women's Healthsharing Collective and NAC secured three years of federal funding from Health and Welfare Canada to develop a national network which would build regional ties among women's health groups in order to collaborate on common goals.<sup>106</sup> Since many of the original groups involved in the endeavor had lost their funding and dissolved, *Healthsharing* became the embodiment of this federally funded, unified network called the Canadian Women's Health Project.

*Healthsharing*, first published by the Women's Healthsharing Collective in November 1979,<sup>107</sup> was created to provide "a kind of health information-sharing not then available to Canadian women."<sup>108</sup> It was dedicated to using a feminist approach to health and was intended to be a non-scientific magazine aimed at making information on women's health more accessible and less intimidating. In the absence of an organized national women's health association, *Healthsharing* was the most far-reaching women's health initiative, as it was distributed Canada-wide and reported health news from across the country. Through the regionally- and nationally-organized efforts of the women's health movement through this journal, women who were active in the health movement gained a legitimate network for sharing in education and research efforts, and for promoting women's health as an important but overlooked aspect of healthcare.

*Healthsharing's* role in unifying women's health initiatives made it the official voice of the women's health movement in Canada at the time of the Royal Commission.

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<sup>106</sup> Boscoe et al., 9.

<sup>107</sup> The founding members of this collective were: Connie Clement, Diana Majury, Gina Jones, Madeline Boscoe, Jennifer Penney, Kathleen McDonnell, and Susan Wortman.

<sup>108</sup> Women's Healthsharing Collective, "Notes from the Collective," *Healthsharing*, 1, no 4 (Fall, 1980): 2.

The Women Healthsharing Collective, through its journal, focused on the need for women to have control over their own bodies; it did this by addressing many health issues that affected women's lives. After 14 years of sharing the health experiences of women from coast to coast, however, the magazine ceased publication at the end of 1993 due to a lack of financial resources. Its job, however, as a networking initiative had been successful, as the establishment of the Women's Health Network meant that regional efforts in the women's health movement would still be supported and shared across Canada.

Articles and personal experiences published in *Healthsharing* called for women to question, and insist on, access to information regarding their health problems. Authors portrayed doctors as members of a profession that liked to keep non-experts (patients) in the dark. They did not, however, advocate complete disregard for, or distrust of, physicians. Rather, they encouraged patients to seek second opinions and insist on being heard by dismissive professionals.

Despite this advice, many women felt that their health concerns were not taken seriously by their doctors. Women's health activists reported that doctors did not understand many of the conditions affecting women, and that instead of listening to their patients, doctors often showed impatience towards them. *Healthsharing* published articles from numerous women who were misdiagnosed and then patronized when they repeatedly told their doctors that they were sick. Maggie Burston, who said she suffered from *candida albicans* overgrowth, and later founded the Candida Research and Information Foundation, wrote in *Healthsharing*:

Erudite specialists told me my problems were "in my head," more times than I care to remember. One famous urologist, furious at my insistence in compiling a detailed

list of symptoms, told me that one-third of his women patients had the same problems I did, and like them, I had better face the fact that I was “over the hill” and learn to live with my pain and infections. There was nothing he could do about them.<sup>109</sup>

She claimed that her condition caused chronic infections and made her allergic to most foods, which lead her to believe she was dying of infection and starvation. Female patients, such as Burston, wanted transparent doctor-patient relationship that allowed for open communication and for patient input on their treatment options.

Although most of its material on reproductive rights was devoted to abortion, the journal also published several informative articles on NRTs. Overall, *Healthsharing* insisted on the dangerous potential NRTs had to divide women further by race and class and ability.

***NAC: The Need for a Woman-Centred Approach to the Study of NRTs***

New reproductive technologies represented a potential step backwards for many feminists who opposed the over-medicalization of women’s bodies and the reinforcement of women’s biological role as mothers. NAC sought a woman-centred research agenda for the study of NRTs, which would focus on how the technologies would impact Canadian women’s lives, health, economic and legal status, as well as their potential for the exploitation of women based on race, class, and ability. NAC believed that these technologies were subject to male bias,<sup>110</sup> and so they called on the

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<sup>109</sup> Burston, 10.

<sup>110</sup> Sandra Harding, “The Woman Question in Science to the Science Question in Feminism.” in *Feminist Theory: A Reader*. (third edition) eds. Wendy K. Kolmar and Frances Bartkowski (New York: McGraw Hill, 2010), 346 -355.

government to ensure that the decisions over women's reproductive health were made in the interest of women.<sup>111</sup>

The international feminist NRT organization, FINNRAGE, analyzed prior studies on NRTs, and concluded that those without clear feminist research agendas were devoid of well-grounded social analysis. FINNRAGE found them to be mere state endorsements of the scientific exploitation of technology, at the cost of women's integrity.<sup>112</sup> These studies included the Warnock Report (1984, UK), the Waller report (1984, Australia), and the Ontario Law Reform Commissions' report (1985). All of these reports recommended that NRTs be permitted to develop under the regulation of scientific and medical regulatory boards, but failed to examine the impact of these technologies on the economy, the family, or women's health. Feminists recognized the potential for non-feminist research to reinforce patriarchal value systems based on gender, class, race, and ability through reproduction.<sup>113</sup> NAC's goal in lobbying for a feminist research agenda was to ensure that the Canadian report would incorporate the feminist perspectives that were absent in the other reports.<sup>114</sup>

### *NAC's Views on NRTs*

NAC's agenda with respect to NRTs was based on a number of views and concerns, which it expressed consistently in its campaign for a national feminist enquiry.

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<sup>111</sup> Heather Menzies, "The Social Construction of Reproductive Technologies and of Choice," in *Open Boundaries: A Canadian Women's Studies Reader*, eds. Barbara A. Crow and Lise Gotell (Toronto: Prentice-Hall, 2000), 309.

<sup>112</sup> Patricia Spallone, "Reproductive Technology and the State: The Warnock Report and its Clones," in *Made to Order: The Myth of Reproductive and Genetic Progress*, eds. Patricia Spallone and Deborah Lynn Steinberg (New York: Pergamon Press, 1987), 167.

<sup>113</sup> Harding, 346-355.

<sup>114</sup> Menzies, 312.

*NRTs and the meaning of motherhood*

Second wave feminism in North America, which had been responsible for the fight for abortion rights, was mainly rooted in the liberal ideology of the individual's freedom and equality under the law.<sup>115</sup> These feminists sought to question and reform traditional spheres, which subjected women to an inferior social status. Canadian historian Wendy Mitchinson reminds us that Canadian women have been judged on their (in)ability to have children. This judgment is especially apparent when a woman is not within the childbearing stage of her life, before puberty and post-menopause.<sup>116</sup> The biological argument of "woman as mother" had prevented women from fully participating in political and economic life, making them financially and socially dependent on men, and taking away their identities as individual human beings.

The existence of NRTs reinforced the traditional social/biological construct of women as mothers by treating involuntary childlessness as an illness.<sup>117</sup> This would place additional social pressure on childless mothers who either could not conceive, even with NRTs, or who simply chose not to bear children. These women would potentially be labeled as deviant or selfish. NRTs threatened to reduce women's status from "mothers" to "breeders" of the human race, and prevent them from participating fully in economic and political life.

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<sup>115</sup> M. Patricia Fernández Kelly, "A Chill Wind Blows: Class, Ideology, and the Reproductive Dilemma," in *Challenging Times: The Women's Movement in Canada and the United States*, eds. Constance Backhouse and David. H. Flaherty (Montréal: McGill-Queen's University Press, 1992), 255.

<sup>116</sup> Mitchinson, *Giving Birth in Canada*, 5-6.

<sup>117</sup> Miall, "Community constructs of involuntary childlessness," 396.

*Ignoring the Causes of Infertility*

NAC opposed the marketing of NRTs as a cure for the problem of infertility. NAC argued that presenting NRTs as a cure for infertility meant placing the benefits of a small portion of women, those that were infertile, above the potential risk of all women losing control over their own bodies. In addition, NAC felt that the resources spent developing NRTs could be better spent investigating the causes of infertility—proactive, instead of reactive. NAC stated, “[t]he NRTs [new reproductive and genetic technologies] devote considerable resources to assisting a small number of privileged women in the first world, while the infertility problems of the majority of women and men are ignored.”<sup>118</sup> For example, Chlamydia cases in women age 15 to 19 were rising.<sup>119</sup> This STI put young women at risk of developing tubal scarring, which has been proven to lead to ectopic pregnancies and infertility.<sup>120</sup> Similarly, 44% of all hospitalized women suffered from pelvic inflammatory disease.<sup>121</sup> Feminists questioned why such contributing factors to infertility remained understudied or ignored by government health initiatives.

National and provincial feminist groups questioned the allocation of public money toward NRTs, in an attempt to solve what they considered to be a small problem. The Ontario government spent more than \$3,200,000 of the 1988/1989 health care budget on funding IVF and other NRTs, while only \$300,000 had been allocated to the

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<sup>118</sup> NAC, *A Technological Handmaid's Tale: Executive Summary*, CWMA NAC fond X10-24, box 651 file 5, ii.

<sup>119</sup> This focus on STIs was not accepted by infertile women as we will discuss in a later chapter. These women resented this discourse as it stigmatized them as being promiscuous, while many cases of infertility were unexplained.

<sup>120</sup> Bonnie LaFave, “Increase in Chlamydial Infections,” *Healthsharing*, 9, no. 1 (Winter, 1987): 9.

<sup>121</sup> *Ibid.*, 9.

study of the causes of infertility.<sup>122</sup> Feminists argued that such public money being devoted to the development of NRTs could be redirected to the study of the causes of infertility, such as environmental and workplace hazards that might compromise reproduction.<sup>123</sup>

### Access to reliable information

NAC sought public education and regulation of NRTs to give women access to complete and comprehensive information about NRTs before investing time, money and hope in fertility treatments.<sup>124</sup> Fertility treatments such as IVF had extremely low success rates, were very costly, and the long term effects of the procedures had not yet been studied.<sup>125</sup> The media painted a picture of “miracle babies” by reporting the success of IVF without addressing its high failure rate, cost, and limited accessibility. A 1991 broadcast of CBC’s *Marketplace* found that fertility clinics gauged success rates differently, some by live births and others by successful conceptions, leading the consumer to believe that success rates were higher than they actually were for live births.<sup>126</sup> Furthermore, women were unaware of the risks and side effects of the drugs

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<sup>122</sup> The Ontario Advisory Council on women’s Issues, *Presentation to the Royal Commission on New Reproductive Technologies*, (October, 1990), 45.

<sup>123</sup> NAC, Resolution #14, *1985 AGM Resolutions*, CWMA NAC X10-24-4, box 641 file 5,

<sup>124</sup> Canadian Advisory Council on the Status of Women (CACSW). *Brief to the Royal Commission on New Reproductive Technologies*, (Ottawa: Canadian Advisory Council on the Status of Women, March 1991), 10.

<sup>125</sup> Groupe de recherche multidisciplinaire féministe (Université de Laval) *Mémoire présenté à la Commission Royale sur les nouvelles techniques de reproduction par Ann Robinson et Colette Gendron*, (Octobre, 1990), LAC RCNRT fond RG33-154 1993-94/531, file PH-1-QUE., 22

<sup>126</sup> CBC. [Marketplace](http://archives.cbc.ca/health/reproductive_issues/clips/3369/): (broadcast date: Jan. 22, 1991), [http://archives.cbc.ca/health/reproductive\\_issues/clips/3369/](http://archives.cbc.ca/health/reproductive_issues/clips/3369/)

regimens that were prescribed for the procedure.<sup>127</sup> Some of these drugs had debilitating effects, including nausea, dizziness, extreme mood swings, drowsiness, inability to concentrate, severe headaches, and the risk of developing ovarian cysts.<sup>128</sup>

### *Rights of the Fetus vs. Rights of the Mother*

The development of futuristic ectogenetic<sup>129</sup> technology posed a threat to the legal rights of mothers, because their development raised the possibility of granting legal rights to the fetus. Canadian law did not recognize the fetus as a separate entity, but considered it part of the mother's body. The development of technology to gestate an embryo outside of the human body, however, implied that the fetus would need rights of its own, similar to the legal protection of an infant. Catherine Tolton, then a law student at the University of Toronto, examined the legal implications of allowing the fetus the same rights as a child under the Canadian Charter of Rights and Freedoms. She found that these rights would allow mothers and doctors to be charged under the Criminal Code in the case of abortions, but these rights would also place a pregnant woman's physical body in virtually the same legal position as a child, or someone who is legally incompetent. In other words, the mother would be legally responsible to do what is in the best interest of the fetus.<sup>130</sup> This scenario would deny women who were pregnant any therapeutic medical procedures, such as chemotherapy, or even life-saving surgery,

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<sup>127</sup> Royal Commission on New Reproductive Technologies. *Personal Experiences with New Reproductive Technologies: Report from Private Sessions*, (Ottawa: Royal Commission on New Reproductive Technologies, 1992.), 2.

<sup>128</sup> Linda S. Williams, "Behind the Headlines," *Healthsharing*, 10, no. 3 (Summer, 1989): 21.

<sup>129</sup> Ectogenesis is the gestation of a being outside the body.

<sup>130</sup> Catherine Tolton, "Medicolegal Implications on of Constitutional Status for the Unborn: "Ambulatory Chalices" or Priorities and Aspirations," *University of Toronto Law Review*, 47, no. 1 (fall 1988): 37.

because such procedures might harm the fetus.<sup>131</sup> Activists opposed legally placing the life of a fetus over the life of its mother,<sup>132</sup> as it allowed the state to remove the mother's autonomy over her own body, potentially allowing them to regulate her eating, drinking and physical activity in the name of protecting the fetus.<sup>133</sup>

### Commodification and Commercialization

American investigative journalist Gena Corea's *The Mother Machine* set the tone for the feminist discourse on commodification of reproduction, and of women's bodies, through her references to the "industrialization" and "commercialization" of birth, processes which reduced children and women to mere commodities.<sup>134</sup> The Canadian women's movement used the parallel Corea creates between business and the delivery room to explain the economic influence driving the threat to hypermedicalize the female body. Corea coins the terms "technocrat" and "pharmocrats" to refer to physicians, the pharmaceutical companies, and other profiting interests in NRTs and women's infertility. She illustrates the various ways in which reproductive material can be harvested, traded, sold and exploited, with the resulting children being viewed as "products."<sup>135</sup>

Another celebrated work which Canadian feminists used to illustrate the impact of commodification was Margret Atwood's *A Handmaid's Tale*. NAC referred to this novel repeatedly in its discussions about NRTs, including appropriating its title for its

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<sup>131</sup> Tolton, 35.

<sup>132</sup> CBC, *Abortion rights: significant moments in Canadian history*, <http://www.cbc.ca/canada/story/2009/01/13/f-abortion-timeline.html> accessed June 4, 2010.

<sup>133</sup> Newman, 276, 278-279.

<sup>134</sup> Corea, *The Mother Machine*.

<sup>135</sup> *Ibid.*, chapter 6 "The Woman Industry: Embryo Transfer in Humans," p. 80 – 97.

own brief to the Royal Commission, *A Technological Handmaid's Tale*. Atwood's novel describes an alternate reality, where the fertile woman's body is regulated to produce children for society's infertile elite, as reproductive servants or "handmaids." Class/labour divisions among women widen as women are exploited for their wombs, and infertile women are cast away. This piece of fiction, NAC insisted, could easily become reality if society allowed NRTs to develop without regulation.

NAC feared the potential risks to women in lower socio-economic brackets presented by both texts: used for their wombs in surrogate motherhood, as presented in Atwood's novel, or used for the trading and selling of eggs or genetic material, as described by Corea. At particular risk were women of colour, immigrant women, and women with disabilities, because these groups tended to fall in the financial bracket most at risk for exploitation in surrogacy arrangements. Women with limited skills, or who faced language barriers might carry a child for a white middle-class woman as a viable, and reliable, source of income. This financial option, however, would reduce the status of these women, and the status of non-commercial child-bearers, to "breeders."

The creation of a "breeder" class further classifies a woman's reproductivity as "labour," and their children simply become the product of a reproductive industry. Corea explains the implications of "mother" being replaced by "breeder" in what she calls the "reproductive brothel":

As I envision it, most women in a reproductive brothel would be defined as "nonvaluable" and sterilized and, in this way, their progeny culled...Certainly women of color would be labeled 'nonvaluable' and used as breeders for the embryos of 'valuable' women. The white women judged genetically superior and selected as egg donors would be turned into machines for producing embryos. Through superovulation [a hormone induced overstimulation of a woman's ovaries to produce more

than one mature egg at a time], “valuable” females as young as 2 years and some as old as 50 or 60 could be induced to produce eggs.<sup>136</sup>

Contract surrogacy also presented the concern that surrogates’ daily physical activities would be monitored and restricted in the interest of carrying healthy children for third parties. These issues had to be examined thoroughly to ensure women maintained control over their own bodies.

### *Discrimination and Eugenics*

As stated in the discussion above, NAC was concerned that NRTs would further the division of Canadians, particularly women, based on race, class, ability, and gender. NAC recognized that Canadian society was struggling with identifying the way it systematically oppressed women and minorities as a result of white, middle-class, ableist values firmly entrenched in attitudes and government policy. Feminist interventions on NRTs, and their impact on the disabled, challenged popular social and medical attitudes toward disability and exposed the explicit eugenics component of NRTs.

First, NAC discussed the issues of sex selection and the termination of “defective” fetuses through prenatal screening. American doctors were debating whether or not to stop revealing the sex of children after amniocentesis because they realized it could lead to sex selective abortions. Studies had shown that most U.S. couples preferred male children as their first born<sup>137</sup> and that the practice of aborting female fetuses after screening was already underway in the United States. In a 1989

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<sup>136</sup>Corea, *The Mother Machine*, 278-279.

<sup>137</sup> *Ibid.*, 12.

special report by Canadian feminist reporter, Ann Pappert, Canadian and American feminist researchers raised concerns over the impact second-born female children would have on society by sending the message that they are less desirable than male children.<sup>138</sup>

The same problem applied to the rights of the disabled. The legitimate termination of fetuses that doctors knew would be born with disabilities would further stigmatize those who became disabled after birth through illness or accident, parents who decided against abortion of a disabled child, and of course, disabled children themselves. NAC and its member disability rights associations opposed NRTs which would screen and justify the elimination of fetuses with disabilities, and the devaluation of those already living with disabilities, as a form of eugenics.

DAWN spokeswoman, Elizabeth Stimpson, rightfully states that, historically, disabled women have been rendered invisible by an ableist society's "extreme bigotry" which ignored the sexuality of the disabled, and took away their rights and ability to reproduce.<sup>139</sup> This bigotry is the remnant of the eugenics movement in post World War I Canada. Along with the public health movement, and the push for healthy babies and lowered maternal mortality in Canada, came the concern for the betterment of the "race."<sup>140</sup> The forced sterilization of the disabled, which happened in Western Canada, was an idea that was considered after World War I, focusing on women, minorities, and immigrants.<sup>141</sup> Canadian historian Angus McLaren writes:

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<sup>138</sup> Barbara Katz Rothman quoted by Ann Pappert. "Can Feminism Survive test-tube revolution?" 12.

<sup>139</sup> Elizabeth Stimpson presentation by the DisAbled Women's Network (Toronto). *Brief to the Royal Commission on New Reproductive Technologies*. Library and Archives Canada, New Reproductive Technologies fond. RG33-154 1993-94/531, file PH-50-TOR, 1.

<sup>140</sup> Angus McLaren. *Our Own Master Race*, (McClelland & Stewart Inc.: Toronto, 1990), 28-45.

<sup>141</sup> *Ibid.*, 94.

If Canada were to be healthy and happy it was necessary to prevent the entry of immigrants who, they asserted, were over-represented by the feeble-minded, the epileptic, the idiotic,...[a]nd if normal Canadian children were to receive a healthy upbringing and a decent education they would have to be protected from disruptive and potentially degrading associations with the abnormal.<sup>142</sup>

These treatments against the disabled received widespread media attention in the late 1980s when lawsuits were directed against the provincial governments of BC and Alberta which forcibly sterilized disabled women.<sup>143</sup>

Much of the international and Canadian feminist literature on NRTs from groups such as FINNRAGE made reference to the Nazi regime and to genocidal notions of valuing one race over another. The termination of fetuses based on ability or race would perpetuate the values of “a racist, patriarchal, imperialist society,” said minority women’s rights activist and former NAC president, Sunera Thobani.<sup>144</sup>

As discussed above, during WWII, the exploitation of economically vulnerable women was a major issue among Canadian feminists. In addition to soliciting the reproductive services of the poor and marginalized, however, was the added issue of access to NRTs. The high cost of fertility treatments, as well as the financial comfort of taking time off work for appointments and fertility sessions, meant that only white middle-class women had access to these technologies. The cost of the technologies would draw a line between who was able to afford fertility and who wasn’t,<sup>145</sup> thereby ensuring the sterility of the disabled, non-white, and lower class.

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<sup>142</sup> Ibid., 94.

<sup>143</sup> Stimpson, 2.

<sup>144</sup> Sunera Thobani, “More than Sexist...,” *Healthsharing*, 12, no. 1 (spring, 1991): 13.

<sup>145</sup> Sunera Thobani, “In Whose Interest?” *Healthsharing*, 12, no. 3 (fall, 1991): 16.

Tannis Doe, a feminist researcher and member of DAWN and the Disability Rights Council, argued in 1994 that “NRTs are actually just new ways to reproduce OLD inequalities.”<sup>146</sup> The potential resurrection of a new eugenics movement, as well as the accessibility of NRTs to the affluent, was one of NAC’s most compelling arguments for the restriction and regulation of NRTs.

### *NAC Faces a New “Rhetoric of Choice”*

Canadian feminists developed their “rhetoric of choice” for the pro-choice campaign, aligning themselves with the liberal democratic belief in the individual’s right to choice in all domains of life:<sup>147</sup> “Because freedom of choice is such a strong value in liberal democratic society, the pro-choice argument became the most successful argument in our repertory and we came to rely on it more and more,” wrote former NAC president, Judy Rebick.<sup>148</sup> In 1993, “freedom of choice” was shifting from the having the right to choose not to be pregnant, to meaning having the right to choose to *be* pregnant. This rhetorical shift implied pregnancy, through any means necessary, was a woman’s right.

The debate over NRTs, however, exposed the limits of the feminist movement’s belief in the right to choose: “The idea that individual choice is the most important social value is not particularly feminist. In fact, in a society of unequal power, an emphasis on individual choice alone usually gives those with power the only real

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<sup>146</sup> Tannis Doe. “The New Reproductive Technologies: Discriminating Misconceptions of Choice.” *Herizons*, 8, no. 1 (Spring, 1994): 45.

<sup>147</sup> Judy Rebick, “Is the Issue Choice?” in *Misconceptions: The Social Construction of Choice and the New Reproductive and Genetic Technologies*, vol 1, eds. Gwynne Basen, Margrit Eichler, Abby Lippman (Hull: Voyageur Publishing, 1993), 88.

<sup>148</sup> *Ibid.*, 87.

choices,” explained Rebick.<sup>149</sup> The rhetoric of choice was being used by pro-NRT groups as a way to advocate the “rights” of infertile women, discrediting NAC as the voice of all women.

As illustrated in the introduction, NAC’s popularity diminished as its tactics became more radical. Many Canadians began to view the women’s movement as obsolete and the Canadian media portrayed NAC as an organization that did not represent the majority of Canadian women.<sup>150</sup> The umbrella organization was criticized for representing radical feminists instead of the majority of women; a countermovement developed in the form of more conservative women’s groups, such as REAL Women (Realistic, Equal, Active, for Life).<sup>151</sup>

The rhetoric of choice was not only used by antifeminist women’s groups, but by feminists as well. NAC’s opposition to NRTs caused dissent from feminists within the movement who identified as infertile. Feminist supporters of NRTs felt marginalized within NAC and eventually left the organization. NAC’s persistence that the technologies used women’s vulnerability to coerce them into participating in harmful procedures created a sense of victimization. The infertile among NAC resented the implication that they were victims.

The Infertility Awareness Association of Canada wrote: “The women’s movement endorses choice on other questions of reproductive health [such as abortion

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<sup>149</sup> Ibid., 88.

<sup>150</sup> Jessica L. Weiser, *Ruling Relations and Representation: The Toronto Star’s Depiction of NAC 1983-1997*, (MA thesis in Sociology and Equity Studies in Education Ontario Institute for Studies in Education of the University of Toronto, 1998), 82.

<sup>151</sup> Sylvia Bashevkin, *Women, Power, Politics: the Hidden Story of Canada’s Unfinished Democracy*, (Oxford University Press: Don Mills, 2009), 126-127.

and midwifery], and then dismisses infertile women as guinea pigs.”<sup>152</sup> Feminist supporters of NRTs within NAC felt that the mainstream women’s movement dismissed their needs. They questioned the women’s movement’s notion of “freedom of choice,” a concept they themselves had fought for. The division between women regarding infertility, stemming from the denial of the infertile experience, is further discussed in chapter 4.

The isolation of feminists struggling with their own infertility issues within the broader women’s movement organizations was not unique to the Canadian context. Naomi Pfeffer and Anne Woollett recount their feelings of isolation from society, and the women’s movement in Britain: “we had expected to be able to talk to other women, to be able to discuss our infertility within a feminist context. But we found the taboos and silence on infertility just as strong within the women’s movement... [This silence] denied the reality of our experience.”<sup>153</sup>

Chapter three will compare the reaction of the medical profession to NRTs versus that of NAC and discuss how the CMA perceived the rights of the infertile. NAC feared that the unregulated development of NRTs could lead to the further medicalization of women’s bodies under the guise of a new rhetoric of choice. NRTs threatened to reinforce a white, middle-class ableist concept of motherhood as well as entrenching women’s social role as mother. They moreover threatened to legitimize discrimination based on race, gender, class and ability. Finally, NRTs threatened to tighten science’s grip on women’s bodies, overturning the gains made by the women’s

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<sup>152</sup> Infertility Awareness Association of Canada (IAAC), *Submission to Royal Commission on New Reproductive Technologies April 30, 1992*, National Library and Archives Canada (LAC), RG33-154 1993-94/531, Box 7 file ph-9-OT, 2.

<sup>153</sup> Pfeffer and Woollett, 1.

health movement. NAC intensified its efforts to educate women and the general public on the risks and realities of NRTs.

## Chapter 3

### *Conceiving Women's Health: the Canadian Medical Association and New Reproductive Technologies*

While NAC and the women's health movement maintained pressure on the medical profession to consider women's health as a relevant issue, the Canadian Medical Association (CMA) began to re-examine its policies and practices in the 1980s and 1990s regarding reproduction, gender, ethics and technology. As Wendy Mitchinson suggests, physicians' practices respond to society's needs and interests.<sup>154</sup> Canadian doctors during this period similarly had to reconsider their position on multiple issues being debated in the media. Euthanasia, midwifery, abortion, stem cell research, and NRTs were among the ethical debates of the time. Public pressure to reassess medical ethics on such issues is evident in the pages of the *Canadian Medical Association Journal* (CMAJ). Through a content analysis of the CMAJ, this chapter examines how the medical profession attempted to reposition itself on the issues of women's health, gender, and NRTs in order to respond to pressures coming from both the inside and outside of the CMA.

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<sup>154</sup> Mitchinson, *Giving Birth in Canada*, 7.

### *The CMAJ and Women's Health*

The CMA welcomed the establishment of the Royal Commission on New Reproductive Technologies. President of the CMA, Dr. John O'Brien-Bell, wrote that women's health issues and medical technology were being discussed at the highest levels of the CMA. He stated that a new division was created to examine the ethical and legal implications raised by these new technologies.<sup>155</sup> Furthermore, the CMA's Board of Directors passed a resolution in the spring of 1989 to "support a national, formal process to increase public awareness about the issues raised by such technologic advances."<sup>156</sup> The resolution focused on ethical matters and called for the involvement of women in the discussion of NRTs.

This gesture by the Board of Directors reflected discussions among the general membership at the time. Letters in the CMAJ reveal public debate on how much gender mattered within their profession. "Why must the inclusion of women's issues have to change everything?" they asked. Public pressure was forcing doctors to reflect on their treatment of female patients, and how their own gender biases could affect their interactions with women.<sup>157</sup>

Meanwhile, the increasing popularity of midwifery was challenging modern medical monopoly over childbirth, and the CMAJ reported on several illegal midwifery cases in Alberta. Moreover, the sensational abortion debate was infiltrating the physician's professional and personal lives, as protesters gathered at clinics, and doctors received threats at their homes. The proposed bill C-43, *An Act respecting abortion*

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<sup>155</sup> CMA, "Royal commission on reproductive technology welcomed by CMA," *Canadian Medical Association Journal (CMAJ)*, 140, no. 10 (May 15, 1989): 1188.

<sup>156</sup> *Ibid.*, 1188.

<sup>157</sup> Jill Rafuse, "Gender sensitivity can translate into more effective patient care, CMA conference told," *CMAJ*, 148, no. 7 (April, 1993): 1194.

(1989), was fuelling the fetal rights debate in Canada, resulting in the CMA's need to justify its own practices and the physician's role in the realm of reproductive medicine.

Internally, the increasing presence of women in medicine was forcing the profession's hand at re-evaluating the way doctors operated their clinics and interacted with patients. A study published in the *CMAJ* reported the clear difference between the way male and female doctors interacted with patients.<sup>158</sup> Women physicians tended not to specialize as much as men, opting for family medicine. On average, women spent more time with patients, thus seeing fewer patients per day than the average male doctor. Women doctors also worked fewer hours than their male colleagues which, it appeared, was due to their traditional role as primary caregivers in the home. Consequently, they earned less than their male colleagues.<sup>159</sup>

At the time, there was concern that these patterns could create labour shortages in the medical profession. Instead of blaming female physicians, however, CMA members questioned the status quo, suggesting that all physicians should work less and make more time for their families.

In 1991, close to fifty percent of new medical school graduates were women. Furthermore, 20.1% of the 45,407 CMA members were women; this percentage was slightly higher than the numbers of women in the profession as a whole, and the percentage was expected to rise with the influx of women graduates.<sup>160</sup> This significant rise in the number of female physicians added to the growing attention that was being

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<sup>158</sup> A. Paul Williams et al., "Women in Medicine: practice patterns and attitudes," *CMAJ*, 143, no. 3 (February, 1990): 194 – 201.

<sup>159</sup> *Ibid.*, 199.

<sup>160</sup> Patrick Sullivan, "New CMA committee intended to increase awareness of women's issues," *CMAJ*, 144, no. 9 (May, 1991): 1146. According to the statistics in this article, women accounted for 17.5% of the total 'manpower' in the medical profession. Female membership in the CMA was 20.1%.

paid to women's issues in medicine. The CMA formed an ad hoc committee in 1991 to focus on women's health care as well as the needs of women physicians. Members included representatives from the CMA board, the Federation of Medical Women of Canada (FMWC), the College of Family Physicians of Canada, and the Canadian Association of Interns and Residents. The ad hoc committee on women's issues was asked to ascertain whether or not the CMA was doing enough to incorporate women's views and needs in its healthcare delivery.

Resistance to this decision was expressed in the columns of the CMAJ. In 1989, one CMA member expresses his disgust in a letter to the editor:

For many years I have sighed over the lack of good science and even decent medical politics in the CMAJ. However, the Nov. 1, 1988, issue,<sup>161</sup> with its cheap and nasty research papers, its inane editorial and its nonmedical "human interests" stories worthy of *Chatelaine*, strikes a new low in medical journalism. Even the letters to the editor lack interest and humour, with the fulminations of the pro- and anti-abortionists continuing to waste time and space.<sup>162</sup>

At least one high-level member of the CMA followed suit. In a 1990 article on *Medical ethics and women*, Dr. Eike-Henner Kluge, then the CMA's director of medical ethics and legal affairs, stated that a female-oriented approach to medicine was politically charged and had no place in medicine: "A female-oriented approach to medical ethics," Kluge wrote, "is not only wrong, it is dangerous."<sup>163</sup> If physicians adopted a female-

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<sup>161</sup> This issue of the CMAJ contained an editorial on journalistic freedom and a research paper about the experiences of an emergency room nurse.

<sup>162</sup> Ian M. Connor, "A new low in medical journalism?" *CMAJ*, 10, no. 1 (January, 1989): 14-15.

<sup>163</sup> Eike-Henner Kluge, "Medical ethics and women," *CMAJ*, 142, no.8 (April, 1990): 878.

oriented approach, there would be “no reasonable way to settle conflicting claims between the two ethical camps.”<sup>164</sup> He concluded:

John Donne said, “No man is an island, entire of itself.” Neither is a woman. Both are embedded in social contexts and both interact with each other. And both are persons. That is the fundamental core of women’s health issues; the accidental factors of sexual differentiation are not. These factors are important, but the ethical framework – the medical ethics that has to deal with this – must be the same for all. Yes medical ethics is a women’s health issue, but only because medical ethics, first and foremost, must deal with women as person.<sup>165</sup>

Various letters printed in the *CMAJ* within this five-year study defended a similar approach to medical practice.

On the other hand, Kluge’s article generated a score of letters, from both women and men, challenging his views and openly endorsing change, including a woman-centred approach to medicine. Dr. Elizabeth Latimer thus argued:

[Kluge] narrowly attributes the different views of women on these issues only to gender and biology, ignoring the different significant psychologic and sociologic life experiences of women. It is only in recent decades that we have begun to acknowledge such difference and to learn its nature and potential ramifications for society.<sup>166</sup>

Some of her male colleagues agreed, including surgeon Adrian F. Hynes:

A female or feminist orientation would suggest valuing subjectivity and relationship along with objectivity and control, the major values of our patriarchal system...If these parts are not integrated into our attitudes and behaviour (including ethical), then essential components

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<sup>164</sup> *Ibid.*, 879.

<sup>165</sup> *Ibid.*, 879.

<sup>166</sup> Elizabeth J Latimer, MD., “Letter Re. Medical ethics and women,” *CMAJ*, 143, no. 4 (August, 1990): 249.

of reality will be missed, and we will all be less fully human... We do not need “either/or”; we need to integrate both ways of thinking and behaving as fully human persons.<sup>167</sup>

Another surgeon, Wena Williams wrote:

As long as men continue to defy the ethical code of medical practice (or are perceived to do so), a female-oriented approach not only is neither wrong nor dangerous but is essential for the health and welfare of the majority of the population.<sup>168</sup>

Some contributions from female physicians clearly demonstrated the growing influence of the women’s movement. For example, an article written by a lesbian physician, Dr. Ruth Simkin, called upon doctors to examine their biases and to consider not only the biological needs of a patient, but also their gender identity and sexual orientation.<sup>169</sup> This view was supported by other readers, such as physiotherapist Shayna Hornstein, who also pointed out a bias in the *CMAJ* editors’ attitude towards Dr. Simkin’s article:

I also wonder why Dr. Simkin’s well-researched piece is “Opinion,” whereas the article on the “safety” of breast implants by a male nonphysician is offered under the heading “Women’s Health.” Surely this indicates a not-so-subtle bias on the part of the editors to defer to the male perspective on women’s health and to marginalize Simkin’s efforts to raise awareness about a totally ignored women’s issue.<sup>170</sup>

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<sup>167</sup> Adrian F Hynes, MB, BCh, “Letter Re. Medical ethics and women,” *CMAJ*, 143, no. 4(August, 1990): 249-50.

<sup>168</sup> Wena Williams, V.P. MB, ChB, “Letter Re. Medical ethics and women,” *CMAJ*, 143, no. 4 (August, 1990): 250.

<sup>169</sup> Ruth J. Simkin, MD, CCFP, “Lesbians face unique health care problems,” *CMAJ*, 145, no. 12 (December, 1991): 1620-1623.

<sup>170</sup> Shayna Hornstein, BSc(PT), “Letter re. Lesbians face unique health care problems.” *CMAJ* 146, no. 9 (May, 1992): 1526.

Indeed, the CMAJ had made light of lesbians' health needs by "reduc[ing] the reality of these women to nothing more than an opinion."<sup>171</sup> Letters such as these called for the medical profession's inclusion of women's issues in their agenda.

### ***Technology and Research***

While many more opinions on women's health issues were published in the CMAJ, the journal also published research papers on reproductive technologies. Research studies included the outcomes of pregnancies achieved through in vitro fertilization, the use of fetal tissue in research therapy, artificial inseminating methods, and the effects and benefits of ultrasound scanning. Some of these studies expressed an awareness of the social, legal, and ethical implications of these technologies, and they called for some form of legal mechanism to regulate them.<sup>172</sup> These studies raised considerable concern over such issues as the use of fetal tissue and the potential transmission of sexually transmitted diseases, particularly Acquired Immune Deficiency Syndrome (AIDS).<sup>173</sup>

The CMA explored in detail why regulation was needed, and many of its arguments paralleled those submitted by NAC. For instance, a 1990 article on eugenic abortion depicted this practice as discriminatory and unethical. "Selective feticide," as the author named it, "involves the deliberate, systematic search for those who may be

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<sup>171</sup> Ibid., 1526.

<sup>172</sup>T. David Marshall, Md, LLB, "Canadian regulation of the medical use of fetal tissue in research and therapy," *CMAJ*, 140, no. 9 (May, 1989): 1022.

<sup>173</sup> Selma G. Scott et al., "Therapeutic donor insemination with frozen semen," *CMAJ*, 143, no. 4 (August, 1990): 274.

unfit in mind or body, the primary intent being to terminate fetal life if such is found.”<sup>174</sup> He identified this new eugenics as a distortion of the discourse of reproductive choice with respect to abortion. The author used objective research to make the case against the safety of amniocentesis. Another article rebutted this statement by reaffirming the necessity for women to have the choice not to have an abnormal child.<sup>175</sup> Although respondents did not condone selective abortion, they advocated the right of prenatal testing to give parents the option, as well as to better prepare them if they decided to continue the pregnancy.

Additionally, physicians acknowledged the vague and misleading information originating from the fertility industry: “Couples seeking information about the success rate of an IVF program may be presented with any one of numerous figures, each perhaps accurate but often misleading,” concluded a study on the rates and outcomes of an IVF program.<sup>176</sup> This study also discussed the observed risks involved with IVF, including spontaneous abortions (miscarriages), the incidence of ectopic pregnancies, and multiple births: “A critical evaluation of IVF in Canada is not only justifiable but also essential,” said the authors, who believed that parents who seek these types of treatment must be given realistic information about the rates of success and the risks involved.<sup>177</sup>

Technology was valued among physicians, but there were cautionary words from members who warned colleagues against complete trust in technology. In 1991, Dr.

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<sup>174</sup> Malcolm N. Beck, MD, CM, FRCPC, “Eugenic abortion: an ethical critique,” *CMAJ*, 143, no. 3 (August, 1990): 181.

<sup>175</sup> Elizabeth Ives et al., “Prenatal diagnosis: the medical genetics perspective,” *CMAJ*, 144, no. 9 (May, 1991): 1129 – 1132.

<sup>176</sup> A. Albert Yuzpe et al., “Rates and outcome of pregnancies achieved in the first 4 years of an in-vitro fertilization program,” *CMAJ*, 140, no. 2 (January, 1989): 170.

<sup>177</sup> *Ibid.*, 167, 168.

Douglas Waugh, former executive director of the Association of Canadian Medical Colleges, stated that man's "fascination with tools and gadgets" should not cloud medical judgment by treating new and existing medical technology as infallible: "Doctors are no more immune from Murphy's Law than are engineers, architects, builders, or even accountants. We're the ones who developed and used thalidomide. We're the ones who used to appear in cigarette ads, saying how a quick smoke helped clam our nerves."<sup>178</sup> Overall, the CMA was committed to keeping its members informed about the advances in medical technologies and to its currency. The CMAJ regularly published articles from provincial technology assessment committees, evaluating the cost and effectiveness of medical technologies, which aid in reproduction and in prolonged life.

In this context, the Royal Commission on NRTs was welcomed by the medical community. The Commission, it was anticipated, would recommend guidelines for their legal regulation; that the Chair of the Royal Commission happened to be one of their own further boosted the confidence of physicians. Charlotte Gray, a feminist journalist and a contributing editor for the CMAJ, praised the appointed Chairperson, Dr. Patricia Baird, for her "impeccable credentials."<sup>179</sup> A geneticist and pediatrician who had authored more than 250 research papers and abstracts, Baird was an expert on birth defects and genetic diseases.<sup>180</sup> Gray also applauded the presence of Alberta doctor Bruce Hatfield, who was the Commission's only practicing physician.

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<sup>178</sup> Douglas Waugh, MD, "Technology and Murphy's Law," *CMAJ*, 145, no. 5 (March, 1991): 545.

<sup>179</sup> Charlotte Gray, "Studying reproductive technologies: 'We'll never please everybody,'" *CMAJ*, 141, no. 12 (December, 1989): 1258.

<sup>180</sup> Charlotte Gray, "Controversial "reprotech" royal commission faces growing criticism," *CMAJ*, 145, no. 10 (November, 1991): 1371.

It was critical for Canadian physicians to have adequate representation on this commission, as the potential regulation of medical research and technology was a very sensitive area. The presence of lawyers and professors on the Commission raised some concerns as the medical profession resented lay interference in its practice. Contributors to the CMAJ asked whether politics had any business in medicine. Some, like Dr. Harry E. Emson, feared that promising research could be halted or postponed by lay persons in government who did not have the credentials to recognize the significance of the science. “Formal legislation may prove to be a backward and regrettable step,” he wrote.<sup>181</sup>

Between 1989 and 1993, the issue of women’s health was increasingly raised in the CMAJ. This trend can be attributed to the growing influence of the women’s movement and to the increasing number of female physicians and is evident in the extent to which women’s reproductive functions and NRTs were discussed: Several articles recognized the need for accurate information regarding the risks, financial commitment and success rates of procedures like IVF, the legal and social questions regarding fetal tissue, and the necessity of some technologies.

Along with NAC, the CMA thus welcomed the government’s decision to establish the Royal Commission on New Reproductive Technologies. The following chapter will discuss how the CMA, and other stakeholders, presented their views on NRTs to the Royal Commission.

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<sup>181</sup> Harry E. Emson, “Medicine, research and the Criminal Code,” *CMAJ*, 143, no. 3 (August, 1990): 95.

## Chapter 4

### *Consensus and Contradiction:*

#### *The Responses to the Royal Commission on NRTs*

The women's movement recognized that the resources needed to support a thorough multidisciplinary study of NRTs in Canadian society surpassed its means. As a result, a nation-wide coalition of women's and special interest groups consolidated their efforts and created the Canadian Coalition for a Royal Commission on New Reproductive Technologies under the guidance of Canadian sociologist Margrit Eichler.<sup>182</sup> Royal commissions are granted sufficient budgets and research staff to conduct large-scale studies on major issues; they also have the added power to subpoena witnesses to give testimony and provide accurate information. After two years of intensive lobbying, the Royal Commission on New Reproductive Technologies was finally announced in the Speech from the Throne in 1989. According to Commissioner

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<sup>182</sup> Margrit Eichler, "Frankenstein Meets Kafka: The Royal Commission on New Reproductive Technologies," in *Misconceptions: The social construction of choice and the new reproductive and genetic technologies*, eds. Gwynne Basen, Margrit Eichler, Abby Lippman (Hull, Quebec: Voyageur Publishing, 1993), 196-197. This Coalition is difficult to comment on because it does not have an archive and the only information that exists regarding it comes from Eichler's article in *Misconceptions: The social construction of choice and the new reproductive and genetic technologies*, a two volume anthology that was released in 1993 to discuss the Royal Commission on NRTs and the feminist perspective on these technologies. Other than this and a few mentions in NAC's fonds, no other information can be found on the operations of the coalition. An interview with Eichler would provide valuable information on this important network of NRT critics but, since this thesis is based on manuscripts, an interview was not warranted at this time.

Maureen McTeer, the government had been looking for a significant social policy to which federal resources could be dedicated.<sup>183</sup>

Seven commissioners and one chairperson were appointed with the mandate to “inquire into and report on current and potential medical and scientific developments related to new reproductive technologies, considering in particular their social, ethical, health, research, legal and economic implications and the public interest, recommending what policies and safeguards should be applied.”<sup>184</sup> The Commissioners were: Dr. Louise Vandelac, a feminist professor of sociology from l’Université du Québec à Montréal; Martin Hébert, a lawyer from Montréal; Dr. Suzanne Rozell Scorsone, a social anthropologist and director of the Office of the Catholic Family Life Archdiocese of Toronto; Maureen McTeer, a feminist lawyer from Ottawa; Dr. Grace Marion Jantzen, a professor of religion who was Canadian-born but living and lecturing in London, England; Dr. C. Bruce Hatfield, a practicing physician from Calgary, Alberta; and Dr. Patricia Baird, a pediatrician and geneticist. Baird would be the Chairperson of the commission.<sup>185</sup>

The composition of the Royal Commission included two feminists, Vandelac and McTeer; two francophones, Vandelac and Hébert; two males, Hébert and Hatfield; five women, Baird (the Chair), McTeer, Vandelac, Jantzen, and Scorsone; two physicians, Hatfield and Baird; two representatives of the church, Jantzen and Scorsone; two

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<sup>183</sup> Maureen McTeer, *In My Own Name: A Memoir*, (Toronto: Vintage Canada, 2004), 209.

<sup>184</sup> RCNRT, *Proceed with Care*. Vol. 1, 3.

<sup>185</sup> Two additional commissioners, Susan McCutcheon and Bartha Knoppers, were hired in 1991, two years after the original Order-in-Council. Four of the original commissioners—Hatfield, Hébert, Vandelac, and McTeer—were fired on December 6, 1991.

lawyers, McTeer and Hébert; and one lesbian, Jantzen.<sup>186</sup> There were no visible minorities, nor were there any persons with disabilities, on the committee. Most significant, there were no representatives from the infertile community.<sup>187</sup> All members were familiar with NRTs; each had been actively serving on technology ethics committees or was researching the social and legal implications of the use of NRTs in society.

The commission held public hearings in all provinces and territories to hear the views and concerns of regionally diverse groups and individuals. This thesis primarily focuses on the views that clearly supported the interests of women, but it also pays close attention to the other stakeholders discussed earlier—physicians and the infertile. For comparative purposes, we will also discuss the views of various religious groups headed by women.

### *The Canadian Women's Movement*

“Most commissioners are strangers to the feminist community,” wrote Nancy Pollak in the BC feminist magazine *Kinesis*.<sup>188</sup> The Canadian women's movement expressed concerns about the Royal Commission from the beginning. While NAC and the Coalition had hoped for a feminist majority on the Royal Commission, only two had been appointed: Louise Vandelac and Maureen McTeer. The lack of feminist

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<sup>186</sup> Royal Commission on New Reproductive Technologies, *Proceed with Care, vol 1*, (Ottawa: Minister of Government Services Canada, 1993), 3.

<sup>187</sup> Due to the treatment of infertility as a private issue, there was little public discussion at the time on the topic, and the infertile were not recognized as a distinct community, in the way cultural/racial minorities and LGBTQ communities were. From the personal stories and celebrations that were recounted in the IAAC newsletter, it is clear that a community did (does) exist among the infertile as these awareness groups act as a support network.

<sup>188</sup> Nancy Pollak, “The Royal Commission a Volatile Mix,” *Kinesis*, (November, 1989).

commissioners fueled fears that the Royal Commission's work would follow a conservative, pro-life, anti-feminist medical/political agenda, entrenching those conservative values in government policy.

Of particular concern was the appointment of the Chair, Dr. Patricia Baird, a geneticist. A professor of Medical Genetics at the University of British Columbia, Baird was the former head of medical genetics at the Grace University, and Children's hospitals in Vancouver. She was a member of the Science Council of Canada and had served on the National Advisory Board on Science and Technology (NABST).<sup>189</sup> Her expertise on the subject and her ties to the PC government through the NABST, however, did little to guarantee that the commission's research into NRTs would not be driven by the geneticist's personal and professional agenda, which favoured pharmaceutical and technological companies. This possibility was especially concerning since these medical industries were ranked first in Canada for manufacturing growth and profitability at this time.<sup>190</sup> Despite being a woman, it was not clear at all what Baird's approach as Chair would be.

Women's groups took the lead in the Royal Commission's consultation process.<sup>191</sup> Over fifty women's groups made submissions to the Royal Commission at nation-wide public hearings held from 1990 to 1992. Women's organizations supported and promoted NAC's position at every hearing; they presented multidisciplinary

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<sup>189</sup> Charlotte Gray, "Studying reproductive technologies: "We'll never please everybody," *CMAJ*, 141, no. 12 (December, 1989): 1258. See also Baird's page on the University of BC website: <http://www.chspr.ubc.ca/about/faculty/baird> accessed on June 14, 2010. The National Advisory Board on Science and Technology was a board which was chaired by the Prime Minister, tying Baird directly to Mulroney.

<sup>190</sup> Laura Sky, "Commercial Interests and New Reproductive Technologies, *Canadian Woman Studies/Les Cahiers de la Femme*, 14, no. 3(Summer, 1994), 105; Maureen McTeer, *In My Own Name: a Memoir*, (Toronto: Vintage Canada, 2004), 211-212.

<sup>191</sup> Ontario Advisory Council on Women's Issues, i.

research that reinforced their point that NRTs should be regulated from a feminist-centred approach. They also reiterated that banning practices that reinforce discrimination and racism would ensure that individual women maintain control over their bodies. These presentations exposed the ideologically driven process of scientific medicalization, which reinforced patriarchal control over women's bodies through a gendered discourse that constructed the category of "woman" only as a biological entity, ignoring the political, social, and economic factors that shaped women's realities.

Feminist groups discussed the social construction of motherhood and showed how NRTs further institutionalized this "natural" role. For example, *le Groupe de recherche multidisciplinaire féministe* of Laval University argued that women had been were no longer under pressure from the clergy and law to have children, however, Western society was perpetuating the idea that real womanhood was not achieved unless women gave birth, thus forcing them to seek the status of birth mother.<sup>192</sup> The Royal Commission's own public survey revealed similar views: childless women had historically been stigmatized as selfish, defective, or deviant.<sup>193</sup> Such pressures forced women to subject their bodies to medical curiosity and ambitions. NRTs further intensified these pressures by constructing infertility as an illness, thus reinforcing the status of "childlessness" as an abnormal state of womanhood that required treatment.

At the same time, the increased medicalization of the reproductive process had established a link between the fetus and the doctor, further diminishing the mother's

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<sup>192</sup> Groupe de recherche multidisciplinaire féministe (Université de Laval), 2.

<sup>193</sup> Royal Commission on New Reproductive Technologies. *Social Values and Attitudes Surrounding New Reproductive Technologies*. (Ottawa: Royal Commission on New Reproductive Technologies, 1993)

status.<sup>194</sup> The technological and ideological separation of fetus and mother happened when the ultrasound presented disembodied images of the fetus in the mother's womb. Separated from the mother in the frame, the ultrasound's representation of the fetus constructed it as an autonomous "public" entity deserving of rights and protection.<sup>195</sup> By separating the mother from the fetus, an opposition is created between her rights and the rights the public perceived should belong to all beings, including the fetus.

NAC and its member organizations consistently opposed the removal of women from the reproductive process, because it shifted the meaning of motherhood to that of mere "vessel." Furthermore, discussions about artificial reproduction, especially with respect to surrogacy, tended to define the offspring, both socially and legally, as the father's genetic property, while the rights of the mother, either "biological" or "social," were viewed as secondary.

Overall, NAC and its member groups feared the control of women's reproductive functions would remain forever in the lab.<sup>196</sup> They recounted the historical subjection of women to invasive procedures and prescribed drug regimens, without the proper consultation and information to make informed decisions about their health. NAC painted the picture of women who faced little hope of successfully conceiving a child and yet endured the psychological and emotional stress of fertility treatments, with little understanding of the long-term effects of the procedures they underwent. They further reminded the Royal Commission that women often died due to medical technology. For example, the Dalkon Shield, an intra-uterine contraceptive device, had not undergone

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<sup>194</sup> Warsh, *Prescribed Norms*, 170.

<sup>195</sup> Julie Palmer, "Seeing and Knowing: Ultrasound images in the contemporary abortion debate," *Feminist Theory*, 10, no. 2 ((2009), 173, 174.

<sup>196</sup> Judy Rebick, fax to Rachel Gillooly, May 16, 1991. Canadian Women's Movement Archives (CWMA), NAC file: 'New Reproductive Technologies 1991-1992.' Box 904.

sufficient trials or testing, yet it was marketed and distributed for commercial gain.<sup>197</sup> In summary, Canadian feminists would not condone another technology that would further subject women's health and safety to capitalist and patriarchal modes of domination.

Feminist groups further argued that once science learned the steps, perfected them, and successfully 'created' life artificially, the womb would cease to be the ideal place for the gestation of embryos.<sup>198</sup> Fertility clinics, they claimed, did not want to cure infertility, rather, they were taking the opportunity to experiment, learn the secrets of reproduction, and seize control under the guise of finding a cure for sterility.<sup>199</sup> Until proper regulations were adopted, scientists would continue to use women as subjects in their experiments, and would encourage the buying, selling, and trading of reproductive material, thus commercializing women until they could remove women from the reproductive process altogether.

Genetic experimentation was seen as a major potential catalyst for the commercialization of reproductive materials because it demanded a supply of sperm, ova, fertilized embryos, and other fluids and tissues. The briefs submitted to the Royal Commission expressed fear regarding the direction science was steering genetic research, and whose interests it would serve by "tampering" with the human genome.<sup>200</sup> Already, the "benefits" of genetic research were being boasted about. For example, somatic gene therapy promised some potential cures for specific disorders such as Tay-

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<sup>197</sup> Andrea Tone, *Devices and Desires*, 274. The Dalkon Shield caused death and infertility in women users due to design problems which lead to serious infection.

<sup>198</sup> Groupe de recherche multidisciplinaire féministe, 14

<sup>199</sup> *Ibid.*, 15.

<sup>200</sup> National Action Committee on the Status of Women (NAC). *Draft NAC Position Paper On New Reproductive Technologies*. Sent by fax Sept 17, 8:00 pm, unknown year. Canadian Women's Movement Archives (CWMA), NAC file: 'New Reproductive Technologies 1991-1992.' Box 904.

Sachs disease.<sup>201</sup> This research, however, fostered the creation of a market for aborted fetuses, whose tissue provided rich material for experimentation.<sup>202</sup> Furthermore, genetic engineering and germ-line therapy experiments and treatments that would directly alter the genetic pool raised the spectre of eugenic practices. Parents would eventually be able to bypass selective abortion and eliminate undesirable traits and disorders in vitro or in utero.<sup>203</sup>

Feminist groups insisted that NRTs had the potential for discrimination against a wide variety of women. The most obvious forms of discrimination would be: the inaccessibility of services due to cost, exclusion based on moral prejudice,<sup>204</sup> or the inability to access information in languages other than English. As a result, NRTs would exacerbate existing divisions based on class, race, and ability, as their access would be available mainly to white, middle and upper class, heterosexual women.

NAC, and other women's groups that raised objections, demonstrated the importance of a feminist-centred perspective in the regulation of NRTs. They asked the Royal Commission to consider the intersection of race, gender, ability, sexuality, and class identities when proposing regulations. Women's groups also feared that NRTs would be used as instruments in the practice of eugenics. Hence, there was a need to regulate tightly the manipulation of genes and the testing and screening of embryos.

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<sup>201</sup> Royal Commission on New Reproductive Technologies, *Proceed with Care*, vol 2 (Ottawa: Minister of Government Services Canada, 1993), 929.

<sup>202</sup> CBC, *Interviews* with Dr. Patricia Baird and Gwynne Basin. *Midday*, broadcast date: November 30, 1993. CBC Digital Archives. [http://archives.cbc.ca/health/reproductive\\_issues/clips/3370](http://archives.cbc.ca/health/reproductive_issues/clips/3370) .

<sup>203</sup> Judy Rebick, fax. See note 12.

<sup>204</sup> CACSW, 6.

Minority women's groups<sup>205</sup>

Discrimination, exploitation, and the threat of eugenics were the main themes depicted in the submissions by immigrant and minority women.<sup>206</sup> Their representatives argued that NRTs were oppressive to women and increased inequalities between them. Many of these women, especially those abandoned by their husbands, lived in poverty and were vulnerable to the promoters of NRTs who could use their bodies for reproductive trades and services.<sup>207</sup> Exploitation of foreign domestic labourers was already prevalent in Canada. The “care drain” phenomenon was created by the demand for nannies in homes where both parents worked. Women from developing countries worked as domestic caregivers for little pay, board, and the opportunity to qualify to be sponsored for the immigration process. This largely unregulated labour system has been dangerous for these nannies, who leave their own families to take care of white, middle class women’s children. They are sometimes subject to abuse, given little time off, and endure restrictive living conditions for up to two years. What if a woman were hired as a surrogate for a third party and then forced to raise the child as a secondary caregiver?<sup>208</sup> The threat of further exploitation of this vulnerable group of women was a real concern.<sup>209</sup>

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<sup>205</sup> Minority women’s groups are defined here as immigrant and visible minority groups. Cultural minorities, such as Acadian women’s groups, were not considered because of a lack of sufficient information.

<sup>206</sup> National Organization of Immigrant and Visible Minority Women of Canada. *Brief submitted to the Canadian Royal Commission on New Reproductive Technologies*. Presented by Betty Lee, written by Luanne Leonard. Oct. 19, 1990. LAC RCNRT RG33 1993-94/531, file PH-9-MCT, 1.

<sup>207</sup> Immigrant Women of Saskatchewan. *Brief presented to the Royal Commission on New Reproductive Technologies* by Nayyar Javed, Anne Marie Dilella, and Bonnie Loewen. (October 25, 1990), LAC RCNRT RG33-154, file no. PH-2-SAS.

<sup>208</sup> Ibid.

<sup>209</sup> Arlie Russel Horchschild. “Le Nouvel or du monde,” *Nouvelles questions féministes*, 23, no 3 (2004), 59-74.

Of further concern to minority and immigrant women was the unequal access to the technologies. The lack of available and comprehensive information in languages other than English and the high cost of the technologies, would exclude many of them. Clearly, NRTs were mostly available to white, heterosexual women of the middle and upper classes. To provide information on NRTs in various languages, and to extend provincial health coverage to fertility services, women's groups suggested as the best means to fight against discrimination.

### Gay and lesbian groups

There was little representation of lesbian groups among the documented submissions of the Royal Commission. Members of EGALE (Equality for Gays and Lesbians Everywhere), which was based in Ottawa, stated that the gay and lesbian community chose to stay out of this debate until the fundamental issue of legal recognition of relationship status was addressed.<sup>210</sup> However, they did respond to the potential restriction of insemination only to heterosexual couples. They declared such a decision to be “morally wrong.”<sup>211</sup> According to representatives from EGALE, the desire to parent and raise children was prevalent within their community. To ban gays and lesbians from access to NRTs would further entrench the legal definition of the family as a heterosexual entity, thereby seriously compromising their struggle for equal rights.<sup>212</sup>

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<sup>210</sup> EGALE. LAC RCNRT RG33-154 1993-94/531, file PH-15-OT.

<sup>211</sup> Ibid.

<sup>212</sup> EGALE, *Brief Presented to the Royal Commission on New Reproductive Technologies* by Les McAfee and Cecelia McWilliams, LAC RCNRT RG33-154, file no. PH-15-OT.

Disability rights groups

Disability rights groups such as the DisAbled Women's Network (DAWN Canada) and the Canadian Disability Rights Council (CDRC) felt people with disabilities were the most vulnerable people in society, their bodies having been medicalized just as much as, or more, non-disabled women.<sup>213</sup> Like NAC and minority women's groups, disabled women's organizations saw NRTs as a woman's issue and recognized the threats of exploitation and commodification these presented to women with disabilities. DAWN further denounced the medical community's discriminatory attitudes towards disabled women, which is reflected in the medical community's use of negative terminology such as "defective," "abnormal," and "anomaly" in an attempt to depict this group as "sub-human."<sup>214</sup> Such attitudes, they claimed, helped justify the termination of pregnancies based on discriminatory prenatal screening. Women with disabilities feared NRTs would increase society's intolerance for disability by allowing assumptions and fears about disabled people to remain unchallenged.<sup>215</sup>

The CDRC devoted the first eight pages of its submission to eugenics, the undervalued lives of the disabled, and how NRTs undermined their struggle for equality.<sup>216</sup> Under Nazi Germany, the disabled had suffered tremendously from eugenic practices such as forced sterilization, institutionalization, and murder.<sup>217</sup> The CDRC's opposition to NRTs was mainly based on critiques of selective screening practices that result in the termination of a pregnancy that could produce a child with a disability.

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<sup>213</sup> Ibid., 3.

<sup>214</sup> DAWN Canada, *Women with Disabilities and New Reproductive Technologies (submission, to the Royal Commission on NRTs)*, LAC RCNRT fond RG33-154 1993-94/531, file PH-23-TOR, 1-2.

<sup>215</sup> Ibid., 2.

<sup>216</sup> Ibid., 2-3.

<sup>217</sup> Canadian Disability Rights Council (CDRC), *Final Recommendations to the Royal Commission on New Reproductive Technologies*, LAC RCNRT fond RG33-154 1993-94/531, file PH-39-VAN, 1-2.

This practice not only served to devalue the life of the child, but also placed an added stigma on people whose disability was not genetic. Screening for disability would give the public the false belief that disability could be completely eliminated when, in fact, disabilities are also the result of illness, accident, or age.<sup>218</sup> In summary, the misleading idea that disability could be eliminated in the womb would reinforce negative attitudes toward the majority of disabled people.<sup>219</sup>

The CDRC called to question the promise of reproductive freedom offered by NRTs, which were administered by predominantly male and able-bodied doctors. “[W]here a fetal disability has been detected, women are frequently coerced and compelled to submit to the systematic practice of abortion. This raises serious doubts about how much ‘freedom’ and how much ‘choice’ such technologies really offer women.”<sup>220</sup> Educating society on the realities of living with disabilities, and providing the resources and counseling needed to raise children with disabilities, would ensure true choice in women’s decisions to carry and raise disabled children. The CDRC asked the Royal Commission to make the tight regulation, or prohibition of screening procedures, a priority in their report in order to dispel the threat of a new eugenics movement.

In their submissions, disability rights groups such as DAWN and CDRC spoke of another kind of discrimination which threatened them more specifically. Disabled women were perceived as not having a sexual life; “an ablest society in its extreme bigotry has tried to make disabled women invisible, cancelling out our sexuality so it

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<sup>218</sup> The Canadian Disability Rights Council, *Disability Rights and the New Reproductive Technologies: A Brief to the Royal Commission on Reproductive Technology*, (November, 28, 1990) LAC RCNRT RG 33-154, File PH-39-VAN, 7.

<sup>219</sup> *Ibid.*, 2.

<sup>220</sup> The Canadian Disability Rights Council, 5.

will not have to be dealt with.”<sup>221</sup> Women with disabilities articulated the stigma they felt over parenthood, the perception that their disabilities would be passed on to their children, placed on them by an ableist society. History had already recorded the forced sterilization of the disabled.<sup>222</sup>

### *Views from women in religious groups*

To examine the views of a selected number of religions provides a useful comparative perspective. Many of these religious groups consisted of women’s organizations, such as the National Jewish Council of Women of Canada, the Muslim Women’s Auxiliary, and the Catholic Women’s League. Other religious groups were representative delegations of women, such as the Mennonite Central Committee (MCC). Each group’s submission was presented by a woman leader from the community. I chose one representative group from each mainstream religion in Canada, based on the 1991 census: Christianity, Islam, and Judaism.<sup>223</sup> This sample also spans different provinces of Canada: Prince Edward Island, Ontario, Manitoba, and British Columbia.

Interestingly, while these groups defended conservative values with respect to the notion of family and marriage, several of their concerns echoed those expressed by feminist and other women’s groups. First and foremost, these groups opposed any reproductive practices which compromised the integrity and sanctity of human life, especially in relation to aborted fetuses and dead newborn infants. For example, though

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<sup>221</sup> the DisAbled Women’s Network (DAWN), Toronto Chapter, *Brief to the Royal Commission on New Reproductive Technologies*, (November 19, 1990) LAC RCNRT RG 33-154, File PH-50-TOR, 1.

<sup>222</sup> *Ibid.*, 2. Forced sterilizations were in the news at that time as cases from Alberta and British Columbia were coming to the public’s attention and victims were filing lawsuits against the state.

<sup>223</sup> Statistics Canada, *Major religious denominations, Canada, 1991 and 2001*.

<http://www12.statcan.ca/english/census01/Products/Analytic/companion/rel/tables/canada/cdamajor.cfm>

Muslim women did not condone abortion, they felt experimentation on the fetus could potentially improve the health and safety of birthing mothers, but opposed the practice if its sole purpose was to serve the interest of science.<sup>224</sup> The Mennonite Central Committee (Ontario) asked that non-therapeutic fetal research be banned for the same reason.<sup>225</sup> It feared that science would begin to harvest fetal tissue simply for the sake of experimentation, thus encouraging women to abort fetuses. Therefore, many religious groups did not fully oppose NRTs, but condoned those that would benefit mother and child.

Because religious groups place much value on the unique gifts given to each individual by God, women in religious groups opposed genetic screening, and selective abortion informed by prenatal screening to determine disability, sex, and any other characteristic deemed undesirable.<sup>226</sup> Some evoked Nazi Germany to illustrate this point; others dismissed both *positive* and *negative* eugenics, which sought to improve the species, the former through the breeding of individuals with desirable traits, the latter through the elimination of those with undesirable traits.<sup>227</sup> Selective abortion, or the manipulation of genes to obtain a desired trait, was considered ‘playing God.’

The definition of the family was also a great source of concern. For example, the Canadian Organization of Catholic Women for Life, Faith and Family opposed all fertility procedures that were not exclusive to husband and wife. Likewise, the Muslim

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<sup>224</sup> Muslim Women’s Auxiliary, *Brief Submitted to Royal Commission on NRTs*, Royal Commission on New Reproductive Technologies fonds, LAC RCNRT RG33 1993-94/531, file SS-11-MAN, 3.

<sup>225</sup> Mennonite Central Committee, *Brief Submitted to the Royal Commission on New Reproductive Technologies*. Royal Commission on New Reproductive Technologies fonds, LAC RCNRT RG33 1993-94/531, file SS-60-ONT, 20.

<sup>226</sup> Religious groups, of course, oppose abortion anyway. This sanctity of life argument gave the pro-life side of the abortion debate more leverage.

<sup>227</sup> Mennonite Central Committee, 21.

women's auxiliary stated that artificial insemination was only acceptable between a married couple.<sup>228</sup> The act of procreation was to take place between two married, heterosexual partners, and the genetic and reproductive materials used were to be their own. They felt that the use of NRTs that could dissociate reproduction from the rearing of children could undermine the traditional family structure and blur the roles of its members. From a religious standpoint, the use of a third party genetic material was considered an act of infidelity, despite the lack of sexual intercourse with a third party.

Finally, religious organizations opposed any economic motive justifying the use of a NRT, specifically when it came to the purchase of sperm and ova. Children were a "gift from God,"<sup>229</sup> and not marketable commodities; the selling of reproductive material, or the renting of a uterus, should thus be banned.<sup>230</sup> In particular, surrogacy for profit was condemned by the National Council of Jewish Women of Canada on the grounds that it was morally wrong to take a child from a woman, regardless of any financial exchange, because the child had already grown emotionally attached to its mother while in the womb and the mother to the child.<sup>231</sup>

### ***Infertility groups***

When the Royal Commission was announced, the reaction from the Infertility Awareness Association of Canada was one of panic. Infertile couples perceived

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<sup>228</sup> Muslim Women's Auxiliary, 2.

<sup>229</sup> Ibid., 3.

<sup>230</sup> Mennonite Central Committee, 7-8; National Council of Jewish Women of Canada. *Brief to the Royal Commission on New Reproductive Technologies*. LAC RCNRT fonds RG33 1993-94/531, file PH-37-VAN, 4. Catholic Women's League of the Diocese of Charlottetown, *A Submission by the Catholic Women's League of the Diocese of Charlottetown to the Royal Commission on New Reproductive Technologies*, LAC RCNRT fonds RG33 1993-94/531, file PH-3-CH, 3.

<sup>231</sup> National Council of Jewish Women of Canada.

potential federal regulations on NRTs as a threat due to the lack of understanding and sympathy shown to them from a pronatal society. The call went out to members of the IAAC to collaborate on a submission explaining to the commissioners that restricting their access to NRTs was as discriminatory as restricting a disabled person's access to a technology that would enhance his or her quality of life.<sup>232</sup>

Infertile people identified themselves as reproductively disabled; indeed, 53.5% of the IAAC's surveyed membership had affirmed that "infertility is a disability."<sup>233</sup> IAAC member Karen Woolridge wrote, "I ask you [NAC] to hear and to help your reproductively-disabled sisters when they tell you what they need."<sup>234</sup> Their disability forced them to cope with the sadness of not having a child, along with the attitudes that separated them from their families and communities.

The IAAC's submission to the Royal Commission focused on the social pressure to have biological children and the existence of a culture of parenthood from which they were excluded. The ability to procreate, it stated, was the fundamental element of gender (sexual) identity.<sup>235</sup> Yet the infertile felt they were denied this identity because the social perception that the problems faced by the infertile were insignificant. In their submission to the Royal Commission on NRTs, Marie Morrissey of the IAAC declared that the infertile of society were isolated, marginalized, and even excluded from the health care system because they have "unimportant problems." Adding to their

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<sup>232</sup> Nancy Jackson, "The Royal Commission – It's Time to Speak Out!" *Infertility Awareness*, 6, no. 1 (Sept/Oct, 1989), 6.

<sup>233</sup> IAAC's Royal Commission Survey, *Infertility Awareness*, 7, no. 4 (May, 1991), 11.

<sup>234</sup> Karen Woolridge, "A Letter to the National Action Committee on the Status of Women (NAC)," *Infertility Awareness*, 7, no. 4 (May, 1991), 3.

<sup>235</sup> Infertility Awareness Association of Canada (IAAC). *Submission to the Royal Commission on New Reproductive Technologies*, (April 30, 1992), LAC RCNRT RG33-154, file no. PH-9-OT, 1. The use of the word gender was misused by the authors as their position as heterosexual couples likely did not differentiate between gender and sex.

marginalization, she said, was the assumption that they “are often dismissed as guinea pigs” by the fertile members of society when undertaking reproductive treatment.<sup>236</sup>

Furthermore, the IAAC considered infertility a disability based on the biological impairment which excluded them from a child-centred culture. The same IAAC submission dwelled on the pressure to become a biological parent, the dominance of a child-centred society, and the feelings of loss, anger, guilt, and exclusion experienced by the infertile. NRTs allowed the infertile to overcome this disability and to participate in a pronatal society. The IAAC did not consider the dangers of NRTs; rather, it called for unrestricted access to these services, which should be funded under provincial health care systems like most disability services/treatments.

The fertile critics of NRTs had implied that the infertile were naively subjecting themselves to expensive health risks, without understanding the low success rate of the procedures. The IAAC deplored their exclusion from the health care system and the dominant perception that the infertile were selfish for wanting to spend money on NRTs because having children was seen as a privilege not a right.<sup>237</sup> The IAAC asserted that infertile couples were certainly aware of the risks and cost involved in using NRTs, but that they knowingly chose to use them because they felt having children *was* a right.

Representatives from the IAAC publicly opposed the Canadian women’s movement by refuting the claims made by NAC to the Royal Commission. NAC called for strict regulation of a variety of NRTs, including surrogate motherhood, claiming that the fertility industry preyed upon the emotions of the infertile. Infertile women resented the material put forth by NAC and other feminist groups, not only because it ignored the

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<sup>236</sup> IAAC. *Submission*, 2.

<sup>237</sup> *Ibid.*, 2

perspective of the infertile, but because their campaign could seriously limit their access to NRTs.<sup>238</sup> Although feminists were not unified in the debate over the technologies, the dominant opposition to NRTs caused many infertile women to leave NAC.<sup>239</sup>

The pages of the IAAC newsletter and the IAAC submission to the Royal Commission on NRTs depict not only the pain of being childless, but also the sadness and anger felt by those women who had been part of a women's movement that was now excluding them. "I mourned the loss of friends in the women's movement and the loss of the support of the community itself,"<sup>240</sup> said Karen Woolridge, a regular contributor to *Infertility Awareness*. Infertile women who self-identified as feminist, and had lived by the ideology of the women's movement, realized they were now on the margins.

Jennifer Smart wrote:

I do feel betrayed by some feminists who now argue [after fighting for reproductive "choice"] against IVF and other reproductive technologies. My infertility is a sign of the times...[t]hose who believe fertility treatment[s should] be banned or that monies [should] be spent on prevention alone have chosen to view this situation very narrowly. In doing so they have decided to leave out all their 'sisters' who believed in having a choice.<sup>241</sup>

Clearly these women could no longer support NAC's agenda and they were now mourning the loss of their place within the women's movement.

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<sup>238</sup> Nancy Jackson, "The Royal Commission – It's Time to Speak Out!" *Infertility Awareness*, 6, no. 1 (Sept/Oct, 1989), 6.

<sup>239</sup> Woolridge, "A letter," 3.

<sup>240</sup> Karen Woolridge, "Feminism at the Conference," *Infertility Awareness*, 7, no. 5 (July/August, 1991), 12.

<sup>241</sup> Jennifer Smart, "But not Just Prevention," *Infertility Awareness*, 8, no. 1 (Sept/October, 1991), 5.

### *The Canadian Medical Association*

The Canadian Medical Association submitted an extensive research paper to the Commission that discussed NRT policy and development throughout the world, as well as the technologies' potential medical, legal, and social implications in Canada. The CMA's brief made recommendations on screening, surrogacy, genetic experimentation, professional considerations, ethics, education, and accessibility. The CMA stated that the recommendations it made were guided by the principles of autonomy, respect for persons, beneficence, equality and justice. It claimed to approach NRTs with a deep sense of social responsibility and conscientiousness: "[The CMA] believes that...reproductive assistance should never forget that the intended outcome of the use of such technologies is a child, and a child is a person."<sup>242</sup> The CMA warned that once a technology was developed, it would not be easy to limit or prevent its application.<sup>243</sup> Canadians should seriously decide whether or not these technologies should be developed, because once they were created and made available, they would significantly alter medicine and society.

The CMA recognized infertility as a "handicap"<sup>244</sup> and stated that the infertile deserved assistance, including access to surrogacy.<sup>245</sup> It further recognized that having children was a social right and not a duty.<sup>246</sup> Therefore, the infertile had the right to seek assistance to accommodate their disability. The CMA recommended that fertility

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<sup>242</sup> Canadian Medical Association, *Brief to the Royal Commission on New Reproductive Technologies* (February, 1991), LAC RCNRT fond RG33/154 1993-94/531, 267.

<sup>243</sup> *Ibid.*, 267.

<sup>244</sup> *Ibid.*, Recommendation A.6, 97.

<sup>245</sup> *Ibid.*, Recommendation P.2, 105.

<sup>246</sup> *Ibid.*, Recommendation A.1, 97.

treatments be considered a “health service” and be accessible to everyone and publicly funded.<sup>247</sup>

The CMA emphasized the need for education for the general public on parenting, infertility, sexual health, STIs, NRTs, and personal health. Other recommendations involved the medical regulation of technology and research, as well as regulations on the professional conduct of those delivering the reproductive services. It further recommended the monitoring, evaluation, and record keeping of fertility services. It supported the development of NRTs as long as their purpose was to provide a health service, and not for any other commercial or scientific motivation.

Interestingly, the CMA made several recommendations equating fertility services with the adoption system. First, it recommended that children born through artificial insemination have access to donor’s information and, with the progenitor’s consent, know their identity.<sup>248</sup> It also recommended in its report that people who seek fertility services be subjected to the same “...criteria that are considered socially appropriate for deciding whether applicants for adoptions will be deemed suitable parents in a given case.”<sup>249</sup> These criteria would subject infertile men and women to financial and mental health evaluations in order to have biological children.

The CMA’s in-depth study provided the perspective of Canadian doctors, as well as situating NRTs in a global context. It stressed the importance of maintaining the patient’s autonomy over his or her body, and insisted that NRTs not be developed unless the intentions were to keep the body healthy. It considered infertility a disability which

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<sup>247</sup> Ibid., Recommendations D.5, F.1. G.1, G.2., 97-100.

<sup>248</sup> Ibid., Recommendations J.1 and J.2, 102.

<sup>249</sup> Ibid., Recommendation G.4, 100.

deserved public assistance. The CMA also advocated the education of Canadians regarding sexual health, infertility, and technology. It concluded by stating that NRTs had the tremendous potential for good, but that Canadians should consider how such advancements in reproduction would change social and legal definitions of the family and the person.<sup>250</sup>

### Conclusion

Canadian feminist author Heather Menzies told lobbyists at a conference on infertility in 1992 that she wished the women's movement had had a thorough discussion on NRTs before the creation of the Royal Commission. Such a discussion would have presented all sides of the NRT debate and feminists could then have stood united. Instead, she said, the technologies were at the heart of the debate, while women's experiences had been neglected, if not forgotten.<sup>251</sup> The issues and arguments presented in this chapter confirm her view. Indeed, the presentations made to the Royal Commission focused on the *technology*, while the majority of women's groups discounted the lived experiences of childlessness.

The dominant message conveyed by NAC was that NRTs would create a society that would biologically discriminate against women based on gender, race, class and disability, and would turn pregnancy into a commercial enterprise. Genetic testing, screening and manipulation, contract surrogacy, and the globalization of a fertility market presented Canadian feminists with the challenge of convincing the Royal

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<sup>250</sup> Ibid., 268.

<sup>251</sup> Heather Menzies, "Some Thoughts on Writing about Infertility," *Infertility Awareness*, 8, no. 3 (Jan/Feb, 1992), 1.

Commission to consider the effects these scenarios would have on women's lives.

Fearing the political endorsement of a "breeder" culture, NAC dismissed the experiences of involuntarily childless women and fought, instead, against the overmedicalization of women's reproductive capacities.

The women's movement appropriated the arguments of DAWN and other disability rights groups to expose the discriminatory practices in public policy that would be endorsed, should the Royal Commission dismiss feminist concerns. NAC recommended the tight regulation of several services and a ban on surrogate motherhood, but stressed the importance of equal access to the technologies if they were to continue to be developed. The women's movement perceived NRTs as a crisis for women's health, which would further divide women based on race, class, and disability. Public policy would legitimize these divisions and serve to control the reproductive lives of women.

For their part, the IAAC and the CMA argued that public health care money and complete access to the technologies should be considered to afford the infertile with the same rights as those with disabilities. But the CMA cautioned the Royal Commission, and stressed the importance of developing and using NRTs in a closely regulated context, respecting the integrity of the body and the patient's right to education and choice. Like NAC, physicians opposed the commercialization of reproduction and wanted regulation in order to ensure the safety of users.

The IAAC feared regulation would limit their options of conception techniques. As long as they had access to NRTs, they could hope for a successful conception and birth. For their part, infertile women felt empowered by NRTs as they provided them

with options. Both the NAC and the Canadian government, however, completely dismissed their point of view.

“Choice” meant something different during this debate than it did during the debate over access to birth control and abortion where it meant women’s control over their reproduction and choose not to be pregnant. The rhetoric of choice used by NRT supporters led NAC to try and persuade the Royal Commission into perceiving NRTs as a threat to women’s freedom and the freedom of the disabled. In doing so, NAC discounted the experience of childlessness, dismissed the infertile as vulnerable to scientific ambition, and argued that the use of NRTs by the infertile would threaten the freedom of all women’s bodies.

## Chapter 5

### *The Royal Commission on New Reproductive Technologies: Dissent and Deception*

The Royal Commission on New Reproductive Technologies ended up disappointing those groups which had hoped it would produce the world's first comprehensive study on NRTs by looking at their economic, social, legal, and medical dimensions. Furthermore, the Royal Commission lost the support of its strongest promoters, NAC and the Canadian Coalition for a Royal Commission on New Reproductive Technologies, halfway through its mandate. Controversy, in-fighting, political tampering, and evidence of bias generated widespread criticism even before the Commission released its report. The two-volume report, *Proceed with Care*, submitted 293 recommendations regarding NRTs, genetic research, contract surrogacy and the prevention of infertility, but it was negatively received by feminists and by the many interest groups which had originally requested the creation of the Commission.

This chapter will first discuss the events that tarnished the Commission's reputation. It will then examine the report and its reception by the major stakeholders we have examined in this thesis: NAC, the IAAC, DAWN, and the CMA. As we shall see, all these groups had come to doubt the validity of the Royal Commission's research and of the impending report due to the controversial events reported in the media, the firing of four Commissioners, and to the two deadline extensions granted to the

Commission by the federal government. Many of the groups that had vested interests in the Commission's work reported on its flaws as they perceived them, as well as their own disillusionment over a report that fell short of all their expectations. After the report's release, NAC, DAWN, and the IAAC engaged in a public critique of the Royal Commission's work. While the CMA shared many of the concerns expressed by these other groups, it did not openly express them, maybe to show professional courtesy for their fellow physician, Dr. Baird.

### ***The Royal Commission: Internal Dissent***

Expectations for the Canadian Royal Commission on New Reproductive Technologies were high.<sup>252</sup> It was hoped that the \$24.7 million<sup>253</sup> budget for the Commission would be used to conduct meaningful multidisciplinary research examining the technologies' biological effect on women, an aspect neglected by previous UK and Australian studies.<sup>254</sup> Instead, the Commission had to deal with internal dissension, a high turnover of its staff, a controlling Chairperson, and overall mismanagement that resulted in a tardy and, for many, unsatisfactory report.

The most controversial issue was the dismissal of four dissenting commissioners, Maureen McTeer, Louise Vandelac, Martin Hébert, and Bruce Hatfield. These four had pressed for information regarding the research agenda, the budget, the roles and responsibilities of the commissioners, the awarding of research contracts, and the hiring

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<sup>252</sup> Pollak, "Royal Commission a Volatile Mix."

<sup>253</sup> Christine Marguerite Massey, *The Public Participation Program of the Royal Commission on New Reproductive Technologies: An Evaluation*, (MA thesis in Communications for Simon Fraser University, 1994), 58.

<sup>254</sup> Patricia Spallone, "Reproductive Technology and the State," 166 - 171.

of office staff.<sup>255</sup> Their repeated requests for ‘in-camera’ meetings (without office staff) to discuss these issues were repeatedly denied by Baird. Increasingly disillusioned, they retaliated by boycotting the Commission’s meetings, thus halting its work due to lack of quorum. In an unprecedented move, Prime Minister Mulroney then appointed two additional commissioners, Susan McCutcheon and Bartha Maria Knoppers,<sup>256</sup> to ensure quorum could be reached without McTeer and the others.<sup>257</sup> The situation endorsed Baird’s authoritarian managerial style and tensions escalated to the point where the four dissenters filed a Statement of Claim against the government and Baird on December 6, 1991. Their main grievances were that Baird was working under her sole authority; the four plaintiffs were excluded from every important decision regarding the research, communication, and financial priorities of the commission; and that these four plaintiffs were denied the opportunity to participate in the Commission’s work.<sup>258</sup>

Ten days later, the four plaintiffs were fired to “ensure,” as it was officially stated, “the continued viability of the Commission and its ability to fulfill its mandate.”<sup>259</sup> In fact, this tactic would help the government keep the plaintiffs away from the courts as their case was over the sharing of information and the distribution of duty and, since they were no longer commissioners, would not have grounds to pursue their case. Moreover, the House had just adjourned for Christmas; this timing prevented debate and critique of the government’s actions until Parliament reconvened.

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<sup>255</sup> Hébert, Vandelac, McTeer and Hatfield, letter to Paul Tellier, Secrétaire général du Conseil Privé, June 26, 1990. Included in Federal Court file No. t-3035-91 (Dec 6, 1991).

<sup>256</sup> Susan E.M. McCutcheon was a teacher and held several corporate directorships. Bartha Maria Knoppers was a law professor at the Université de Montréal., who specialized in human genetics.

<sup>257</sup> Eichler, “Frankenstein Meets Kafka,” 200.

<sup>258</sup> McTeer et al. Statement of Claim, t-3035-91, 273 – 284.

<sup>259</sup> McTeer, *In My Own Name*, 221.

Officially, there was no explanation as to why the Commission conducted its business with such secrecy, including enforcing the signed privacy statements to an extreme level. Some staff members decided to expose anonymously their own experience in a two-volume critique of the Royal Commission entitled *Misconceptions: The social construction of choice and the new reproductive and genetic technologies*.<sup>260</sup> They feared severe consequences for speaking publicly because they had earlier signed a “gag order” which prohibited them from discussing even trivial office matters. Usually, confidentiality forms protect information regarding the research, meetings, and sensitive materials handled by government agencies, not routine office activities. Office staff remained anxious and was unwilling to speak publicly even after the Commission’s mandate was over, for fear of legal action. This strict secrecy created an environment of paranoia. Staff was allegedly under surveillance, and workers were fired for having interactions with the wrong people, or for making statements contradicting the dominant views of the Commission’s chair.<sup>261</sup>

Such secrecy surrounding a massive publicly funded research project drew the attention of professional organizations such as the Canadian Association of University Teachers and the Social Science Federation of Canada (SSFC).<sup>262</sup> The latter group established a task force that repeatedly requested information from the Commission

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<sup>260</sup> This collection of essays from feminist critics, including McTeer, Vandelac, and former NAC president Judy Rebick, was edited by former Royal Commission supporter, Margrit Eichler, and members of NAC’s special committee on NRTs Gwynne Basen and Dr. Abby Lippman, a professor of biology and genetics at McGill University.

<sup>261</sup> Anonymous 5, *Misconceptions: The social construction of choice and the new reproductive and genetic technologies*, Gwynne Basen, Margrit Eichler, Abby Lippman (eds). (Hull, Quebec: Voyageur Publishing, 1993), 232.

<sup>262</sup> Massey, 93. The Canadian Association of University Teachers represented 60,000 professors in Canada and the SSFC represented over 15,000 Canadian social scientists.

regarding its research.<sup>263</sup> Its letter to Baird asked to clarify the Royal Commission's research mandate and release information on contracts awarded, the peer review process, and the reasoning behind the veiled activities regarding the Commission's business.<sup>264</sup> The SSFC did not get its requested information and publicly called into question the integrity of the Commission's research.<sup>265</sup>

Groups like NAC, DAWN and the IAAC questioned the legitimacy of the Commission, both before and after the dismissal of McTeer, Hébert, Vandelac, and Hatfield, primarily because those with disabilities or from the infertile community had no representation on the Royal Commission. Furthermore, after the removal of these four members, the Commission had no more representation from men, or from Québec, and it had lost its only practicing physician, Dr. Hatfield. Significantly, the only two Commissioners who were determined to pursue their mandate with a feminist agenda, Vandelac and McTeer, had been removed. These drastic actions taken by the government seriously undermined the credibility of the Commission.

### ***“Proceed with Care”: Main Resolutions***

*Proceed with Care* discussed many of the issues it heard at the public hearings held in 1990 and 1991. Its guiding principles were based on what the remaining Commissioners understood to be the values of Canadian society as gleaned from surveys and presentations made at public hearings. These principles were individual autonomy, equality, respect for human life and dignity, protection of the vulnerable, non-

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<sup>263</sup> Eichler, *Frankenstein Meets Kafka*, 211. .

<sup>264</sup> Massey, 93.

<sup>265</sup> *Ibid.*, 93.

commercialization of reproduction, appropriate use of resources, accountability, and balancing individual and collective interests.<sup>266</sup> The report made 293 recommendations, which included the creation of a regulating body, the prohibition of various practices involving the commercialization of genetic material and genetic experimentation altering the gene line under the Criminal Code, and the licensing and monitoring of fertility services. These recommendations addressed the main concerns of women's groups, such as the medicalization of the body, as well as legal, ethical, medical, and moral areas of concern. The report's assessment of NRTs stated these technologies should not be used to discriminate, eugenically or otherwise, against any person based on race, sexual orientation, or class.<sup>267</sup>

The report's most significant recommendation was the creation of a regulatory body comprised of representatives from both sexes, all regions, disabilities, minorities, and infertility groups. The independent National Reproductive Technologies Commission would be charged with regulating the technologies to serve the public's interest.<sup>268</sup> It would be responsible for setting guidelines, licensing fertility clinics that offer IVF and artificial insemination, inspecting these clinics and enforcing the regulations. It would also monitor technological developments and adjust regulations according to changing social values. The model for this Commission would be that of the existing National Transportation Agency and the Canadian Radio-Television and

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<sup>266</sup> Ibid., 52 – 59.

<sup>267</sup> Royal Commission on New Reproductive Technologies, *Proceed with Care*, vol. 2 (Ottawa: Minister of Government Services Canada, 1993), 737.

<sup>268</sup> Ibid., 112. Recommendation 1.

Telecommunications Commission (CRTC), both of which take care of the licensing, monitoring and advisory functions of these services.<sup>269</sup>

### ***Reaction to “Proceed with Care”***

#### *The National Action Committee on the Status of Women*

The Royal Commission on NRTs had lost the support of NAC following the dismissal of the four dissenters. As indicated earlier, the Commission was left with five white, middle class women, none of whom understood the needs and concerns of women’s groups, and led by a geneticist. NAC questioned the legality of the firings and the legitimacy of the Commission itself.<sup>270</sup> It called for the disbandment of the Royal Commission, and it urged its member groups to boycott it on the basis that 45% of the Royal Commission’s membership had been dismissed, and because of the overwhelming influence the pharmaceutical and medical industries would be able to exert on the Commission.<sup>271</sup>

Not surprisingly, Margrit Eichler, who had headed the Canadian Coalition for a Royal Commission on New Reproductive Technologies, became one of the Commission’s fiercest critics. “We are in the position of the horrified parents who find their child horrendously transformed,” she declared in 1993.<sup>272</sup> Eichler teamed up with

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<sup>269</sup> Ibid., 114.

<sup>270</sup> NAC, Dossier d’information, La commission royale sur les nouvelles techniques de reproductions: Le processus a échoué – le rapport est-il fiable?, CWMA NAC X10-1 box 68 file NAC Press Releases 1991-94 (2 of 2), 2.

<sup>271</sup> NAC Press release, “NAC Calls for Disbanding and Boycott of Royal Commission on New Reproductive Technologies,” (no date).

<sup>272</sup> Basen et al., *Misconceptions*. 217. Methodological note: There was a very high turnover rate in staff at the Royal Commission on NRTs. The accounts that Eichler has noted in her text are anonymous and they could possibly express hostility toward those in charge. Eichler does quantify her research data, however, by detailing the percentage of respondents who had positive and negative dealings with the

other critics of NRTs, such as Gwynne Basen, who headed NAC's NRT Committee and was a pioneer in the women's health movement. They joined forces to publish the aforementioned damning appraisal of the Royal Commission on NRTs (*Misconceptions*) even before the report's release. They found that the conduct of the Commission and its staff, as well as its research and its evaluation of the issues, were largely deficient.

NAC argued that the Royal Commission's report merely proposed to regulate NRTs instead of effectively addressing their impact on the shifting definitions of "family," "parents," and "child." At their 1994 Annual General meeting, NAC members supported DAWN in denouncing the Royal Commission's final report because of its "neglect of all concerns expressed by women with disabilities, and its use of biased, discriminatory and otherwise ableist language."<sup>273</sup> By endorsing pre-natal genetic testing, the report further failed to address the eugenic implications of NRTs: "What does this say about a society that won't accept the disabled, and won't tolerate difference?" asked then-president of DAWN, Joan Meister.<sup>274</sup> Tannis Doe, a feminist researcher and member of DAWN and the Disability Rights Council, wrote, "the problems faced by people with disabilities and their families are not related to genetics or even biology, but to systemic barriers and discrimination."<sup>275</sup> These barriers and this kind of discrimination were condoned by the report and by the segment of the medical profession that stated that it would be "socially irresponsible" to give birth to a child

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commission and acknowledges positive responses in her text. See her explanation of her research on page 204 of *Misconceptions*.

<sup>273</sup> NAC., resolution 500.40.13/95. Index of Abridged Resolutions 1972-1995. Canadian Women's Movement Archives (CWMA), University of Ottawa. Box 62, file NAC – Constitution index to resolutions and related material 1993-1995 (1 of 2). 44.

<sup>274</sup> Joan Meister as quoted in Shannon E. Ash's article "The Royal Commission on NRTs: Less...in 1,200 pages," *Kinesis*, (February, 1994): 4.

<sup>275</sup> Tannis Doe. "The New Reproductive Technologies: Discriminating Misconceptions of Choice," *Herizons*, vol 8, no. 1 (Spring, 1994): 44.

with a genetic disorder when the technology exists to screen for these problems.<sup>276</sup> The humanitarian argument, in this case, was a smoke screen for what doctors perceived as a cost-effective way to deal with the disabled.<sup>277</sup>

The absence of any discussion of the economic dimension of NRTs and of biomedicine was also raised. According to Laura Sky, the NAC secretary and founding member of the Feminist Alliance on NRTs, pharmaceutical and biotechnology companies ranked first in Canada in terms of growth and profitability, and figured among the highest ranking manufacturing sectors worldwide.<sup>278</sup> She and Basen criticized the report for not having included any analysis of the implications the North American Free Trade Agreement (NAFTA) might have on the health care system and reproductive technologies. Coupled with the new Patent Act, Bill C-91,<sup>279</sup> NAFTA would effectively transfer the control over regulations from the government to the private sector.<sup>280</sup> The privatization of services, such as fertility clinics, would have serious economic implications due to the different provincial Medicare coverage of reproductive technologies. According to feminist economists Lorna Weir and Jasmin Habib, it was imperative that the Canadian reproductive technology industry be situated

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<sup>276</sup> Gwynne Basen. "The New Reproductive Technologies: Genetics, Manipulation and the Corporate Connection," *Herizons*, vol 8, no. 1 (Spring, 1994): 44.

<sup>277</sup> Basen and Doe, *Herizons*. 44.

<sup>278</sup> Laura Sky, "Commercial Interests and New Reproductive Technologies," *Canadian Women's Studies/Les cahiers de la femme*, vol 14, no. 3 (Summer, 1994): 105.

<sup>279</sup> Bill C-91 was the amended version of Bill C-22 to accommodate NAFTA, Margaret Smith, "Patent Protection for Pharmaceutical Products in Canada – Chronology of Significant Events," Depository Services Program, PBR 99-46E. (March 30, 2000). <http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/BP/prb9946-e.htm>

<sup>280</sup> Sky, 107.

in the world context to envisage NAFTA's potential impact on health care and reproduction.<sup>281</sup>

In addition, the Royal Commission did not assess the true impact of NRTs from a legal, philosophical and ethical standpoint; instead the report approached the problem from a purely regulatory angle. "Dr. Baird saw the issues narrowly, as being questions of management that could be handled through regulatory measures, such as a stricter definition of informed consent"<sup>282</sup> concluded dismissed commissioner Maureen McTeer. While acknowledging that up to 80% of treatments were under-researched, hence the call for more "evidence based medicine,"<sup>283</sup> the final report did not question the systems and bias underlying scientific and medical research and practices.<sup>284</sup>

Baird's approach to regulation was highlighted in the four broad topics the Commission pursued: the prevalence, risk factors, and prevention of infertility; methods of assisted human reproduction; prenatal diagnosis techniques and genetics; and research involving human zygotes and embryos and involving fetal tissue.<sup>285</sup> Thus, the report considered all types of technology instead of opting for a more thematic approach, such as what the technologies would mean for the lives of the disabled, and how it would change the definition of mother, father and child. Additionally, Baird's priorities were questioned because of the strong representation from medical and pharmaceutical firms at the consultation sessions.<sup>286</sup> Sky, Basen, Weir and Habib, suggested that the omission

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<sup>281</sup> Lorna Weir and Jasmin Habib, "A Critical Feminist Analysis of the Final Report on New Reproductive Technologies," *Studies in Political Economy*, vol 52 (Spring, 1997): 144.

<sup>282</sup> Maureen McTeer, "The Body of Politic: Temple or Bazaar," *Herizons*, vol 8, no. 1 (Spring, 1994):22.

<sup>283</sup> RCNRT, *Proceed with Care*, 70.

<sup>284</sup> Weir and Habib, 143, 149.

<sup>285</sup> RCNRT, *Proceed with Care*, 5.

<sup>286</sup> RCNRT, *Update*. (Ottawa: Royal Commission on New Reproductive Technologies, August 1992), 10. Consultations were separate from the public hearings.

of critical views on NRTs was likely due to a situation of conflict of interest, as due to by the fact that some of the Commission's research was conducted by public relations firms that counted pharmaceutical companies as their clients.

Women's groups, however, were not displeased with all aspects of the Commission's final report. Nevertheless every bit of praise was qualified with an explanation for why the recommendations did not go far enough. For instance, some feminists supported the Commission's recommendation to ban the exchange of genetic material and birthing services like surrogate contracts. However, they also pointed out that a complete ban would not necessarily protect vulnerable women but instead drive practices like surrogacy underground, much like the Criminal Code did to women seeking safe abortions prior to 1988.<sup>287</sup>

In sum, feminists were deeply disillusioned with the report and the flawed process that led to its publication. "It's not much to come to these conclusions after 4 years... It's very sad that we spent \$28 million just to condemn practices that were already condemned,"<sup>288</sup> lamented dismissed commissioner Louise Vandelac in the *Globe and Mail*, a national newspaper. NAC would continue to discuss NRTs and make resolutions against genetic experimentation well into the 1990s, demanding a full education campaign – a task they felt should have been undertaken by the Royal Commission. NAC resolved to lobby for a moratorium on the funding of research projects that aimed to expand the clinical applications of NRTs and genetic technologies

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<sup>287</sup> Massey and Morrison. 4.

<sup>288</sup> Louise Vandelac as quoted in Rod Mickleburgh, "Panel was mired in Controversy," *The Globe and Mail*, (Nov 30, 1993): A6.

until regulatory guidelines were put in place. This moratorium did not happen and NRTs continued to develop.

*DisAbled Women's Network (DAWN)*

Through its periodical, entitled *Thriving*, DAWN Canada discussed how the final report of the Royal Commission on NRTs reinforced the stereotypes, ignorance and prejudice against disabled individuals in Canada, thus furthering their invisibility in society.<sup>289</sup> DAWN opposed the use of discriminatory language, the prenatal screening and selection of recommended embryos, and the impact the recommendations would have on the public's perception of disability.

For example, chapters 25 to 28 of the Royal Commission's report examined prenatal testing in its social context and the resulting discrimination.<sup>290</sup> The report articulated the concerns of people with disabilities and acknowledged the discrimination against certain types of fetuses inherent in screening practices.<sup>291</sup> Recommendations 207 to 213, however, made provisions such as counseling services for parents and others seeking prenatal screening and for those who wished a "termination because of a fetal disorder."<sup>292</sup> Any practice of prenatal testing and selection was perceived as discriminatory by disability groups, a view which the Commission finally dismissed in its recommendations. "All pregnant women in Canada should have reasonable access to

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<sup>289</sup> Maria Barile, "Exclusion et la Commission Royale d'Enquête," *Thriving*, (French edition) (September, 1994): 13.

<sup>290</sup> RCNRT, *Proceed with Care*, 729 – 919.

<sup>291</sup> RCNRT, *Proceed with Care*, 736. The word choice is disputed by DAWN. This is discussed below in DAWN's critique.

<sup>292</sup> RCNRT *Proceed with Care*, 780, 784.

prenatal testing,”<sup>293</sup> the report concluded, because, based on the rhetoric of choice, Canadians could choose not to have a disabled child.

Moreover, DAWN condemned the language used in the report because it tended to reinforce the prejudices of an ableist society. The report referred to the fetus with genetic disabilities as abnormal and defective while constructing a non-disabled fetus as healthy: “An abnormal result in one of these tests suggests that the fetus has an increased likelihood of having a congenital anomaly.”<sup>294</sup> The conceptualization of disability as unhealthy disempowered the disabled and sent society the message that they were defective or less than human. The inclusion of such language in the report would only lead to continuing discrimination against disabled people.

Scientifically reinforced discourse constructing disability as preventable would place further stigma on the parents of children with disabilities as well as reduce the value of those children’s lives. According to DAWN, only three out of every 100 children were born with genetic disorders, with the rest linked to environmental factors or an accident.<sup>295</sup> Put crudely, screening would only eliminate three percent of the disabled population, while spreading the belief that disability was preventable through selective abortion. In sum, DAWN declared that none of its concerns were considered in the report. Rather, the testimony by DAWN was treated as a curiosity,<sup>296</sup> thus sending a clear message that disabled people do not matter.<sup>297</sup>

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<sup>293</sup> Ibid., 807. Recommendation 219.

<sup>294</sup> RCNRT, *Proceed with Care*, 751.

<sup>295</sup> Eileen O’Brien, letter, *Thriving*, (September, 1994): 8. O’Brien was a member of the editorial board.

<sup>296</sup> Ibid., 12.

<sup>297</sup> Barile, 12.

*Infertility Awareness Association of Canada*

The IAAC had its own concerns with the Commission and its report prior to its release in 1993. Members of the IAAC said that they were once again being forced to wait for a judgment on their future.<sup>298</sup> One IAAC member felt patronized by the Commission's principles:

One of these [principles] is 'protection of the vulnerable', which they specify, includes 'individuals seeking to use NRTs,' I protest. I am neither vulnerable nor am I a victim of science, medicine, or technology. I do not want your protection. I have a physical disability but I am a free, thinking person who is capable of making up my own mind about whether a medical technology is safe and effective (providing, of course, that I have easy access to current information.<sup>299</sup>

Some IAAC members felt vindicated in the Royal Commission's acknowledgement of infertility as a legitimate health issue.<sup>300</sup> They were also pleased that the licensing of fertility clinics was recommended, thus ensuring regulated and uniform standards of safety and information. The IAAC deplored, however, the Commissioners' bias as reflected in the prohibition of some technologies, such as surrogacy.<sup>301</sup> The trend in the last decades, they stated, had been to decriminalize reproductive practices such as contraception and abortion, yet methods to become pregnant would be criminalized.<sup>302</sup>

Finally, the IAAC perceived recommendations for more evidence-based medicine as a threat that would limit their access to technologies. According to the

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<sup>298</sup> IAAC, "It's all about having choice," *Infertility Awareness*, vol 8, no. 4, (April/May 1992): 2.

<sup>299</sup> Karen Woolridge, letter, *Infertility Awareness*, vol 9, no.1 (April, 1993), 3.

<sup>300</sup> Dr. Arthur Leader, "Royal commission Report: What does it mean to the infertile?" *Infertility Awareness*, vol 10, no. 1 (February, 1994): 1.

<sup>301</sup> *Ibid.*, 5.

<sup>302</sup> Jamie Cameron, "Reproductive Choice and Technology," *Infertility Awareness*, vol 10, no. 1 (February, 1994): 8.

report, evidence-based medicine was “the medical practice and management of the health care system based on knowledge gained from appropriate evaluation of treatments and their results...”<sup>303</sup> Therefore, proof of success and safety standards would be required before a patient could use these technologies. Waiting for proven successes would severely limit an infertile person’s access to such procedures as invitro fertilization, as it has a low success rate, costs thousands of dollars per cycle and requires drugs which had not yet been subjected to long term studies on their long term effects.

The Royal Commission insisted that its call for more evidence-based medicine was motivated with the health and safety of women in mind. The Commission cited the examples of the Dalkon Shield, diethylstilbestrol (DES), and thalidomide as examples of harmful applications of medical technologies that were not subjected to long term studies on their safety and effectiveness and yielded tragic results.<sup>304</sup> Yet, despite the absence of evidence-based medicine, infertile couples wished to secure access to all procedures and technologies.

### *The Canadian Medical Association*

The Royal Commission was first mentioned in the CMAJ in May 1989, shortly after it was established. The headline of the two-paragraph article indicates that the CMA welcomed the Commission. The editors were not simply paying the Commission lip-service. Dr. John O’Brien-Bell, president of the CMA, was the spokesperson on this subject; he explained the establishment of this Royal Commission came after the CMA’s

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<sup>303</sup> RCNRT, *Proceed with Care*, 70.

<sup>304</sup> *Ibid.*, 71.

Board of Directors passed a resolution to “support a national, formal process to increase public awareness about the issues raised by such technologic advances.”<sup>305</sup> The CMA resolution was focused on the ethics of NRTs and the need for involvement from the community and especially from women.

Several years later, however, the once highly acclaimed Royal Commission on NRTs was subjected to criticism from Charlotte Gray, the same feminist writer who had praised Baird and the commissioners at the time of their appointment. This commission was now accused in the CMAJ of being a ‘smoke screen’ to divert attention from “Ottawa’s inactivity in other areas” and alleged the Canadian government had set the commission up for failure from its inception.<sup>306</sup> Permitting an outsider like Gray to target the Commission allowed the CMA to put the alarmists’ message out to its membership without compromising their professional integrity and openly repudiating their colleague.

Gray went along with her feminist colleagues in accusing the Commission of pandering to groups with “voted [financial] interest,” and of conducting biased research. By bringing to light conflicts between feminist Commissioners, McTeer, Vandelac, and Baird, calling attention to the absence of a research agenda and by interviewing Commission critics such as Dr. Abby Lippman, former Liberal Health Minister Monique Bégin, and feminist writer Ann Pappert, Gray transmitted to the CMA views which

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<sup>305</sup> CMA, “Royal commission on reproductive technology welcomed by CMA,” *Canadian Medical Association Journal (CMAJ)*, 140, no. 10 (May 15, 1989): 1188.

<sup>306</sup> Stated by former Liberal Health Minister, Monique Bégin. Charlotte Gray, “Controversial ‘reprotech’ royal commission faces growing criticism,” *CMAJ*, vol 145, no. 10 (Nov 1991): 1371. Gray authors one more article on NRTs in 1994 and continued to contribute to the CMAJ until 2003, writing on feminist issues and critiquing government health policy.

reflected NAC's now critical views on the Royal Commission.<sup>307</sup> However, Baird was given the opportunity to save face by publishing an article in the *CMAJ* on the Commission's research into reproductive hazards in the workplace. The article appeared in 1993, just prior to the report's release.<sup>308</sup>

Overall, it seems that the CMA preferred to let others publicly criticize the Commission while refraining from passing judgment on Baird's work. CMA president John Williams did not comment on the Commission's final report. Rather, he stated: "The report was directed to the federal government and unless it decides to take some action, there is little reason for us to comment."<sup>309</sup> In 1994, Gray once again published an article on the Commission and its report. She outlined the controversy over research contracts, the extended deadlines and the budget, and she deplored the narrow scope of the report which was largely restricted to medical and legal issues.<sup>310</sup> Gray's reporting style, however, was much more neutral than in the past. Her tone was less accusing and more objective. She had said enough to the members of the CMA. Professional courtesy would stand in for any more criticism.

Several articles appeared in the following months concerning some of the report's recommendations. One issue contained a series of articles allowing for a conversation involving the Canadian Fertility and Andrology Society (CFAS) and Dr. Donald Rieger, a physician and associate professor in the Department of biomedical Sciences at the University of Guelph, with Baird herself as the respondent. The CFAS

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<sup>307</sup> Feminist journalist Ann Pappert had been hired to conduct some studies on NRTs but was, at the time of Gray's interview, preparing a lawsuit against the Commission.

<sup>308</sup> Patricia A. Baird, "Reproductive hazards and the workplace," *CMAJ*, vol 147, no. 2 (July 1992): 157.

<sup>309</sup> John Williams as quoted by Charlotte Gray, "The report on new reproductive technologies: will it lead to change, or gather dust?" *CMAJ*, vol 150, no. 2 (January, 1994): 267.

<sup>310</sup> Gray, "Controversial 'reprotech' royal commission faces growing criticism," 267. This was the comment of Dame Mary Warnock who headed the UK Warnock Report on NRTs.

and Dr. Rieger both stressed the importance of scrutiny before considering implementing any of the recommendations. The CFAS opposed some of the recommendations, such as the banning of surrogate motherhood, stating that some of the restrictions were unnecessary.<sup>311</sup> Rieger opposed the restrictions recommended on, for example, the altruistic donations of ova for research purposes.<sup>312</sup> Baird diplomatically addressed their concerns. She reiterated the necessity for a regulating body and outlined the Commission's rationale behind its restrictive approach.<sup>313</sup>

Critiques of the Royal Commission disappeared from the pages of the *CMAJ* after 1994. After this point the *CMAJ* was focusing more on the research elements included in the Commission's report.

As we have seen, the groups most interested in the Commission's final report ended up being the most critical of its recommendations. Except for the CMA which remained rather quiet, at least officially, other groups such as NAC and DAWN openly expressed their discontent. They denounced the report's perpetuation of discrimination in Canadian society and its narrow scope. As a result, feminists, disability rights groups and the infertile felt they had no other choice but to continue debating the implications of NRTs, how they should be regulated, what should be restricted, what effects they would have on women, and to what end should they be allowed to develop.

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<sup>311</sup> CFAS, "Response to the report of the Royal Commission on New Reproductive Technologies: a summary," *CMAJ*, vol 151, no. 10 (November, 1994), 1430.

<sup>312</sup> Donald Rieger, "Gamete donation: an opinion on the recommendations of the Royal Commission on New Reproductive Technologies," *CMAJ*, vol 151, no. 10 (November, 1994), 1433.

<sup>313</sup> Patricia A. Baird, "New reproductive technologies: the need to ensure that uses in Canada are safe, effective and in the public interest," *CMAJ*, vol 151, no. 10 (November, 1994): 1439-1442.

## Conclusion

The Royal Commission on New Reproductive Technologies represents a major episode in the history of the contemporary Canadian women's movement and of the politics of reproductive choice. This thesis has focused on the establishment and work of the Royal Commission on and the conflicting interests of women regarding NRTs. As we have seen, debate over NRTs vividly illustrates how the shifting content of the "rhetoric of choice" put NAC under considerable external and internal pressure regarding its claim to speak on behalf of all Canadian women.

This thesis also provides insights into the organization and advocacy work conducted by the little-studied Canadian women's health movement. Through the efforts of women's health activists working under NAC, the Royal Commission on NRTs was established to study their potential advantages, risks, and impact on Canadian society. The resulting debates on women's health issues propelled the women's health movement to the national stage.

The national debate over NRTs during the Royal Commission's mandate also showcased the views of infertile women, another seldom-heard group. Their perspective derived from their perceived exclusion from a child-centred society. The inability to conceive or to carry a fetus to term shaped their self-identification as a disabled group which had the same rights for accommodation as other individuals with disabilities. This led to increasing tensions between infertile and fertile feminists with both sides clashing over the meaning of "reproductive choice".

The “rhetoric of choice,” which had previously spearheaded the campaigns for abortions was thus appropriated by the infertile and by other supporters of NRTs to advocate that a woman has a right to choose to have children by artificial means, if desired or necessary. Their views were contested by NAC, which claimed to speak on behalf of all women. NAC perceived NRTs as an attempt by doctors and scientists to tighten their control of women’s bodies. The women’s health movement feared that NRTs would reverse the gains giving women more control over their reproductive functions. Furthermore, women’s groups within NAC, such as disability rights groups and minority women’s groups, opposed NRTs on the basis that they could be used to discriminate against these women, through measures restricting their access to these technologies or through eugenic practices aimed against them. Offering reproductive choice to white, middle class women could potentially lead to the exploitation of poor women of colour, or disabled women, by creating a breeder class, or to the creation of a market for reproductive materials such as eggs, sperm, and embryos. Since all these arguments against NRTs did not consider the experiences of infertile women, NAC became the target of anti-feminist medical and of NRT supporters.

The debate over NRTs and the work of the Royal Commission also demonstrates the tensions between NAC and the Canadian government between 1989 and 1993. The appointment of only two feminist commissioners, and their dismissal two years later, was only one indicator of the deteriorating relationship between the Mulroney government and the Canadian women’s movement. Funding cuts targeted at women’s groups and the government’s refusal to meet with NAC during their lobby sessions also testified to the hostility between government and feminists.

As feminists had anticipated, the Royal Commission's report did not lead to effective regulatory measures. The Liberal government of Jean Chrétien, elected in 1993, shelved the report. Rather, the Standing Committee on Health established a special committee, under the leadership of MP Bonnie Brown, to produce a report on NRTs, which consulted with stakeholders who were not part of the original process between 1989 and 1993. The Brown Report, published in 2001, resulted in three failed attempts to pass a bill on the regulation of NRTs.

By the time Bill C-6 was successfully passed, eleven years after the release of the Royal Commission's report, NRTs were referred to as Assisted Human Reproductive Technologies (AHRT).<sup>314</sup> The Assisted Human Reproduction Agency of Canada (the Agency), the legislated regulatory body on NRTs recommended by Bill C-6, was not established until 2006, under the Conservative government of Prime Minister Steven Harper.<sup>315</sup> The Agency's mandate was to enforce the regulations outlined in Bill C-6 and to advise the Minister of Health on matters governed by the act, to conduct research, collect data, and review licenses.<sup>316</sup>

The debate over NRTs is still relevant today; indeed, NRTs in Canada remain unregulated because the Agency has not been able to accomplish its mandate due to conflicts among board members and legal cases debating Bill C-6. In Canada, C-6 was successfully challenged by the province of Quebec, which argued that the regulation and promotion of NRTs fall under the jurisdiction of provincially controlled health care and

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<sup>314</sup> Alison Harvison Young, "Let's Try Again... This Time with Feeling: Bill C-6 and New Reproductive Technologies," *UBC Law Review*, 38, no. 1 (2005), 124.

<sup>315</sup> The proposed bills C-56, C-13, and the successful Bill C-6 do not differ much in language. Slight changes in wording, the addition of a sub-clause periodically throughout the bills, are the only changes visible to the lay-reader.

<sup>316</sup> House of Commons of Canada, *Bill C-6, An Act respecting assisted human reproduction and related research*. February 11, 2004.

medical funding.<sup>317</sup> Another legal case over NRTs, *Prattern v. British Columbia*, has challenged the constitutionality of sperm donor anonymity. Prattern was conceived through artificial insemination and now, as an adult she is fighting for donor files to be kept and made accessible to the children of sperm donors for medical and psychological health reasons.<sup>318</sup>

Canada has not yet witnessed such sensational cases as the birth of Nadya Suleman's octuplets in California, which earned her the name "Octomom," or the accidental implantation of another couple's embryo in an Ohio woman's uterus in 2009.<sup>319</sup> It would be very interesting to know what reaction the federal government would have if similar cases occurred in Canada.

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<sup>317</sup> Reference re Assisted Human Reproduction Act, 2010 SCC 61. (Dec. 22, 2010) accessed online at: <http://scc.lexum.org/en/2010/2010scc61/2010scc61.html>  
<http://scc.lexum.org/en/2010/2010scc61/2010scc61.html>

<sup>318</sup> Angela Cameron, Vanessa Gruben, and Fiona Kelly, "De-Anonymising Sperm Donors in Canada: Some Doubts and Directions," *Medical Law International*, (forthcoming) 10, no. 3 (2010), 6,7. If sperm donor anonymity is deemed unconstitutional the litigant, and other children born of sperm donors, will have retroactive access to information about their fathers thus compromising the sanctity of woman-led families.

<sup>319</sup> Associated Press. "Woman with wrong embryo gives birth," *CBC online*. Accessed April 4, 2011 at: <http://www.cbc.ca/news/world/story/2009/09/26/wrong-embryo.html>

## Appendix A

### New reproductive technologies considered in this thesis

Amniocentesis – a procedure in which a sample of amniotic fluid from the uterus is examined for serious abnormalities. It will detect chromosomal abnormalities, the sex of the fetus, and the rate of maturity of major organs.

Artificial insemination – A concentrated dose of donor's sperm is washed and injected into a woman's uterus with a catheter for the intentions of attaining pregnancy.

Chorionic villi biopsy – tissue from the chorionic villi is tested for birth defects in the early stages of pregnancy.

Cryopreservation (of sperm, ova, embryos) – The genetic material is frozen for future use. The cryopreservation of eggs is commonly used in IVF treatments to allow multiple embryo transfers from a single egg collection.

Egg donation – eggs from a woman are given to another woman for implantation. The eggs are treated as the second woman's own.

Embryo transfer – one or more embryos are placed in the uterus of a woman to attain pregnancy.

Gamete intrafallopian transfer (GIFT) – a woman's ovaries are stimulated to retrieve eggs. The eggs are then put into a catheter, then a bubble of air, then some spermatozoa. There is no manipulation of the embryo.

Germ-line therapy – manipulation of germ cells which would be transferred to future generations thus altering the genetic line forever.

Intraperitoneal fertilization – sperm is injected into the rectouterine pouch to inseminate a mature egg. The eggs are then naturally aspirated by the fallopian tube or by a doctor and implanted in the uterus.

In vitro fertilization – An egg is removed from mother and is fertilized outside the body in a petri dish. The embryo is then implanted in the mother's uterus.

Surrogacy – a third party mother agrees to be inseminated by the intended father. The biological mother then agrees to give up parental rights to the offspring and the intended mother assumes her role as parent.

Somatic gene therapy – The treatment of an individual's cells to correct an absent or malfunctioning gene. This does not affect the gamete cells and no permanent alteration to the genetic line is made.

Ultrasound – sound waves penetrate the mother's uterus and are reflected off its

contents. The image shows the fetus in the womb.

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